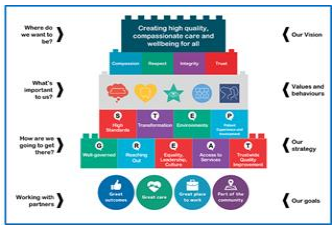


NHS
Leicestershire Partnership
NHS Trust

# Dissemination, implementation & monitoring of National Institute for Health and Care Excellence (NICE) Guidance Policy

This Policy describes the process for the dissemination, implementation, & monitoring, of National Institute for Health and Care Excellence (NICE) Guidance.

**Key words:** NICE, Guidance, Agreed Best Practice

**Version:** 10

**Approved by:** Clinical Effectiveness Group

**Ratified By:** Quality Forum

**Date this version was ratified:** May 2024

**Date issued for publication:** 29th May 2024

**Review date:** December 2025

**Expiry date:** July 2026

**Type of Policy:** clinical and non-clinical

# Contents

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## SUMMARY & AIM

It is necessary to have a consistent approach and a clearly identified process for the evaluation, dissemination, implementation, and monitoring of NICE guidance across LPT.

The purpose of this policy is to ensure the appropriate implementation of NICE guidance, in line with publications by NICE - Practical steps to improving the quality of care and services using NICE guidance (2018) and Principles for putting evidence-based guidance into practice (2018) and to comply with requirements as set out by the Care Quality Commission (CQC) Regulations 9 and 12.

## TARGET AUDIENCE:

All LPT staff.

## TRAINING

There is no training requirement identified within this policy.

## KEY REQUIREMENTS

This policy outlines the system and processes for the dissemination, implementation, and monitoring of NICE guidance throughout LPT. National "best practice" guidance enables staff to make evidence-based decisions about treatment and healthcare.

In the white paper *"First Class Service: Quality in the NHS"*, the Department of Health declared that all patients should have fair access to high quality care which is based on clear evidence of best practice (DH 1999). From this white paper came the implementation of the National Institute for Health and Care Excellence (NICE) and the National Service Frameworks (NSFs). As a result of the findings of the Francis report 2013, The Department of Health produced Hard Truths: The journey to putting patients first 2014. Reports by Keogh 2013 - 'Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report' and Berwick 2013 'Improving the Safety of Patients in England' highlighted failings in patient care and their safety' which provided the basis for further patient centred care guidance.

# 1.0 Quick look summary

Please note that this is designed to act as a quick reference guide only and is not intended to replace the need to read the full policy.

## 1.1 Version control and summary of changes

| Version number | Date | Comments (description change and amendments) |
|---|---|---|
| Version 1.0 | Dec 2011 | Harmonisation of former organisations' policies |
| Version 2.0 | Feb 2012 | Comments incorporated received from key staff. |
| Version 2.1 | 8 Feb 2012 | Policy approved at the Senior Clinical Quality Group subject to minor amendments. |
| Version 2.2 | 14 Feb 2012 | Gone to Quality Assurance Committee for ratification. |
| Version 3.0 | May 2013 | Revised policy |
| Version 3.1 | 15 Aug 2013 | Policy approved at Policy Group meeting subject to minor amendment in readiness to be adopted at the next QF meeting. |
| Version 4.0 | 17 Jun 2016 | Elena Relph & Julie Warner – Grammatical and reference amendments. Fern Barrell – Risk register and CEG involvement clarification.<br>Jude Smith - Confirmation of Clinical Directors' financial involvement. 360 Assurance – approval of BAT when compliant (see 6.7 point 2) |
| Version 5.0 | 1 Aug 2016 | Circulation list updated and sent to additional Clinical Directors (no additional comments received by deadline of 19 August 2016). |
| Version 6.0 | Dec 2016 | Reference to NHS Litigation Authority (NHSLA) removed from section 13 and appendix 4. |
| Version 7.0 | Jun 2018 | Amendments made due to movement of responsibility from CQETL to HOP. |
| Version 8.0 | Sept 2020 | Amendments made due to appointment of Associate Director for Quality Improvement and as a result of actions required in 360 Assurance Clinical Audit and NICE report. |
| Version 9.0 | June 2022 | Amendments made due to change of role from Associate Director of Quality |

| Version number | Date | Comments (description change and amendments) |
|---|---|---|
| | | Improvement to Head of Clinical Quality Governance.<br>Removal of references to other nationally agreed best practice including National Confidential Enquiries as these are dealt with via alternative routes.<br>Amendments following introduction of the NICE review group.<br>Updates to appendix 2 to include consideration of risk |
| Version 10 | April 2024 | Reference to CANQI (Clinical audit, NICE and Quality Improvement) amended to CEG.<br>NICE and Effectiveness Officer role title amended to Quality Improvement Practitioner (NICE).<br>References to collection of evidence on the BAT (baseline assessment tool) amended to include the option to record evidence in AMaT.<br>Reference to Quality Assurance Committee amended to Quality Forum.<br>Responsibilities that were assigned to CANQI moved to CEG section 5.9.<br>Responsibility of clinical staff section updated.<br>Paragraph added in section 6.2 relating to how compliance is recorded when there are gaps in service provided due to commissioning.<br>References and bibliography section updated. |

