Trust Policy

Management and Implementation of National Best Practice Guidance Policy

Issue Date	Review Date	Version
September 2018	June 2023	3.1

Purpose

The purpose of this Policy is to set out the Trust's approach to ensuring the uptake of national clinical guidance recommendations into practice according to a set of core implementation principles and to detail the key responsibilities for operating and governing the process.

Who should read this document?

All Trust staff who have a role in bringing national guidance recommendations into Trust practice.

Key Messages

- Best practice guidance includes, but is not limited to, all forms of NICE guidance, guidance issued by Royal Colleges and the outputs of the National Confidential Enquiries.
- All relevant guidance must be assessed, reviewed and implemented to a timescale appropriate for the type of guidance. The expected timescales are presented in Appendix 1.
- The Trust has adopted a three tier model for review and implementation of NICE guidance:
  - **Level 1**: Guidance that is straightforward and speciality specific will be assigned to a Service Line to manage and will utilise the Implementation Lead Clinician model.
  - **Level 2**: Guidance that affects multiple Service Lines will be managed at Care Group level. Responsibility for review and implementation of the relevant recommendations will be assigned to relevant service lines but co-ordination and oversight will be managed at Care Group level.
  - **Level 3**: Guidance that has Trust wide implications will be assigned to the established Lead for that subject or if such a role does not exist, will be reviewed in the first instance by Clinical Effectiveness Group (CEG) to determine how the review and implementation of the guidance should be managed.
- For Level 1 and Level 2 guidance, working in collaboration with the Implementation Lead Manager, Implementation Lead Clinicians are accountable for delivery of guidance (or a subset of guidance) and have the key role in providing the necessary leadership and expert clinical knowledge to drive the changes necessary to achieve full implementation.
- Service Line Managers, supported by Service Line Governance Teams, are responsible for progress monitoring any actions required to respond to recommendations that are not currently met.
- Service Line Managers are responsible for ensuring that Decisions to not implement Guidance (in full or in part) are approved by Service Line and Care Group Governance Committees prior to submission to Clinical Effectiveness Group for Trust approval.

- Service Lines are accountable to Care Group Management Teams for ensuring that applicable guidance is implemented and that declared compliance is based on robust, timely assessment and the arrangements for renewal of assessments in this policy are followed.
- The detail of compliance for NICE and National Confidential Enquiries is recorded in compliance registers managed by the Audit, Assurance and Effectiveness Team.
- The Audit, Assurance and Effectiveness Team operates a monitoring process to assess completion of timely self-assessment, follow-up assessment and further activities ensuring implementation of NICE guidance and National Confidential Enquiries recommendations.

Core accountabilities	
Owner	Julie Morgan, Head of Audit, Assurance and Effectiveness
Review	Clinical Effectiveness Group
Ratification	Medical Director/ Assistant Medical Director for Quality and Safety
Dissemination (Raising Awareness)	Emma Talliss, Assurance Officer
Compliance	Clinical Effectiveness Group

Links to other policies and procedures
Procedure for Review and Implementation of Recommendations from Maternal and Perinatal Mortalities National Enquiries. Clinical Audit Policy The Introduction of New Clinical Devices and Procedures Policy

Version History		
1	August 2012	Implementation of Recommendations of National Confidential Enquiries into Suicide and Homicide (CISH) Policy, National Confidential Enquiries into Patient Outcomes and Deaths (NCEPOD) – Policy for Reporting Enquiries, High level Enquiries – Policy for Implementation of Recommendations and Implementation of NICE Guidance Procedure and Monitoring Process combined to produce single Policy for the Management and Implementation of National Guidance and Enquiries
2	May 2015	Policy updated to reflect a review of the policy, processes and governance arrangements for assessing compliance with national best practice guidance.
3	June 2018	Update to reflect review of process and include guidance published by Royal Colleges.
3.1	September 2018	Minor amend to approval process for decisions not to implement relevant recommendations for Level 3 guidance – amendment requested by Safety and Quality Committee.