For Further Information Contact: lpt.WeImproveQ@nhs.net

## 1.2 Key individuals involved in developing and consulting on the document

| Designation |
|---|
| Associate Director of AHPs and Quality |
| Director of Corporate Governance |
| Trust Lead for QI and Quality Governance |
| QI Practitioner (NICE) |
| Medical Director |
| Chair of CEG |
| Head of Patient Safety |
| Head of Pharmacy |

| |
|---|
| Divisional Clinical Quality Governance leads for CHS, DMH and FYPC.LDA directorates |
| Head of Nursing - CHS, DMH and FYPC.LDA directorates |
| Chairs of DMH CASEQI, CHS SCT, FYPC.LDA Clinical Leadership Forum |
| Head of Research and Development |
| Quality and Data Analyst |
| QI Practitioner |
| Clinical Director - CHS, DMH and FYPC.LDA directorates |
| Pharmacy Services Manager |
| Trust Policy Experts |

## 1.3 Governance

**Level 2 or 3 approving delivery group – Clinical Effectiveness Group**

**Level 1 Committee to ratify policy – Quality Forum**

## 1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

## 1.5 Due Regard

LPT will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 6) of this policy

## 1.6 Definitions that apply to this policy.

| | |
|---|---|
| **Consent** | A patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:<br>• be competent to take the particular decision;<br>• have received sufficient information to take it and not be acting under duress. |
| **Due Regard** | Having due regard for advancing equality involves:<br>• Removing or minimising disadvantages suffered by people due to their protected characteristics.<br>• Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low. |
| **Best practice guidance** | This policy refers to clinical guidance documents and any high-level enquiry documents that make recommendations for patient safety. |
| **Nationally agreed** | Documents that have been published by national organisations which have an official advisory or regulatory role for the National Health Service. |
| **NICE** | **The National Institute for Health and Care Excellence (NICE)** is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales. |
| **CG** | NICE **Clinical Guideline** - guidance on the appropriate treatment and care of people with specific diseases and conditions. |
| **HTE** | NICE **Health Technology Evaluations** – an approach which allows rapid assessment of digital products, devices and diagnostics for clinical effectiveness and value for money. So that the NHS and patients can benefit from these promising technologies sooner. |
| **NG** | NICE Guideline – Replaced CG in January 2015 as a means to identify new clinical guidance. |
| **IPG** | NICE **Interventional Procedures Guidance -** on procedures used for diagnosis or treatment that involves incision, puncture, entry into a body cavity, electromagnetic or acoustic energy. |

| | |
|---|---|
| **TAG** | NICE **Technology Appraisal** –Guidance on the use of new and existing medicines and treatments. |
| **PH** | NICE **Public Health** guidance provides guidance on the promotion of good health and the prevention of ill health. These are: “Public Health Intervention Guidance” and “Public Health Programme Guidance” |
| **QS** | NICE **Quality Standards -** A concise set of statements designed to drive and measure high-priority quality improvements in a particular area of care and to achieve improved quality of care in local settings. General Public and People receiving health care services, can access information about the quality of services and care they should expect from their health care provider |

## 2.0 Purpose and Introduction/Why we need this policy

It is necessary to have a consistent approach and a clearly identified process for the evaluation, dissemination, implementation and monitoring of NICE guidance across LPT.

The purpose of this policy is to ensure the appropriate implementation of NICE guidance, in line with publications by NICE - Practical steps to improving the quality of care and services using NICE guidance (2018) and Principles for putting evidence-based guidance into practice (2018) and to comply with requirements as set out by the Care Quality Commission (CQC) Regulations 9 and 12.

This policy outlines the system and processes for the dissemination, implementation and monitoring of NICE guidance throughout LPT. National “best practice” guidance enables staff to make evidence-based decisions about treatment and healthcare.

In the white paper “First Class Service: Quality in the NHS”, the Department of Health declared that all patients should have fair access to high quality care which is based on clear evidence of best practice (DH 1999). From this white paper came the implementation of the National Institute for Health and Care Excellence (NICE) and the National Service Frameworks (NSFs). As a result of the findings of the Francis report 2013, The Department of Health produced Hard Truths: The journey to putting patients first 2014. Reports by Keogh 2013 - ‘Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report’ and Berwick 2013 ‘Improving the Safety of Patients in England’ highlighted failings in patient care and their safety’ which provided the basis for further patient centred care guidance.

This policy covers the implementation and monitoring of NICE guidance for best practice within LPT. It sets out a coordinated process to identify and disseminate

relevant documents. In addition, it covers conducting an organisational gap analysis and monitoring of the implementation process.

For the purposes of this document, the term, “guidance” is a collective term, and applies to guidance published by NICE.

This Policy applies to all staff within LPT involved in any aspect of the review and/or recommendations from nationally agreed best practice guidance documents.

## 3.0 Policy Requirements

NICE guidance is:

- Intended to improve the outcomes for people who access health service providers.
- Produced by health and social care professionals, patients, and the public.
- Evidence based guidance and advice for health, public health, and social care practitioners.
- Transparent in its development, consistent, reliable and based on a rigorous development process.
- Evaluated, weighing up the cost and benefits of treatments to ensure money is well spent.
- Internationally recognised for its excellence.
- Issued as NICE (formerly clinical) guidelines, quality standards, interventional procedures guidance, health technology evaluation guidance, highly specialized technologies guidance, medical technologies guidance, diagnostic guidance, and technology appraisals.

NICE also produce Pathways that provide guidance on the range of guidance available for a range of topics.

**NICE guidelines**

- Are recommendations by NICE on the appropriate treatment and care of people with specific diseases and conditions within the NHS.
- Based on the best available evidence.
- Assist health professionals in their work but do not replace their knowledge.

**NICE Technology Appraisals**

- Are guidance on the use of new and existing medicines and treatments.
- Assess the clinical and cost effectiveness of health technologies.

- Have stated timescales associated with them and must be implemented within three months of their publication.

**NICE Quality Standards**

- Are a concise set of statements designed to drive and measure priority quality improvements within a particular area of care.
- Are derived from the best available evidence such as NICE guidance and other evidence sources accredited by NICE.
- Enable service providers to quickly and easily examine the performance of their organisation and assess improvement in standards of care they provide.
- Provide the general public and people receiving health care services with easily accessible information about the quality of services and care they should expect from their healthcare provider.

**NICE Public Health Guidance**

- Makes recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health.
- May focus on a particular topic, a particular population, or a particular setting.

Care Quality Commission (CQC)

The Care Quality Commission undertakes special reviews and studies, which look in- depth at different aspects of health and adult social care, to assess and drive improvement for people using the services e.g., how well the health and social care pathway is working for people who had a stroke and their carers.

## 4.0 Duties within the Organisation

It is recognised that adequate implementation of NICE guidance requires a robust process that involves all LPT staff.

**The Chief Executive** is accountable for the implementation of this policy and ensuring that LPT has a process for the consideration, dissemination, and implementation of all NICE guidance.

**LPT Trust Board** will ensure that LPT operates effectively and efficiently and fulfils all its statutory duties and responsibilities in accordance with the approved LPT Scheme of Delegation, including delegation to the Clinical Effectiveness Group.

**Medical Director**

- Work with the Clinical Directors to estimate the cost of additional resources for the implementation of non-drug specific NICE guidance and support the negotiation of resources. (Appendix 1)
- Also work with the Clinical Directors to ensure the operational delivery of all NICE guidance.

**Head of Pharmacy (HoP)**

- Will work with the Quality Improvement Practitioner (NICE) and the Weekly Alerts Review Group (WAR), Directorate Clinical and Quality Governance leads to agree which NICE guidelines are relevant to the Trust and to provide a rationale for those not relevant to LPT.
- Receive medicines related NICE guidance from the QI Practitioner (NICE) and establish relevance for each Directorate.
- Contribute to the completion of baseline assessment tool (BAT)/ AMaT (Audit Management and Tracking) as required.
- Work in collaboration with the Medical Director and Clinical Directors to assess financial implications (Appendix 1).

**Clinical Directors**

- Will advise service leads/service managers in an assessment of the financial/contractual implications associated with implementation of NICE guidance (Appendix 1).
- Will assess, in conjunction with the relevant approving group, the evidence provided to support the completion of NICE guidance documentation in order to establish completeness and compliance.

**Weekly Alerts Review Group (WAR)**

Members of the WAR group will work with the QI Practitioner (NICE) to:

- Confirm relevance/non-relevance of NICE guidance and Technology Appraisals within 2 weeks of initial review by the HoP.
- Identify individual(s) to complete the baseline assessment tool (BAT)/AMaT if guidance deemed to be relevant to their service area.
- Respond to exceptions highlighted by the QI Practitioner (NICE) regarding completion of the BAT/AMaT.
- If required, identify a senior lead to implement cross-divisional work, e.g., development of trust-wide pathway, training plan or clinical audit.

Quality Forum (QF) – will assess assurances received from CEG related to the implementation of NICE guidance and ratify decisions not to implement guidance.

**Clinical Effectiveness Group (CEG)**

- Will receive assurance reports from the QI Practitioner (NICE)/Trust Lead for Quality Improvement and Quality Governance.
- Approve decisions not to implement guidance and report their decisions to QF.
- Ensure that identified risks related to non-compliance are escalated to QF and recorded on the risk register.
- Have oversight of the progress of NICE implementation work within the Trust.
- Receive reports from the QI Practitioner (NICE) giving a review of the number of outstanding actions and action plans in place to address non-compliant recommendations, the number and stage (not started, incomplete, complete) of NICE baseline assessment tool completion, details of guidance that has been escalated due to lack of progress and guidance that has been closed as fully compliant or partially compliant.
- Monitor completion of NICE BATs within the 18-month timeframe following publication (see section 6.1).
- Agree and monitor NICE Quality Improvement activities including monitoring and clinical audits.
- Ensure compliance with Technology Appraisals is confirmed within 3 months of publication.