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

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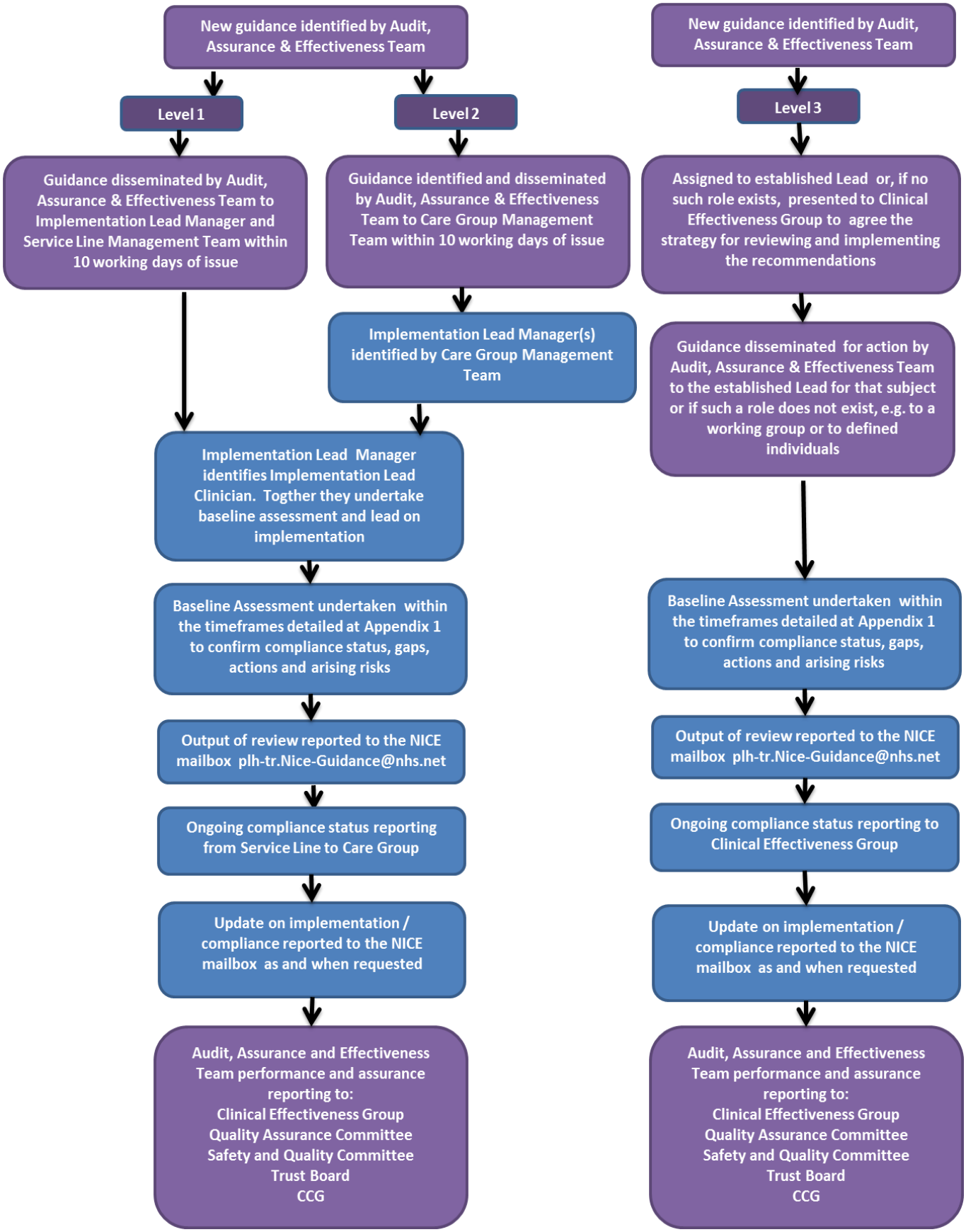
1 NICE Guidance Process Overview



2 Introduction

The implementation of national guidance issued to the NHS is a key aspect of the Trust's approach to providing clinically and cost effective services. Wherever possible, the Trust intends to use all available national best practice guidance applicable to its services to the maximum benefit of patients.

This means a commitment to effectively translating national recommendations into demonstrable improvements in practice. Timely implementation of recommendations is important in achieving a high quality, nationally consistent service that will meet patients' expectations.

3 Purpose

This policy sets out the processes by which the Trust can achieve consistent and timely uptake of all relevant recommendations, the arrangements for governing the processes and the method for assuring the Board and the Trust's regulators and commissioners of timely implementation.

A flow chart outlining the process for NICE guidance is detailed in section 1.

4 Duties

Trust Board
The Trust Board needs to be assured that the Trust has an appropriate process in place to manage the response to national guidance and enquiries and will seek this assurance from the Clinical Effectiveness Group and Quality Assurance Committee via Safety and Quality Committee.

Chief Executive
The Chief Executive is ultimately accountable for the process of responding appropriately to national guidance and enquiries. The Chief Executive delegates this responsibility to the Medical Director.

Medical Director
The Medical Director is accountable for ensuring that there is a co-ordinated approach to governing national guidance implementation across the Trust.

Responsibility for providing clinical leadership to the governance arrangements designed to ensure effective consideration and implementation of national best practice guidance is delegated to the Assistant Medical Director for Quality for NICE and National Confidential Enquiries into Patient Outcome and Death and to Care Group Directors for all other guidance.

Assistant Medical Director for Quality
The Assistant Medical Director for Quality is responsible for providing clinical leadership to the governance arrangements designed to ensure effective consideration and implementation of NICE guidance. With the support where required of the Clinical Effectiveness Group, the Assistant Medical Director for Quality is also responsible for ensuring that assessments of applicability of NICE guidance to the Trust and assessments of compliance are robust and based on sound judgement and evidence.

Head of Audit, Assurance and Effectiveness
The Head of Audit, Assurance and Effectiveness is responsible for ensuring that appropriate arrangements are in place for facilitating the consideration of all national best practice guidance published by NICE and recommendations arising from National Confidential Enquiries, for monitoring compliance with this policy and reporting compliance status and the efficacy of the governance arrangements to Clinical Effectiveness Group, Quality Assurance Committee, Safety and Quality Committee and to external regulators and commissioners.

Audit, Assurance and Effectiveness Team
The Audit, Assurance and Effectiveness Team is responsible for:

- Acting as the co-ordination point for all national guidance published by NICE and National Confidential Enquiries within the Trust, disseminating information to the relevant leads and maintaining oversight of the implementation of NICE guidance and National Confidential Enquiries. This includes liaison with the Clinical Effectiveness Governance Manager at the Clinical Commissioning Group regarding commissioning arrangements for NICE-approved interventions.
- Maintenance and development of the compliance registers which provide the definitive record of assessment activity and compliance status for all relevant NICE guidance and National Confidential Enquiries.
- Providing updates on the Trust's position in relation to NICE guidance and National Confidential Enquiries to the Head of Audit, Assurance and Effectiveness, highlighting any organisational gaps in compliance, areas of organisational learning and escalating recommendations that are at high risk of breach to allow urgent action to be taken. Receipt of reports as detailed at Appendix 1 will underpin these updates.
- Reviewing the effectiveness of the working processes involved in the identification, dissemination and reporting of NICE guidance and National Confidential Enquiries.
- Co-ordinating organisational responses to NICE consultations.
- Reviewing planned clinical audits to ensure that all appropriate linkage is made between guidance and planned audit priorities.

Implementation Lead Manager
The Implementation Lead Manager is usually a Service Line Manager. Implementation Lead Managers are accountable for ensuring that:

- an appropriate individual is assigned as Implementation Lead Clinician;
- baseline assessment, action planning and reporting requirements are undertaken in accordance with this policy;
- effective mechanisms are in place to identify, manage and report issues representing non-compliance;
- risks are subject to thorough assessment according to the Risk Management process, including appropriate scoring and inclusion on the risk register; and
- guidance-informed development priorities are built into local business plans.

Implementation Lead Clinician
Working in collaboration with the Implementation Lead Manager, Implementation Lead Clinicians are accountable for delivery of a piece of guidance or subset of guidance and have the key role in providing the necessary leadership and expert clinical knowledge to drive the changes necessary to achieve full implementation. The Lead Clinician can be any appropriate senior health professional. They are

required to work closely with the Service Line / Care Group Management / Governance team and with their own and other clinical teams / leaders. To facilitate this work, appropriate administrative / managerial resource should be identified by the Service Line Manager. For Level 3 guidance, appropriate resource may be assigned by the Medical Director.

The Implementation Lead Clinician's responsibilities are primarily to:

- Apply their expert knowledge of the guidance topic and clinical area to the baseline self-assessment and advise on the key compliance gaps, actions and risks. This is completed with the support of the Lead Implementation Manager.
- With the assigned Implementation Lead Manager, lead any necessary re-design of their service, ensuring that all affected are engaged in the development and that audit / measurement arrangements are effectively deployed.
- With the assigned Implementation Lead Manager, engage fully with the commissioners / the wider health community where necessary to ensure effective implementation.
- With the Implementation Lead Manager and others, report on updates on implementation progress to the Service Line Management Team, Care Group Management Team and Audit, Assurance and Effectiveness Team at a frequency determined by the type of guidance (see table, Appendix 1).

Service Line Clinical Directors support the role of the Implementation Lead Clinician (if not undertaking the role) and work with the Service Line Manager to develop services in line with action plans, review new organisational self-assessments, validate the self-assessed position and any risks, and agree priorities for clinical audit.

Clinical Governance Leads have responsibility for ensuring that they are aware of all guidance with implications for their speciality or service line and that it is governed according to this policy. Clinical Governance Leads promote evidence based practice by supporting and embedding the implementation of national guidelines and standards.

Care Group Clinical Directors and Managers are accountable for ensuring that:

- Service Lines are responding appropriately to Level 1 national guidance and enquiries.
- Level 2 Guidance is effectively managed within the Care Group.
- Effective support is provided for the implementation of Level 3 guidance.

Care Group Quality Managers support the implementation of this policy within their Care Groups.

The **Director of Operational Finance** has overall responsibility for ensuring the timely funding of NICE guidance, effective forward planning where possible and ensuring that exceptions are appropriately addressed with Management Accountants. Management Accountants, with Service Line Managers, will normally have responsibility for costing of NICE guidance; however this role may be better placed with a specialist individual familiar with the technology or service.

Pharmacy
The Medication Safety Officer (MSO) Pharmacist has responsibility for co-ordination of NICE Technology Appraisal Guidance (TAGs) which makes recommendations on the use of new and existing drugs to ensure that:

- NICE TAG Applications are completed by nominated **clinicians**, indicating that their clinical practice complies with the guidance, identifying any financial or service implications and highlighting any difference in expected local patient numbers compared to the NICE prediction.
- Completed applications are considered and approved by the **Medicines Utilisation and Assurance Committee**.
- Care Group and Service Line Lead Clinicians and Managers and the Clinical Effectiveness Lead are notified of decisions made by the Medicines Utilisation and Assurance Committee.

Pharmacy prepares monthly reports for the Medicines Utilisation and Assurance Committee outlining any outstanding TAGs.

The Clinical Commissioning Group automatically adds TAGs to the Formulary 60 days after issue by NICE.

Clinical Effectiveness Group
The Clinical Effectiveness Group (CEG) is the central monitoring committee charged with overseeing governance of best practice guidance. It is an advisory and co-ordinating group enabling peer review and learning to take place between Care Groups with respect to guidance implementation, clinical audit and other measurement activity. The NICE compliance register is used to identify where barriers to implementation of either the guidance or this policy in relation to it (or both) lies. CEG serves to:

- ensure robust governance arrangements according to this policy are functioning by receipt of reports from the Assurance Officer;
- assist in resolving issues presenting barriers to guidance assessment or implementation;
- consider and have oversight of Level 3 guidance to ensure a co-ordinated response across the relevant parts of the organisation;
- review the assurances provided by Care Groups in relation to specific guidance programmes;
- agree issues appropriate for escalation via exception reporting on to the Safety and Quality Committee and commissioners; and
- ensure appropriate standards of governance and practice are met in the introduction of new practices and procedures in line with national guidance.

The Trust National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Local Reporter (Head of Audit, Assurance and Effectiveness) has responsibility for ensuring that the Trust responds to applicable data requests from the NCE co-ordinating centres. They act as the main point of contact and ensure the involvement of the Medical Director and Clinical Leads when a new NCEPOD study is announced, to ensure that all parties are aware of their obligations for participation. The Deputy Audit, Assurance and Effectiveness Manager supports the NCEPOD Local Reporter in fulfilling this role.