**Directorate sub-groups of CEG**

- Ensure that NICE is a standing agenda item on the relevant directorate sub-groups of CEG. Bi-monthly reports providing an update on review of relevant NICE guidelines to be provided by the QI Practitioner (NICE), these reports will also include any guidance deemed to be not applicable to the Trust for further consideration by the sub-group(s) as necessary.
- Approve compliance with the guidelines once fully reviewed and adequate evidence provided, noting this in the minutes of the meeting.
- Disseminate guidance to appropriate services throughout the directorate.
- Respond to exceptions highlighted by the QI Practitioner (NICE) regarding confirmation of relevance, evidence of dissemination.

- Identify risk associated with the implementation of guidance and update risk register as appropriate.
- Oversee implementation of action plan within BAT/AMaT.
- Identify NICE related clinical audits in partnership with QI Practitioner (NICE) and consider whether Clinical Audit is the appropriate means of confirming compliance with NICE guidance or if there are other means of assurance.
- Ensure that confirmation of compliance with NICE guidance is completed within an appropriate timescale.

**Trust Lead for Quality Improvement and Quality Governance**

- Oversee NICE reporting and assurance mechanisms.
- Work with Directorate Clinical and Quality Governance Leads to escalate exceptions.
- Ensure links between NICE and Clinical Audit are integrated and supported by the clinical audit forward plan and quality improvement work.

**Quality Improvement Practitioner (NICE)**

- Oversee and co-ordinate the Trust NICE guidance implementation procedure.
- Identify new NICE guidance published on the NICE website on a monthly basis.
- Work with the Trust Lead for Quality Improvement and Quality Governance, Head of Pharmacy and WAR group to agree which guidance is relevant to the Trust and to provide a rationale for guidelines which are not relevant to LPT.
- To receive a response from the WAR group on the relevant/non-relevant guidance within two weeks of the initial review by the HoP.
- Receive names of individual(s) to review NICE guidance from the WAR group.
- To send the relevant BAT to the nominated individual(s) to complete, providing support if necessary, or to support completion of the review on AMaT.
- Collate completed BATs and Quality Standard from each Directorate.
- Collate evidence of dissemination of guidance from each Directorate.

- Inform WAR group of areas which require action plans, cross-referencing with other divisions to avoid duplication of effort.
- Collate evidence of implementation by updating the Guidance Activity and Compliance Statements section of AMaT (Audit Management and Tracking) with details of progress towards implementation, identifying high priority and significant recommendations and acting accordingly.
- Along with other members of the WeImproveQ team, support directorates to identify and deliver NICE related quality improvement projects (including Clinical Audits).
- Provide status reports to each Directorate sub-group (subgroups of Directorate Clinical Governance Groups). To include Clinical Audit, cost implications and exceptions at each stage, e.g., confirmation of relevance, completion of BATs, evidence of dissemination and implementation.
- Where the baseline assessment reveals a need for additional financial investment/resource ensure the procedure in Appendix 1 is followed.
- To be aware of areas of risk which potentially are to be re-assessed e.g., where NICE guidance has been revised, new services or areas of organisational risk/serious incidents, via the Head of Pharmacy, Trust Lead for Quality Improvement and Quality Governance and the Clinical Effectiveness Group (CEG).
- To liaise with the LPT Risk Manager, prior to reporting to CEG, when areas of non-compliance are identified to plan approach to the risk.
- Provide assurance reports for all guidance and exception reports to CEG.
- Maintain the Guidance Activity and Compliance section of AMaT, detailing the stages of the implementation procedure and related correspondence, including rationale for non-relevant guidance.
- Escalate issues/lack of progress etc. to relevant groups and meetings including subgroups of CEG, as necessary.

**All clinical staff**

All staff have a professional responsibility to:

- Implement relevant guidance and make evidence-based decisions about treatment and health care.
- Consider NICE when planning and carrying out any Quality Improvement activities, service design/redesign, incident reviews, service delivery and transformation.

- Ensure that Trust policies and other guidelines reference NICE where applicable and the relevant guideline is reviewed during any policy review and updated, as necessary**.**

# 5.0 Process for Identifying and Dissemination of Relevant Documents

## 5.1 NICE guidance

An up-to-date schedule of forthcoming NICE guidance is available on the NICE website (www.nice.org.uk).

- All guidance issued by NICE each month will be reviewed initially by the QI Practitioner (NICE) and confirmed by the HoP and relevant clinical representation in terms of potential relevance to LPT.
- The QI Practitioner (NICE) will then disseminate details of all NICE guidance to the WAR Group where leads will be nominated to review as appropriate.
- The QI Practitioner (NICE) will forward the NICE BAT and NICE guidance document to the nominated individuals for completion and return, confirming full compliance or detailing any action required/risks identified. Evidence of compliance may also be added directly into AMaT – currently this depends on when the guidance was published/updated.
- The nominated lead will supply the QI Practitioner (NICE) with electronic copies of documents used as evidence of compliance, e.g., Standard Operating Guide, patient leaflet, link to Trust policy (where a Trust policy is used as evidence in the BAT, the nominated lead will state which section of the policy covers the recommendation). This evidence will be uploaded to the relevant guidance section in AMaT.
- The nominated lead(s) will also work with the QI Practitioner (NICE) to establish an action plan for any non-compliant recommendations (using SMART guidelines), monitor the actions and update the QI Practitioner (NICE) with progress.
- The nominated lead will, if necessary, assemble a working group for the BAT review, maintain regular communication with the QI Practitioner (NICE) and provide updates on progress of review when requested and escalate any issues to the QI Practitioner (NICE).