5 Definitions

National best practice guidance is clinical guidance issued to the NHS from national government, professional and expert sources. For the purposes of this policy these sources are considered primarily to include:

National Institute for Health and Care Excellence (NICE)

An independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health (http://www.nice.org.uk/Guidance). The guidance published by NICE includes the following:

Guidelines (clinical, social care and public health): General guidance. NICE guidelines each cover a range of practice and interventions, with recommendations ranging from 'must do' (where compliance with legislation is required) and 'should do' (where there is strong evidence of effectiveness), to 'don't do', where compelling evidence that an intervention is ineffective or harmful has been identified.

Safe Staffing Guidelines: Definitive guidance on safe and efficient staffing levels in a range of NHS settings identifying organisational and managerial factors required to support safe staffing.

Cancer Services Guidance (CSG): NICE Improving Outcomes Guidance for Cancer is a sub-set of the Guidelines programme that focuses on the planning, commissioning and organisation of cancer services. Implementation and monitoring is largely assured via the Cancer Peer Review Process and through Service Specifications.

Antimicrobial prescribing guidelines: These guidelines help the NHS make the best use of antibiotics, as part of the broader antimicrobial stewardship effort.

Quality standards: The statements in Quality Standards identify important aspects of practice in which there is significant variation across the NHS.

Interventional Procedures: Interventional procedures offer advice about the safety and effectiveness of surgical techniques and some other kinds of procedures. Advice normally relates to the kind of consent (normal or special) required from patients before the procedure is undertaken, but in a small number cases, where major safety concerns have been identified, a 'do not use' recommendation is made.

Technology appraisals and highly specialised technologies: This guidance can 'recommend' the use of a new drug or other treatment, 'optimised use', in which the recommendation is positive for some but not all uses, or 'not recommend' routine use in the NHS. Research only use is also sometimes recommended.

Medical technologies: Guidance on new medical technologies (medical devices) is normally framed in terms of whether or not the case for use in the NHS has been successfully made by the manufacturer.

Diagnostics guidance: New diagnostic techniques are recommended or not recommended for routine use in the NHS, or sometimes for research.

Evidence summaries and medtech innovation briefings: Both publications provide information (but not guidance) about a particular topic.

Surveillance reviews: These reports bring knowledge of current evidence on guidance already published up to date.

Royal College Guidance
The Royal Colleges produce guidelines based on the best medical evidence as an aid to good clinical practice.

National Confidential Enquiries
National Confidential Enquiries are nationally defined as Clinical Outcome Review Programmes that are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness. The Enquiries aim to improve clinical practice through the investigation of deaths in specific circumstances and comprise:

- The Medical and Surgical Programme (NCEPOD).
- The Child Health Programme (NCEPOD).
- The Mental Health Programme: National Confidential Inquiries into Suicide and Homicide by People with a Mental Illness (NCI/NCISH).
- The Maternal Newborn and Infant Programme: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

Other guidance to which the Trust must have regard

The processes for organisational assessment and the assurance/governance arrangements described in this Policy can equally apply to other sources of recommendations including high-level Enquiries / Inquiries for example, Lord Laming's House of Commons Health Committee report: The Victoria Climbié Inquiry Report (addressing Children's Safeguarding) and National Audit reports.

Self-assessment / gap analysis

Self-assessment is a structured review of the relevance, implications and level of compliance with recommendations issued within national guidance. It clearly identifies the gaps in terms of standards of practice not yet attained. It therefore provides the basis for identifying actions and resources required to enable implementation and compliance.

Effective translation of recommendations into practice is assisted by adoption of the following five core principles:

1) Receipt by the organisation and assignment of responsibility for implementation to those with management responsibility and key influence upon / expert knowledge of the topic.

2) Thorough and timely review of the implications via a baseline organisational self assessment / gap analysis.

3) Effective communication and joint working between clinical leaders, management teams and, where required, with commissioners.

4) Effective processes for effecting change to practice where the need is identified.

5) Effective and efficient evaluation of practice, measured against the standards set within the guidance.

Section 6 sets out how these principles are embedded in the Trust's processes.

6 Dissemination, implementation and monitoring of national best practice guidance

This section sets out a generic approach expected to be followed for national clinical guidance, although the process particular to each guidance type may vary and the specifics for the management of NICE guidance are clearly stated.

The Trust has adopted a three tier model for review and implementation of NICE clinical guidance:

Level 1: Guidance that is straightforward and speciality specific will be assigned to a Service Line to manage and will utilise the Implementation Lead Clinician model.

Level 2: Guidance that affects multiple Service Lines will be managed at Care Group level. Responsibility for delivery will be assigned to service lines but co-ordination and oversight will be managed at Care Group level. There may be some exceptions such as those in infection control where a lead is already in place and resourced to deliver what is required; such guidance would be managed as Level 1.

Level 3: Guidance that has Trust wide implications will be assigned to the established Lead for that subject or if such a role does not exist, reviewed in the first instance by Clinical Effectiveness Group (CEG). CEG will determine how the review and implementation of the guidance should be managed. It may be appropriate for example to appoint leads in each Care Group or to allocate specific recommendations to appropriate individuals. Consideration should be given to convening a guidance-specific working group, or assigning the work to an appropriate Specialist Group. The overall assessment / implementation timeframe may reasonably be extended where this applies. If appropriate and if the Guidance is of significance to the Trust, additional resource may be assigned to support the review and implementation of a piece of Guidance by the Medical Director. Progress would be overseen by an appropriate person e.g. a named clinician, a member of the Audit, Assurance and Effectiveness Team, a Service Improvement lead or by a member of the Quality Faculty. CEG would monitor progress and implementation. The principles described in the following sections will apply.