A BAT is published by NICE for the majority of all new NICE guidance. This incorporates all required recommendations, a baseline assessment of compliance, and an action plan.

The BAT enables detailed consideration of the guidance and provides the Trust with a process for conducting an organisational gap analysis.

The QI Practitioner (NICE), Head of Pharmacy, Trust Lead for Quality Improvement and Quality Governance and Directorate Clinical and Quality Governance Leads will monitor baseline assessment tools, in terms of delivery and follow up. It is expected that the initial review of the BAT will be completed within 3 months of publication and the final position of compliance to be completed within 18 months of publication.

Where a guideline is fully or partially non-compliant due to a gap in commissioning, the relevant recommendation(s) should be marked as relevant to LPT but not compliant due to the gap in commissioning. This will provide a clear picture in the event of service review and when providing NICE compliance reports within LPT and to its stakeholders.

Appendix 2 outlines the process and responsibilities for reviewing relevance, compliance, and dissemination of NICE guidance.

### 5.2 Quality Improvement including Clinical Audit

The National Institute for Health and Care Excellence, Principles for Best Practice in Clinical Audit (NICE: 2010) state that:

“Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.”

Through Clinical Audit, services can measure compliance against the recommendations made by the NICE guidance and improve patient care.

The BAT lead and the QI Practitioner (NICE) will consider relevant NICE guidance for inclusion in the Clinical Audit Forward Plan. NICE produces Clinical Audit tools and Quality Standards to inform Clinical Audits.

Where other quality improvement methodologies are more appropriate, action will be taken and assistance provided where necessary, see Appendix 2. Quality Improvement (including Clinical Audit) project support will be provided through the QI design huddle and the use of LifeQI and/or AMaT. Further details can be found in the LPT Quality Improvement policy.

## 6 Process for conducting an Organisation Gap Analysis

Implementation of all types of guidance will have an impact on the provision of services and require a system for assessing the gaps and action planning. For NICE guidance, the BAT is used. (Gap analysis is based on the Lloyds Register LRQA ISO 9001 model).

### 6.1 Resource and financial implications

It is recognised that implementation of guidance will often have a financial impact.

The process to be followed in relation to financial decisions and cost implications is outlined in Appendix 1. Resource implications will be detailed in a NICE cost assessment template. Copies of this and other correspondence will be kept on the AMaT database maintained by the QI Practitioner (NICE).

### 6.2 Financial Planning

Where Directorates have identified cost implications associated with the implementation of guidance, recommendations will be built into contractual discussions on an annual basis led by the Director of Finance, Business & Estates. (Appendix 1).

## 7 Process for ensuring that recommendations are acted upon throughout the organisation

Regular reports from the Head of Clinical Quality Governance /QI Practitioner (NICE) outlining performance and exceptions in terms of dissemination, action planning, implementation, Quality Improvement or Clinical Audit, will be reported to:

- Directorate Clinical Quality Governance Leads/Directorate sub-groups (Appendix 3)
- CEG (Appendix 3)
- Quality Forum (Appendix 3)
- Commissioners (Appendix 3)

## 8 Process for documenting any decision not to implement NICE recommendations

Any decision not to implement National Guidance must be approved by the Clinical Effectiveness Group and ratified by the Quality Forum.

## 9 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is

thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision
- Remember that information
- Use the information to make the decision
- Communicate the decision

## 10 Monitoring Compliance and Effectiveness

The Trust Lead for Quality Improvement and Quality Governance will audit this document by means of a review of the records maintained by the QI Practitioner (NICE) on an annual basis (September each year) against the following standards:

- NICE guidance is disseminated according to this policy.
- A gap analysis is undertaken against all new guidance.
- Recommendations are acted upon.
- A report providing commissioner assurance.

Duties outlined in this Policy will be evidenced through monitoring of the other minimum requirements. Where monitoring identifies any shortfall in compliance the Clinical Effectiveness Group (CEG) shall be responsible for developing and monitoring any action plans to ensure future compliance.

| Page/Section | Minimum Requirements to monitor | Method for Monitoring | Responsible Individual /Group | Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring |
|---|---|---|---|---|
| | How the organisation identifies which NICE guidelines are relevant to its services | The NICE guidance is reviewed monthly by the HoP and QI Practitioner (NICE) who identify guidelines relevant to directorates. This is then validated | HoP and relevant clinical representation in the WAR group. | Bi-monthly to Directorate groups – DMH CASEQI, CHS senior clinical team, FYPC.LDA clinical leadership group. |

| Page/Section | Minimum Requirements to monitor | Method for Monitoring | Responsible Individual /Group | Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group). Frequency of monitoring |
|---|---|---|---|---|
| | | by the WAR group. | | Quarterly to CEG |
| | How action plans are created to address any shortfalls (including recording decisions not to implement NICE guidelines) | Process for conducting an Organisational Gap Analysis.<br>Plans to address shortfalls are developed by the BAT lead or Trust-wide via CEG.<br>Decisions not to implement are made by CEG and verified by QF. | Monitoring via the Trust Lead for Quality Improvement and Quality Governance/QI Practitioner (NICE)/Quality and Data Analyst<br>Clinical Quality Governance Teams/Chairs of CEG and QF. | As above |