Process for identifying relevant documents and assigning responsibility for implementation

Relevant NICE guidance is identified via the newly published guidance available on the NICE website by the Audit, Assurance and Effectiveness Team.

The Assurance Officer ensures the addition of newly identified NICE guidance to the compliance register and, for Level 1 and 2 Guidance assigns the guidance to a Care Group, Service Line and an Implementation Lead Manager. Any difficulties with assignment are initially raised with the Care Group Management Team. Implementation Lead Clinician assignment is agreed in Service Lines, unless the scope of the guidance substantially affects more than one Service Line, in which case the Care Group Management Team or Assistant Medical Director for Quality / Medical Director will agree assignment. Responsibility for Level 3 Guidance is assigned by Clinical Effectiveness Group unless there is an established lead for the subject.

Other national best practice guidance is identified by Service Lines e.g. via the Royal College websites. The Service Line is expected to identify an appropriate lead to implement the guidance and disseminate to all interested parties.

Process for disseminating NICE guidance
Within ten working days of publication, the Clinical Effectiveness Administrator sends a standard email for each piece of newly published NICE guidance to the Identified Implementation Lead Manager which includes a link to all related documents and assessment tools. This email is copied to the Service Line Manager (if they are not the Identified Implementation Lead Manager), Service Line Clinical Director and Service Line Clinical Governance Lead. For Level 2 Guidance this will be sent to the Care Group management team.

Process for conducting self-assessments (gap analyses) and developing implementation action plans
The principle of organisational self-assessment applies to all guidance that is of relevance to the Trust.

Guidance that, on initial review, is considered not relevant to the scope of the Trust's services can be registered as such without further assessment. Where only selected recommendations impact on Trust services, compliance assessment is conducted for the relevant elements only.

Self-assessments form a record of:

- which recommendations are relevant and which are not;
- which recommendations are currently met and which are not met;
- what needs to happen and what level of resource (including financial) would be required to address identified non-compliance;
- the assessed level of risk associated with non-compliance;
- who will take responsibility for each action; and
- the target timeframe for each action.

Recommendations not met and without an intention to implement will not have actions but must be explicit within the assessment record. These must be addressed via the arrangements for 'decision to not implement' - see page 17.

The format for assessment and the expected timeframe for assessment completion will vary according to the guidance type. The target timeframes for completion of an initial assessment / action plan for each guidance type are as presented in Appendix 1. The approach to assessment will also be modified if prior guidance has been assessed addressing the same / a similar topic or service area. National Confidential Enquiry reports and (from April 2010) NICE Clinical Guidelines are issued with a pre-prepared baseline assessment table which the Trust uses and adapts as required. A generic assessment template (see Appendix 2) is available from the Clinical Effectiveness page on Staffnet. This follows a format that can be used for most assessment needs; however this policy intentionally does not specify a set format.

Sufficient administrative support must be provided within Service Lines to enable timely assessment. For Level 3 guidance this support may be assigned by the Medical Director.

In some circumstances a more global position statement may be considered more appropriate than a per-recommendation analysis. An assessment structured according to the recommendations within the guidance should however be considered the norm. A baseline compliance self-assessment (gap analysis) for all newly issued Trust-relevant guidance underpins an initial declaration of the level of compliance and should directly inform production of an action plan for implementation. Typically it is not expected that a separate action plan is required since the self-assessment is the action plan.

For extensive gap analysis tables, it is good practice to produce a separate 'key gaps' record to distil the record down to those items requiring onward action and monitoring. This aids clarity and governance of the action plan. All actions stated should be produced according to the S M A R T acronym: Specific, Measurable, Achievable, Realistic (and within Resource), and Time-bound. Individuals assigned action must be consulted and made aware of the timeframes expected.

For extensive implementation programmes, a dedicated action plan will be required separate from the gap analysis. The Implementation Lead Manager will lead production of the action plan where this is required. It may be appropriate to implement a targeted approach addressing the most important issues first.

The receipt of new or updated best practice guidance is likely to necessitate the review of existing clinical guidelines or development of new guidelines. Clinical guidelines should reflect best practice and not just the operationally possible. If there is a gap between best practice and what is currently operationally possible then this should be assessed and plans put in place to develop a business case, implement practice change or secure additional funds. This should be added to the risk register as required. Where the national guidance is not possible to operationalise, an exception report should be produced outlining why the guidance is not followed, together with, what (if any) action plans are required to ensure current practice is altered. This should be reported to Service line and Care Group governance meetings prior to reporting to Clinical Effectiveness Group.

Where implementation of a recommendation will require investment then commissioning intent must be sought prior to implementation. Where this relates to NICE guidance, such issues must be escalated to the Assurance Officer in the Audit, Assurance and Effectiveness Team.

Any funding requirements that emerge from the compliance assessment should be escalated through the Trust's financial approval processes. This should be the responsibility of the Service Line Manager and be compliant with the Trust's financial standing orders and detailed scheme of delegations. This will mean financial approval will be required by the Service Line Manager, Care Group Manager, Director of Finance or Trust Management Executive as per the delegated limits in these documents. Funding sources (or lack of) for any such pressures need to be made clear. The Finance Department through the Business Advice and Management Accounts Team can support the Service Line in assessing the funding required. Where appropriate the correct procurement procedures should also be applied.