## 11 References and Bibliography

High Quality Care for All, NHS Next Stage Review Final Report – June 2008

NICE website – including Interventional Procedures Programme manual, Legal Context of NICE guidance, NICE Quality Standards, NICE – what we do, NICE Into Practice Guide

The Health Foundation – Rising to the challenge – using evidence about what works to improve quality and save money – November 2009

LPT Quality Improvement policy

## 12 Fraud, Bribery and Corruption consideration

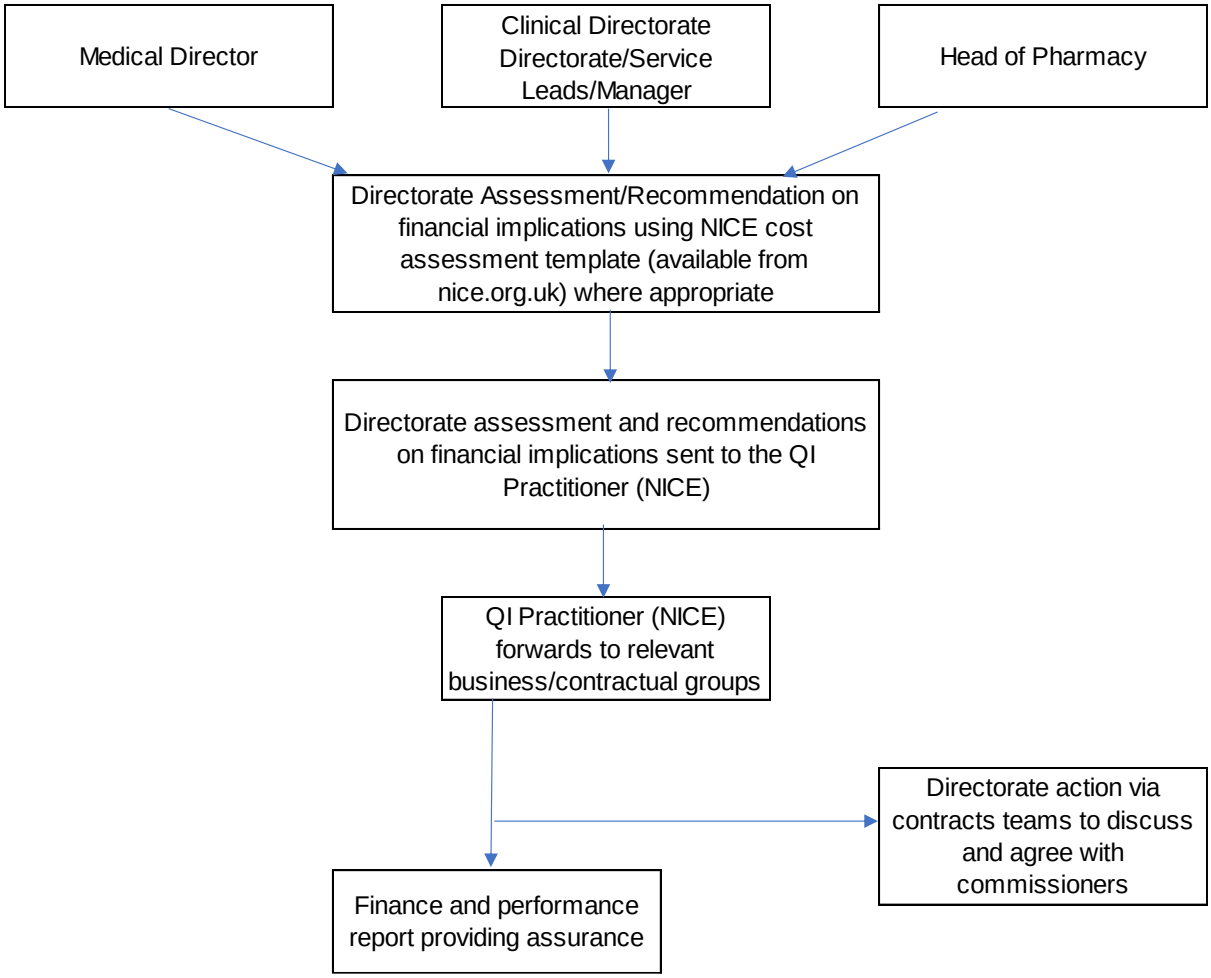
The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