Where guidance or enquiries cross organisational boundaries, the Implementation Lead Manager will initially only be expected to respond to those elements of the guidance which are relevant to the services we provide. Where multi-agency working parties are convened to consider the implementation of guidance across

organisational boundaries then the relevant leads will be expected to contribute to this process.

For NICE guidance, failure to complete a required self-assessment (or progress position statement) to an adequate quality and timeframe will be addressed via escalation to the Service Line Management Team in the first instance, then to the Care Group Management Team, and, if required, to the Clinical Effectiveness Group. This escalation will be initiated by the Audit, Assurance and Effectiveness Team and tracked on the compliance register.

Risk Assessing compliance gaps
The Implementation Lead Manager should ensure that for each issue of non-compliance, a risk assessment is undertaken and recorded on Datix identifying the consequence and likelihood of non-compliance in line with the Trust's Risk Management processes. The risk rating will be recorded on the action plan.

Process for recording compliance status
On completion, all assessments for NICE guidance must be submitted to the NICE Guidance mailbox (plh-tr.Nice-Guidance@nhs.net). The self-assessments and action plans are reviewed by the Audit, Assurance and Effectiveness Team with the support where required of the Assistant Medical Director for Quality and reported to the Clinical Effectiveness Group. Any compliance gaps or issues that may require escalation will be reported to the Care Group Management Team for resolution in the first instance.

A central record of assessment and corresponding compliance status for NICE guidance is maintained by the Assurance Officer on the compliance register. This includes the compliance position according to the scheme detailed at Appendix 3. The register provides Service Lines and Care Groups with the source data for all governance / compliance / performance reporting and an extract of the NICE and NCEPOD records is available from the Clinical Governance Leads drive.

Service Lines are expected to follow a similar approach for all other national best practice guidance applicable to their service.

Process for ensuring that recommendations are implemented
The identified lead is expected to provide details on the gap analysis on how the guideline will be monitored or audited and if local guidelines need to be updated.

Service Line Managers are responsible for monitoring progress on action plans for all guidance applicable to their services and ensure that the Service Line Governance Committee is alerted to issues preventing full uptake of recommendations.

All active assessments / action plans must be monitored within Service Lines to ensure that relevant recommendations are acted upon, for example at specialty review meetings where these are established. Care Group Management Teams, through their Governance Committees, must be assured of compliance and progress on relevant action plans via routine reports and exception reports from Service Lines.

Service Line-level review of exceptions and available assurance from Service Lines on service-level implementation progress must be undertaken to an agreed schedule of reporting, as set by the Care Group Governance Committee.

In gaining updates from Implementation Leads on continued progress with action plans designed to address areas of partial or non-compliance, the following principles apply:

- Summary progress statements from Leads can be accepted as assurance and as a basis for reviewing compliance categories (Appendix 3).
- The following should be clearly established:
  - Remaining gaps and accompanying actions including a statement on progress to planned time frames.
  - Risk assessment as applicable.
  - Use of recommendations to inform approved guidelines, protocols etc.
  - Progress with any planned clinical audit or other data capture, and any known outputs / indicators that inform compliance.

The Assurance Officer will seek regular updates on progress with the implementation of NICE guidance at a frequency determined by the timescales set within the action plan. Progress will be routinely reported to Clinical Effectiveness Group. All areas of non-compliance with, or derogation from, NICE guidance is to be reported to Clinical Effectiveness Group, Safety and Quality Committee and Trust Board.

Exceptions in terms of areas of non-compliance and derogation from Royal College and other best practice guidance should be included in Core Service self-assessments and Care Group Annual Governance Reports to Quality Assurance Committee. Any concerns can be escalated from Quality Assurance Committee to Clinical Effectiveness Group and to Safety and Quality Committee.

Timescales for review of compliance status

Implementation Lead Managers will be requested to re-confirm the compliance status for NICE guidance in accordance with the following timescales:

Status	Timeframe
Not applicable	Review the decision every 3 years from last assessment.
Decision not to implement	Review the decision every 2 years from last assessment.
Compliant	Review every 3 years. Check there is evidence to demonstrate ongoing compliance.

Ongoing assurance on compliance is strengthened when supported by a range of internal and external sources. Linkage to (for example) the performance attained within related national audits, external accreditation / inspection feedback, peer reviews, continuous measurement programmes and national clinical outcomes benchmarking can be integrated into progress reporting, where applicable. These sources will together often be applicable to a service rather than specific guidance.

Clinical audit

Where guidance has been considered as a priority for audit as part of the annual Service Line audit programme planning cycle, the outputs of the audits will be reported to the relevant service line forum to enable learning and improvement where needed. Guidance Implementation Lead Clinicians will take the lead in acting on the results of audits.

As common national priorities frequently drive both national audit programmes and national guidance production, national audit participation should be considered the

mainstay of assurance, noting that national audit reports themselves are a source of recommendations to further inform local delivery. Available nationally-defined quality standards / indicators should inform local measurement and improvement activity.

Decisions to not implement relevant recommendations
The Trust recognises that on occasion justifiable alternative practices may exist and it is therefore not always appropriate to implement published guidance either in full or in part.

For guidance relating to a single Service Line, it is for the Service Line Governance Committee to consider any decisions to not implement recommendations and to ensure that the reasoning for non-uptake is explicit. Any decision to not implement must be justifiable and risk assessed. The risk assessment must be recorded on Datix. The exception must be reported to the Care Group Management Team, Audit, Assurance and Effectiveness Team and approved by the Clinical Effectiveness Group. Where significant resource constraints inhibit uptake, the reporting must permit Executive ownership of decisions regarding the impact. It must be explicit whether the non-compliance will be considered permanent or whether plans will be made to allocate or bid for resource in the longer term.

For Level 2 guidance it is for Care Group Governance Committee to consider any decisions to not implement recommendations and to ensure that the reasoning for non-uptake is explicit. Any decision to not implement must be justifiable and risk assessed. The exception must be reported to the Audit, Assurance and Effectiveness Team and approved by the Clinical Effectiveness Group.

For Level 3 guidance Clinical Effectiveness Group will determine, based on advice from the relevant clinical specialists, and with reference to Trust priorities, whether guidance, or elements of a piece of guidance, will not be implemented. These decisions will be approved by Clinical Effectiveness Group.

Unless anything changes in the interim, all decisions not to implement guidance should be reviewed every two years to determine whether the original decision remains relevant or should be reconsidered.

NCEPOD
The Deputy Audit, Assurance and Effectiveness Manager supports the NCEPOD Local Reporter by acting as a link between the non-clinical staff at NCEPOD and University Hospitals Plymouth NHS Trust compiling and sending datasets that are requested by NCEPOD, identifying suitable sample cases for specific studies, distributing questionnaires to clinicians, contacting the relevant clinicians to inform them about the study and what will be required of them and supporting clinicians in participating, such as assistance with the retrieval of medical records. The Deputy Audit, Assurance and Effectiveness Manager ensures that data is provided to NCEPOD in the required format by the date requested. The resulting NCEPOD Report will be subject to the processes described above for dissemination, gap analysis, risk assessment and implementation.

The **Procedure for Review and Implementation of Recommendations from Maternal and Perinatal Mortalities National Enquiries** deals with all enquiries related to mothers and babies and is dealt with exclusively within the Women and Children's Care Group.

The relevance to the Trust of recommendations resulting from **National Confidential Inquiries into Suicide and Homicide by People with a Mental Illness** will be assessed by the Deputy Audit, Assurance and Effectiveness Manager. Any recommendations deemed to be relevant to the Trust will be disseminated and acted upon in accordance with this Policy.

7 Consultation and approval

The design and process of review and revision of this policy document will comply with the Trust's formal policy on policy and procedural documents.

The review period for this policy document is set as five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision of the policy.

This document is approved by the Trust's Clinical Effectiveness Group and ratified by the Medical Director.

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

A copy of the policy will be disseminated to all Care Group Directors, Care Group Managers, Service Line Clinical Directors, Service Line Managers, Clinical Governance Leads and Care Group Quality Managers.

Document control arrangements will be in accordance with the Trust's formal policy on policy and procedural documents.

9 Monitoring Compliance and Effectiveness

The Audit, Assurance and Effectiveness Team will provide the Service Lines with regular access to a summary of the compliance status for all NICE guidance applicable to the Service Line. Quarterly exception reports will be provided to the Care Groups.

Clinical audit has a key role in ensuring that NICE and National Confidential Enquiries Report recommendations are adopted into practice and providing assurance of ongoing compliance. The monitoring processes operated by the Clinical Audit Team and linked to the Clinical Audit policy will also contribute to national guidance monitoring arrangements: The evaluations will be reported to the Clinical Effectiveness Group and any arising issues communicated to Care Groups via quarterly reporting from the Audit, Assurance and Effectiveness Team.

The output of this monitoring together with recommendations and actions to address any arising issues will be reported to the Clinical Effectiveness Group who will monitor implementation of any actions identified in accordance with the severity of the issues arising.

Assurance on the effectiveness of the Trust's arrangements for reviewing and implementing NICE guidance and National Confidential Enquiries will also be reported to the Quality Assurance Committee annually within the Clinical Effectiveness Topic Compliance Assessment.

Management of Royal College and other best practice guidance should be included in Core Service self-assessments and Care Group Annual Governance Reports to

Quality Assurance Committee. Any concerns can be escalated from Quality Assurance Committee to Clinical Effectiveness Group and Safety and Quality Committee.

10 References and Associated Documentation

http://www.nice.org.uk/

NICE Implementation Guide (2005)

Into Practice Guide: Using NICE guidance and quality standards to improve practice (2013)

http://www.ncepod.org.uk/links.htm

Taunton and Somerset NHS Foundation Trust Policy: National best practice guidance – assessment, implementation and governance

Format and timescales for initial self-assessment, assessment review and full implementation - according to guidance type

Appendix 1

Guidance Type	Format for assessment	Target timeframe for initial self-assessment	Implementation period	Milestone reporting	Audit expectation
NICE Technology Appraisal Guidance (TAGs) (Drugs)	Structured template	2 months	3 months (DH mandate)	Not usually required (exception reporting applies)	For selected audit, priority according to experience in use and criteria for use.
• **NICE Guidelines (Clinical, Social Care and Public Health)** • **Safe Staffing Guidelines** • **Cancer Services** • **Antimicrobial Prescribing guidelines** • **NICE Quality Standards**	NICE baseline assessment tool or UHPNT baseline assessment tool (Appendix 2)	Contained within single service: 3 months (Level 1) If wide stakeholder group and/or extensive recommendations extension up to 6 months by Service Line agreement (Level 2/3)	Dependent upon scale of change / additional funding required.	Where gaps in compliance exist, this will be determined by the Assurance Officer based upon the timescales set within the Action Plan.	All for consideration in audit programmes.
NICE Interventional Procedures	UHPNT baseline assessment tool (Appendix 2)	*3* months	No set expectation. If procedure is undertaken, the stated arrangements are expected to be followed.	Where gaps in compliance exist, this will be determined by the Assurance Officer based upon the timescales set within the Action Plan.	Audit expected if procedure adopted as a newly introduced intervention.
NICE Technology Appraisals (exc drugs) and highly specialised technologies	UHPNT baseline assessment tool (Appendix 2)	*3* months	Dependent upon scale of change / additional funding required.	Where gaps in compliance exist, this will be determined by the Assurance Officer based upon the timescales set within the Action Plan.	All for consideration in audit programmes.
• **NICE Medical Technology Guidance** • **Diagnostics Guidance**	UHPNT baseline assessment tool (Appendix 2)	*3* months	Dependent upon scale of change / additional funding required.	Where gaps in compliance exist, this will be determined by the Assurance Officer based upon the timescales set within the Action Plan.	Audit expected if adopted as new technology.
National Confidential Enquiry Reports e.g. NCEPOD **Other Guidance e.g. High Level Enquiries**	Baseline assessment table as supplied or, if not, UHPNT baseline assessment tool (Appendix 2)	Contained within single service: 3 months (Level 1) If wide stakeholder group and/or extensive recommendations extension up to 6 months by Service Line agreement (Level 2/3)	Dependent upon scale of change / additional funding required.	Where gaps in compliance exist, this will be determined by the Deputy Audit, Assurance and Effectiveness Manager based upon the timescales set within the Action Plan.	All for consideration in audit programmes.
Royal College and other national best practice Guidance	UHPNT baseline assessment tool (Appendix 2)	Contained within single service: 3 months (Level 1) If wide stakeholder group and/or extensive recommendations extension up to 6 months by Service Line agreement (Level 2/3)	Dependent upon scale of change / additional funding required.	Where gaps in compliance exist, this will be determined by the appropriate governance forum (e.g. Service Line Governance meeting) based upon the timescales set within the Action Plan.	All for consideration in audit programmes.

Assessment Template — Appendix 2

BEST PRACTICE GUIDANCE SELF-ASSESSMENT AND ACTION PLAN	
GUIDANCE REF AND TITLE:	
ISSUED DATE:	

RECC. REF	NICE RECOMMENDATION	APPLICABLE TO THE TRUST (YES/NO)?	CURRENT ACTIVITY/EVIDENCE	CURRENT COMPLIANCE (SELECT FROM DROP DOWN)	ACTIONS NEEDED TO IMPLEMENT RECOMMENDATION OR TO PROVIDE ASSURANCE OF COMPLIANCE	IS THERE A RISK ASSOCIATED WITH NOT IMPLEMENTING THIS RECC?	PERSON(S) RESPONSIBLE FOR ACTION	TARGET COMPLETION DATE	PROGRESS UPDATE ON ACTIONS

A copy can be located on Staffnet here:
http://staffnet.plymouth.nhs.uk/Departments/OtherSupportServices/ClinicalEffectiveness.aspx

Compliance category definitions
for use in compliance register and assurance reporting

Appendix 3

These definitions apply to the management of NICE guidance but can be applied to all other national best practice guidance.

Category	Category Definition
Compliant	Trust practice meets guidance recommendations.
Partial Compliance	• Gap analysis indicates that there are gaps in our current compliance and actions are required to achieve full compliance. • Identify the consequences/implications of not achieving compliance and add risk to Risk Register (Datix). • Judgement will be on basis of either self-assessed position and/or available data (including clinical audit findings).
Non-compliant	• Practice is at significant variance with the majority of or all recommendations. • The Trust is unable to implement due to interdependency with other organisations. • Judgement will be on basis of either self-assessed position and/or available data (including clinical audit findings). • Escalation of issues preventing compliance required immediately. Executive awareness must be ensured. • Liaison with commissioners may be required to agree plan for resolution. • Identify the consequences/implications of not achieving compliance and add risk to Risk Register (Datix). • All areas of non-compliance to be reported to Clinical Effectiveness Group, Safety and Quality Committee and Trust Board.
Decision not to implement	Indicates guidance that is applicable but for which there is currently no plan to implement. A formal decision not to implement must be submitted to and approved by Clinical Effectiveness Group. All areas of derogation from best practice guidance to be reported to Clinical Effectiveness Group, Safety and Quality Committee and Trust Board.
Not applicable, replaced or withdrawn	Indicates guidance that is not applicable to the Trust or has been withdrawn by NICE or superseded by newer guidance.
No status, either: • **New Guidance Response Overdue (Not known) or** • **New Guidance (<3 months since issue, response not yet due) (New)**	Indicates that this is new guidance for which a compliance assessment has not yet submitted.

Dissemination Plan and Review Checklist | Appendix 4

Dissemination Plan	
Document Title	Policy for the Management and Implementation of National Guidance & Enquiries
Date Finalised	June 2018
Previous Documents	
Action to retrieve old copies	To be managed by the Document Controller

Dissemination Plan

Recipient(s)	When	How	Responsibility
All staff		Vital signs	Document Controller
Care Group Directors, Care Group Managers, Service Line Clinical Directors, Service Line Managers, Clinical Governance Leads and Care Group Quality Managers.	July 2018	Personal email	Paul McArdle
Updated information to be available on StaffNET page	July 2018	Review and update page including key contact numbers, templates and tools	Deputy Audit, Assurance and Effectiveness Manager

Review Checklist		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes

Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment | Appendix 5

Core Information	
Date	June 2018
Title	Policy for the Management and Implementation of National Guidance & Enquiries
N.B. The Equality and Diversity Manager (Service) confirmed that this document does not require an Equality Impact Assessment.	