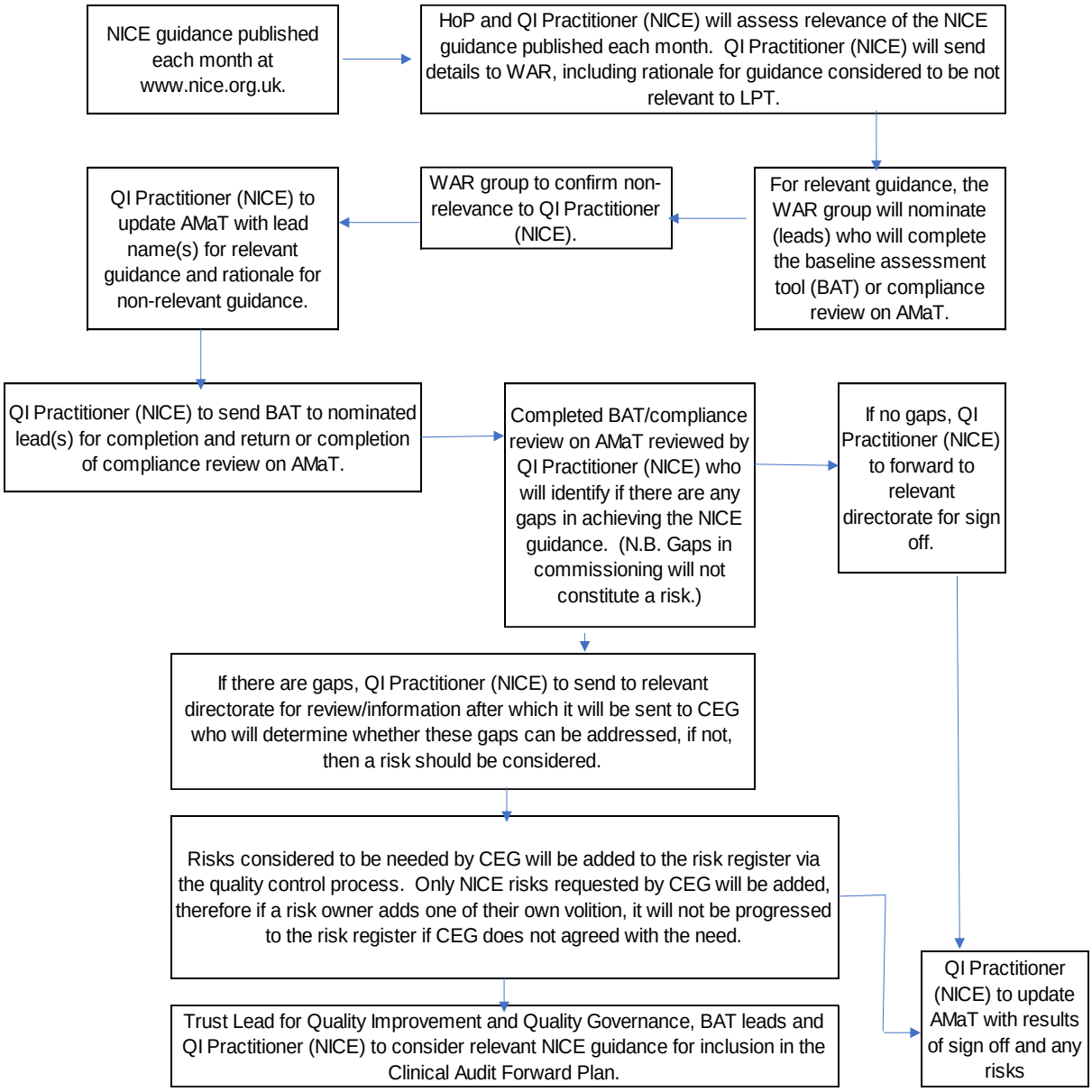
Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

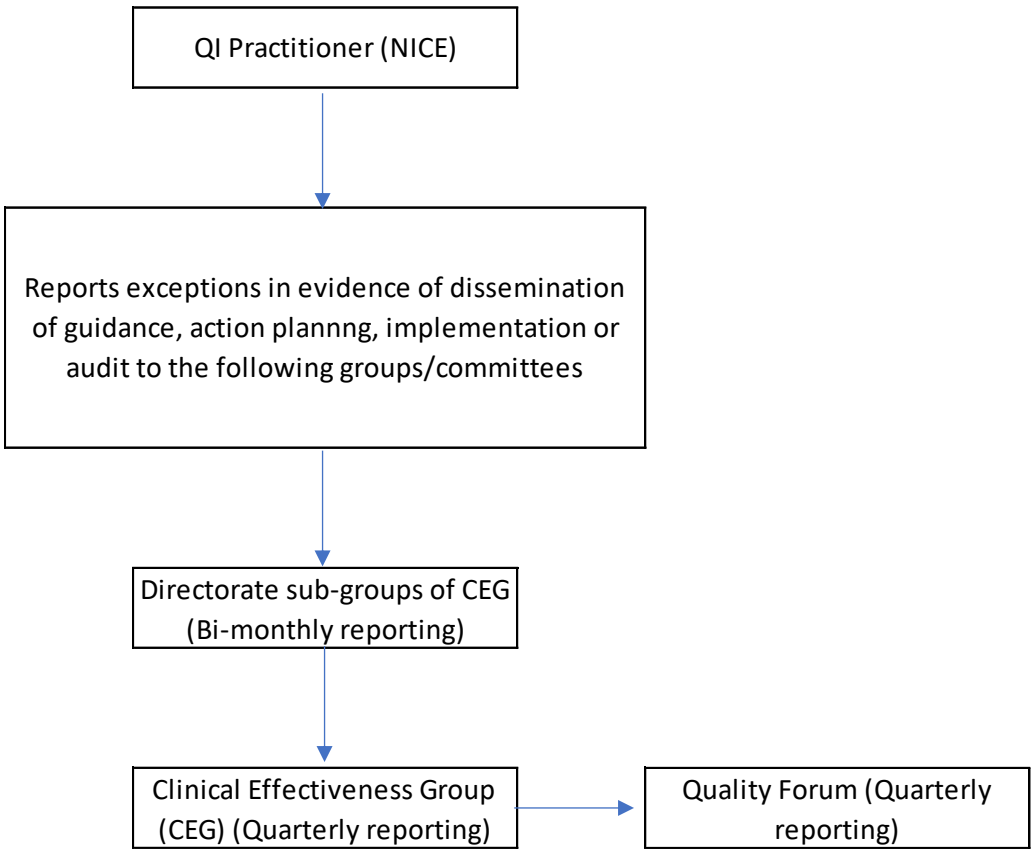
# Appendix 1: Financial decisions in relation to cost implications



# Appendix 2: NICE guidance, relevance, compliance, risk, dissemination and clinical audits



## Appendix 3: Exceptions, assurance and reporting to Divisional sub-groups of Clinical Governance Groups, CEG, QF and Commissioners



# Appendix 4 Training Needs Analysis

| | | |
|---|---|---|
| **Training topic:** | Delete answers that are not applicable * | |
| Type of training:<br>(see study leave policy) | Not Required | |
| Directorate to which the training is applicable: | | |
| Staff groups who require the training: | | |
| Regularity of Update requirement: | | |
| Who is responsible for delivery of this training? | | |
| Have resources been identified? | | |
| Has a training plan been agreed? | | |
| Where will completion of this training be recorded? | | |
| How is this training going to be monitored? | | |
| **Signed by Learning and Development Approval name and date** | | Date: |

## Appendix 5 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

**Shape its services around the needs and preferences of individual patients, their families and their carers. Yes**

**Respond to different needs of different sectors of the population. Yes**

**Work continuously to improve quality services and to minimise errors. Yes**

**Support and value its staff. Yes**

**Work together with others to ensure a seamless service for patients. Yes**

**Help keep people healthy and work to reduce health inequalities. Yes**

**Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance. Yes**

# Appendix 6 Due Regard Screening Template

| Section 1 | |
|---|---|
| Name of activity/proposal | The policy outlines the system and processes for the dissemination, implementation and monitoring of NICE guidance throughout LPT. National “best practice” guidance enables staff to make evidence-based decisions about treatment and healthcare. |
| Date Screening commenced | 1 February 2024 |
| Directorate / Service carrying out the assessment | WeImproveQ Team |
| Name and role of person undertaking this Due Regard (Equality Analysis) | Heather Darlow, Trust Lead for Quality Improvement and Quality Governance |
| Give an overview of the aims, objectives and purpose of the proposal: | |
| AIMS: To establish a policy and procedure for NICE guidance. | |
| OBJECTIVES: To disseminate, implement and monitor NICE practice. | |

| Section 2 | |
|---|---|
| Protected Characteristic | If the proposal/s have a positive or negative impact please give brief details |
| Age | No |
| Disability | No |
| Gender reassignment | No |
| Marriage & Civil Partnership | No |
| Pregnancy & Maternity | No |
| Race | No |
| Religion and Belief | No |
| Sex | No |
| Sexual Orientation | No |
| Other equality groups? | No |

| Section 3 | |
|---|---|
| Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below. | |
| Yes | No ✓ |
| High risk: Complete a full EIA starting click here to proceed to Part B | Low risk: Go to Section 4. ✓ |

| Section 4 | | | |
|---|---|---|---|
| If this proposal is low risk, please give evidence or justification for how you reached this decision: | | | |
| The policy outlines the system and processes for the dissemination, implementation and monitoring of NICE guidance throughout LPT. National “best practice” guidance enables staff to make evidence-based decisions about treatment and healthcare. | | | |
| Signed by reviewer/assessor | Heather Darlow | Date | 26 April 2024 |
| *Sign off that this proposal is low risk and does not require a full Equality Analysis* | | | |
| Head of Service Signed | Heather Darlow | Date | 26 April 2024 |

# Appendix 7 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

| | | |
|---|---|---|
| **Name of Document:** | Dissemination, implementation and monitoring of National Institute for Health and Care Excellence (NICE) guidance | |
| **Completed by:** | Heather Darlow | |
| **Job title** | Trust Lead for Quality Improvement and Quality Governance | **Date** 24 April 2024 |

| **Screening Questions** | **Yes / No** | **Explanatory Note** |
|---|---|---|
| **1.** Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document. | No | |
| **2.** Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document. | No | |
| **3.** Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document? | No | |
| **4.** Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used? | No | |
| **5.** Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics. | No | |
| **6.** Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them? | No | |
| **7.** As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private. | No | |
| **8.** Will the process require you to contact individuals in ways which they may find intrusive? | No | |

| | |
|---|---|
| **If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk<br>In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.** | |
| **Data Privacy approval name:** | **N/A** |
| **Date of approval** | |

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust