Royal Devon and Exeter NHS
NHS Foundation Trust

National Best Practice Clinical Guidance Implementation Policy

Post holder responsible for Procedural Document	Head of Governance
Author of Policy	Clinical Audit Manager
Directorate responsible for Procedural Document	Governance & Patient Safety
Contact details:	x3933
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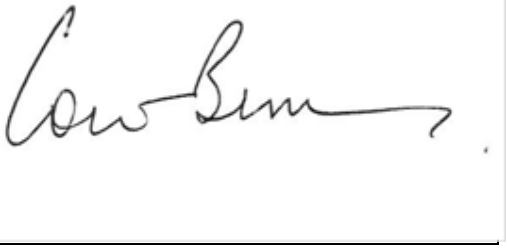
Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience	✓	Waiting	
Assurance Framework		Privacy and Dignity	
Monitor/Finance/Performance		Efficiency and Effectiveness	
CQC Regulations/Outcomes:	**Outcome 4**	Delivery of Care Closer to Home	
		Infection Control	
NHSLA Risk Management Standards for Acute Trusts		**Standards 2.8 and 2.9**	
NHSLA CNST Maternity Clinical Risk Management Standards:			
Other *(please specify)*:			
Note: This policy has been assessed for any equality, diversity or human rights implications			

Version:		**Status: FINAL**	
Version	Date	Author (Title not name)	Reason
1.1	March 2011	Head of Patient Governance	*New Policy*
1.2	March 2013	Clinical Audit Manager	*Minor amendments*

To be used in conjunction with:	
In consultation with and date: Clinical Effectiveness Committee, 16 May 2013*;* Policy Expert Panel, 2 April 2013; Governance Leads, 5 March 2013; Head of Governance, 30 January 2013; Joint Medical Director, 30 January 2013; Perinatal and Child Death Review Coordinator, 23 January 2013.	
Review Date *(Within 3 years)*	October 2015
Contact for Review:	Clinical Audit Manager
Executive Lead Signature: Dr Colin Berry, Executive Medical Director	

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1. INTRODUCTION

1.1 The implementation of national clinical guidance issued to the NHS is a key aspect of the Royal Devon and Exeter NHS Foundation Trust's (hereafter referred to as 'the Trust') approach to providing clinically- and cost-effective services. The Trust intends to use all available national best practice clinical guidance applicable to its services to the maximum benefit of patients. This means a commitment to effectively translating the recommendations from national sources into demonstrable improvements in practice. Timely implementation of recommended treatments and service arrangements is crucial to achieving a high quality, nationally consistent service that will meet patients' expectations.

1.2 *Regulatory Context*

The Care Quality Commission (CQC)[1] and the NHS Litigation Authority (NHSLA)[2] have requirements to systematically implement recommendations from national clinical guidance sources within their standards. In terms of outcomes for patients, the objective is effective, evidence-based care that reflects all relevant guidance from professional / expert bodies.

2. PURPOSE

2.1 This policy sets out:

- the core processes by which the Trust can achieve consistent and timely uptake of all relevant 'national best practice clinical guidance' recommendations
- the arrangements for governing the processes including the method for assuring the Executive Board and the Trust's regulators / commissioners of timely implementation

3. DEFINITIONS

"National Best Practice Clinical 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 of Health & Clinical Excellence (NICE) - *see Appendix A for a full list of NICE guidance programmes*
- Clinical Outcome Review Programmes - *see Appendix B for a full list of Clinical Outcome Review Programmes*
- Other high-level enquiries/ inquiries

National clinical guidance is issued from a large range of other sources including national audit reports and safety alerts. These additional sources of national recommendations are specifically addressed in the relevant related policies.

[1] *CQC Essential Standards of Quality & Safety,* Outcome 4: Care and Welfare of People who use Services (2010)

[2] *NHSLA Risk Management Standards 2012-13,* Standards 2.8 & 2.9 Best Practice: NICE and National Confidential Enquiries & Inquiries (2012)

4. DUTIES AND RESPONSIBILITIES OF STAFF / COMMITTEES / GROUPS

4.1 Executive Medical Director

The Executive Medical Director is accountable at executive level for ensuring that a co-ordinated approach to governing national clinical guidance implementation functions across the Trust and for providing assurance to the Executive Board, via the Governance Committee, on the operation of the processes set out in this policy.

4.2 Associate Director of Midwifery and Patient Care

The Associate Director of Midwifery and Patient Care is responsible at an executive level for ensuring the implementation of national best practice clinical guidance relating specifically to maternity services.

4.3 Head of Governance

The Head of Governance has a responsibility to maintain an awareness of all clinical guidance with implications for the Trust and to ensure that any relevant guidance is governed according to this policy. This includes ensuring:

- an assessment of the baseline position against guidance is conducted and reported within the relevant timescales
- all identified 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
- the compliance registers are maintained

4.4 Clinical Effectiveness Committee

The Clinical Effectiveness Committee (CEC), chaired by the Executive Medical Director, is the central monitoring committee responsible for overseeing the governance of national best practice clinical guidance. It will:

- monitor the compliance of the directorates with this policy
- consider issues of cross-directorate significance to ensure a co-ordinated response across the relevant parts of the Trust
- review and approve any intentional non-implementation of national best practice clinical guidance due to local clinical disagreement
- escalate any risk issues of concern via exception reporting to the Governance Committee
- provide assurance to the Governance Committee / commissioners on the implementation of national best practice clinical guidance across the Trust

4.5 Directorate Governance Groups

The Directorate Governance Groups (DGGs) are responsible for overseeing the implementation and governance of national best practice clinical guidance within their directorates. They are responsible for:

- reviewing completed baseline assessments of new clinical guidance applicable to their services
- agreeing action plans to achieve compliance with national best practice clinical guidance within their directorates

- monitoring the completion of action plans within the directorate to ensure that national best practice clinical guidance is fully implemented within the agreed timescales
- escalating any risk issues and / or intentional non-implementation of national best practice clinical guidance via exception reporting to the CEC

4.6 **Implementation Lead**

The assigned Implementation Lead for a piece of national best practice clinical guidance provides leadership and expert clinical knowledge to drive the changes necessary to achieve full implementation. The Implementation Lead can be any appropriate senior health professional. The Implementation Lead's primary responsibilities are to:

- apply their expert knowledge of their clinical area to undertake a baseline self-assessment against the new guidance and identify key compliance gaps, risks and actions required within the timescales outlined in this policy
- lead any necessary re-design of their service, ensuring all affected are engaged in the development and that appropriate clinical audit/ monitoring arrangements are initiated to demonstrate compliance has been achieved and sustained

4.7 **Directorate Governance Leads**

The Directorate Governance Leads facilitate the governance and implementation of national best practice clinical guidance within their directorates. Their role is to support individual implementation leads by providing expert governance advice on the completion of baseline assessments, risk assessments and action plans. They are responsible for ensuring completed baseline assessments and action plans are discussed at their DGGs, and for ensuring that the central National Best Practice Clinical Guidance Co-ordinator is kept informed of the position of the implementation of national best practice clinical guidance within the directorate.

4.8 **National Best Practice Clinical Guidance Co-ordinator**

The National Best Practice Clinical Guidance (NBPCG) Co-ordinator (for Mothers and Babies – Reducing Risk through Audits & Confidential Enquiries across the UK (MBRRACE-UK) this is the Perinatal and Child Death Review Coordinator; for all other guidance this is the Clinical Audit Manager) acts as a link between the national centres issuing national best practice clinical guidance and the Trust. Their duties are:

- to facilitate the requests for data for confidential enquiries/ reviews, ensuring that these are submitted to the national centres by the relevant deadlines
- to receive all new clinical guidance and disseminate to the relevant leads
- to maintain a central compliance register for all national best practice clinical guidance
- to produce reports for the purposes of monitoring compliance with the implementation of national best practice clinical guidance for DGGs, CEC or commissioners as requested
- to escalate any concerns regarding the dissemination or implementation of national best practice clinical guidance to the Head of Governance/ Associate Director of Midwifery and Patient Care as appropriate

4.9 **All Health Professionals**

All health professionals have a responsibility to be aware of relevant national clinical guidance applicable to their practice, to contribute to relevant assessment and implementation activity, and to consider all relevant recommendations when making decisions with patients about their care.

5. PROCESS FOR RESPONDING TO REQUESTS FOR DATA FOR CONFIDENTIAL ENQUIRIES / REVIEWS

5.1 Notifications of forthcoming Confidential Enquiries/ Reviews are received by the NBPCG Co-ordinator.

5.2 An appropriate Implementation Lead is identified (on advice from the relevant Directorate Governance Lead or the Executive Medical Director if required).

5.3 Data requests are received from the national centres by the NBPCG Co-ordinator and logged on the central compliance register. Data requests may include patient lists, organisational questionnaires, case note extracts, or clinical questionnaires.

5.4 The data request is responded to by either the NBPCG Co-ordinator or forwarded to nominated Implementation Lead. All data requests will be responded to within the specified timescales, monitored by the NBPCG Co-ordinator.

6. PROCESS FOR THE DISSEMINATION AND IMPLEMENTATION OF NATIONAL BEST PRACTICE CLINICAL GUIDANCE

6.1 Identifying which Guidance is relevant to the Trust's Services

6.1.1 The NBPCG Co-ordinator undertakes regular horizon scanning for new clinical guidance potentially applicable to the Trust's services. Newly released clinical guidance is logged on the central compliance register.

6.1.2 New clinical guidance is reviewed for applicability to the services provided by the Trust by the NBPCG Co-ordinator, with advice from the Governance Leads / Executive Medical Director as required. If it is agreed that the recommendations are not relevant to the Trust, this will be recorded on the compliance register.

6.2 Conducting Self-Assessments (Gap Analyses)

6.2.1 If the guidance is considered applicable, an appropriate Implementation Lead is identified (on advice from the relevant Directorate Governance Lead or the Executive Medical Director if required).

6.2.2 A baseline self-assessment template will be provided to the Implementation Lead to complete a gap analysis of the extent to which the Trust's current service matches the best practice guidance. The baseline self-assessments form a record of:

- which recommendations are currently met / not met
- available evidence which would demonstrate compliance with the recommendations which are met
- what needs to happen and what level of resource would be required to address identified non-compliance
- who will take responsibility for each action item
- the target timeframe for each action item

6.2.3 If the Implementation Lead disagrees with any of the recommendations and does not wish to implement them into Trust practice this must be noted on the self-assessment and dealt with in accordance with the process outlined in this policy (6.4).

6.2.4 A copy of the completed baseline self-assessment should be returned to the NBPCG Co-ordinator for logging on the central compliance register within the timescales specified for each guidance type (*see Appendices A & B*). Failure to return the baseline self-assessments within the specified timescales will be escalated as follows:

- Initial request for self-assessment sent to Implementation/ Governance Lead within 1 week of guidance being released by the NBPCG Co-ordinator
- One month before the deadline for return, a reminder will be sent to the Governance / Implementation Lead by the NBPCG Co-ordinator
- On breach of the deadline a reminder will be sent to the Implementation Lead cc the Governance Lead, Divisional Manager, Clinical Director and Head of Governance
- Any continued nil return will be raised at the CEC and dealt with directly by the Executive Medical Director

6.2.5 If the implementation of national best practice clinical guidance involves the introduction of a new drug or clinical procedure, these must be introduced in line with the Trust's New Drugs and New Clinical Procedures Policies respectively.

6.2.6 If there are any changes in practice or the services provided by the Trust which affect the Trust's compliance with an aspect of national best practice clinical guidance, subsequent to the baseline self-assessment being completed, it is the responsibility of the Implementation Lead to inform the NBPCG Co-ordinator for central logging and appropriate action.

6.3 Developing Action Plans to Achieve Full Implementation of Clinical Guidance

6.3.1 Once the baseline self-assessment template has been completed this will form the action plan to achieve full compliance - there is no expectation that a separate action plan will be completed. However, for extensive gap analyses the Implementation Lead may wish to transfer actions required into a separate action plan template for clarity.

6.3.2 All actions required should be produced according to the 'SMART' acronym: Specific, Measurable, Achievable, Realistic (within Resource) and Time-bound. Individuals who are assigned actions must be consulted and made aware of the given timeframes for completion.

6.3.3 Where baseline self-assessments reveal non-compliance with any national best-practice clinical guidance recommendation it is the responsibility of the Implementation Lead, in liaison with the Governance Lead, to undertake a risk assessment in accordance with the Trust's Risk Assessment Policy.

6.3.4 The action plan and risk assessment will be presented to the relevant specialty or directorate governance group for approval and monitoring. If the guidance/ recommendations have relevance across several Directorates the action plans/ risk assessments will be presented to a nominated specific Trust group or committee relevant to the topic area of the guidance, or by the CEC for approval and monitoring.

6.3.5 Once action plans have been completed and full implementation achieved, the Implementation/ Governance Lead will inform the NBPCG Co-ordinator for central logging.

6.4 Decisions *Not* to Implement Relevant Recommendations / Guidance

6.4.1 Where there is disagreement with any recommendation within a piece of national best practice clinical guidance, either for clinical or resource reasons, the justification for non-implementation, an outline of the Trust's alternative practice, and a completed risk assessment of this position will be presented to the relevant specialty or directorate governance group for discussion (or directly to the CEC if guidance is multi-directorate). If a position of intentional non-compliance is agreed at the specialty or directorate governance group this decision will be presented to the CEC for final review and approval. The Trust's position will be recorded on the central compliance register by the NBPCG Co-ordinator.

6.4.2 As there is a statutory requirement to implement NICE Technology Appraisals, there is *no* option for any applicable Technology Appraisal not to be implemented within the Trust.

6.4.3 Where applicable, areas of *clinical* disagreement with national best practice clinical guidance will be fed back to the relevant national centre by the Implementation Lead.

6.5 Ensuring National Best Practice Clinical Guidance is Implemented and Followed in Practice

6.5.1 All active assessments/ action plans will be monitored within the relevant directorates to ensure all actions are fully completed. Progress against action plans will be reviewed on a regular basis at the relevant specialty or directorate governance group. Assessments/ action plans for national best practice clinical guidance which is multi-directorate will be monitored either through a nominated specific Trust group or committee relevant to the topic area of the guidance, or by the CEC. Any concerns or issues regarding the completion of an action plan will be flagged to the CEC in the first instance.

6.5.2 National best practice clinical guidance will be a standing agenda item for the CEC, and an exception report will be presented by the Clinical Audit Manager giving an overview of the Trust's compliance status against applicable national best practice

clinical guidance. Any unresolvable risk issues will be escalated to the Governance Committee through the CEC sub-committee report by exception.

6.5.3 National best practice clinical guidance assessed as 'compliant' which is considered by the directorate a priority for clinical audit will be put on the relevant directorate clinical audit programme for auditing the following financial year. Each directorate will be provided with a list of applicable national best practice clinical guidance by the Clinical Audit Department at the beginning of each year to aid with the planning of their clinical audit programmes. Completion of the directorate clinical audit programmes will be monitored by the Clinical Audit & Guidelines Group as described in the Trust's Clinical Audit Policy.

7. ARCHIVING ARRANGEMENTS

7.1 The original of this policy will remain with the author (the Clinical Audit Manager in the Clinical Audit Department). An electronic copy will be maintained on the Trust Intranet (IaN), A-Z Policies List, under 'N'. Archived copies will be stored on the Trust's "archived_policies" shared drive and will be held for 10 years.

8. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

8.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

No.	Minimum Requirements	Evidenced by	NHSLA standard
1.	All data requests by the national centres are responded to within the specified timescales.	Compliance register	2.9
2.	All self-assessments are fully completed with actions required, named leads and deadlines for completion.	Compliance register	2.8 & 2.9
3.	All self-assessments are returned to the NBPCG Co-ordinator within the specified timescales.	Compliance register	2.8 & 2.9
4.	All national best practice clinical guidance identifying areas of non-compliance are risk assessed.	Compliance register/ committee minutes	2.8 & 2.9
5.	Any intentional non-compliance with a piece of national best practice clinical guidance has the justification noted on the self-assessment form; a risk assessment undertaken; and is formally presented and approved through the CEC.	Compliance register/ committee minutes	2.8 & 2.9
6.	All action plans against national best practice clinical guidance are monitored through the relevant DGG, group or committee.	Committee minutes	2.8 & 2.9
7.	A national best practice clinical guidance exception report is presented to every CEC	CEC minutes; CEC sub-committee	2.8 & 2.9

No.	Minimum Requirements	Evidenced by	NHSLA standard
	meeting; all unresolvable risk issues are escalated to the Governance Committee.	reports to Governance Committee	

7.2 **Frequency**

In each financial year, the Clinical Audit Manager will audit a sample of national best practice clinical guidance against the standards given above to ensure that this policy has been adhered to. A formal report will be written and presented at the Clinical Effectiveness Committee.

7.3 **Undertaken by**

Clinical Audit Manager

7.4 **Dissemination of Results**

At the Clinical Effectiveness Committee which is held bi-monthly.

7.5 **Recommendations/ Action Plans**

Implementation of the recommendations and action plan will be monitored by the Clinical Effectiveness Committee, which meets bi-monthly.

7.6 Any barriers to implementation will be risk-assessed and added to the risk register.

7.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Leads cascade system.

9. REFERENCES

- *CQC Essential Standards of Quality & Safety,* Outcome 4: Care and Welfare of People who use Services (2010)
- *NHSLA Risk Management Standards 2012-13,* Standards 2.8 & 2.9 Best Practice: NICE and National Confidential Enquiries & Inquiries (2012)

10. ASSOCIATED TRUST POLICIES

- Central Alerting System and Disseminating Alerts Policy & Procedure
- Clinical Audit Policy
- Introduction of New Clinical Procedures in the Trust Policy
- New Drugs Policy
- Risk Assessment Policy

Appendix 1: NICE Guidance Programmes (with Assessment and Implementation Deadlines)

Guidance Type	Background	Timeframe for Self-Assessment	Full Implementation Period
Technology Appraisals (TAs)	Recommendations on the use of new and existing medicines and treatments within the NHS based on a review of clinical and economic evidence.	2 months	3 months (statutory requirement)
Clinical Guidelines (CGs)	Recommendations by NICE on the appropriate treatment and care of people with specific diseases and conditions within the NHS.	6 months	5 years
Interventional Procedures (IPs)	Assessments of new interventional procedures used for diagnosis or for treatment, providing guidance on the safety of the procedure; whether it works well enough for routine use; whether special arrangements are needed for patient consent.	2 months	N/A
Public Health (PH)	Recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health. These are applicable to primary care.	N/A	N/A
Diagnostics Guidance (DGs)	Evaluations of innovative medical diagnostic technologies in order to ensure that the NHS is able to adopt clinically and cost effective technologies rapidly and consistently.	2 months	N/A
Medical Technology Guidance (MTGs)	Evaluations of new or innovative medical technologies (including devices and diagnostics) to help the NHS adopt efficient and cost effective medical devices and diagnostics more rapidly and consistently.	2 months	N/A
Quality Standards (QS)	Concise sets of statements designed to drive and measure priority quality improvements within particular areas of care.	6 months	5 years

Appendix 2: Clinical Outcome Review Programmes (with Assessment and Implementation Deadlines)

Guidance Type	Background	Timeframe for Self-Assessment	Full Implementation Period
National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	NCEPOD reviews medical and surgical clinical practice and makes recommendations to improve the quality of the delivery of care. They undertake two themed reviews per contract period, reviewing the quality of care received by patients in hospital	6 months	5 years
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH)	The Inquiry examines suicide and homicide committed by people who had been in contact with secondary and specialist mental health services in the previous 12 months. It also examines the deaths of psychiatric inpatients which were sudden and unexplained. This is applicable to mental health trusts.	N/A	N/A
Child Health Reviews (CHR-UK)	This is a national programme of work to examine the incidence and associated features of mortality and serious morbidity in 1-18 year olds and aims to improve the delivery and outcomes of health care to children within the UK. This includes a retrospective analysis of mortality using existing datasets which will be carried out by the Institute of Child Health and a themed review of death and cases of serious morbidity.	6 months	5 years
Mothers and Babies – Reducing Risk through Audits & Confidential Enquiries across the UK (MBRRACE-UK)	This programme will investigate maternal deaths and conduct national surveillance of late foetal loss, stillbirth and infant deaths. They also conduct themed confidential clinical reviews of maternal and infant morbidity topics. The aim is to provide robust information to support the delivery of safe, equitable, high quality maternal new born and infant health babies.	6 months	5 years
Other National Reviews/ Enquiries	Various	6 months	5 years

Appendix 3: Rapid Impact Assessment Screening Form

RAPID IMPACT ASSESSMENT SCREENING FORM

Name of procedural document	Nationally Agreed Guidance Policy
Directorate and Service Area	Governance & Patient Safety
Name, job title and contact details of person completing the assessment	Katie Boucher, Clinical Audit Manager, Katherine.boucher@nhs.net , x3715
Date:	22 January 2013

EXECUTIVE SUMMARY

This section summarises:

- the impacts identified for action
- mitigating action
- the likely severity of the impact as a result of that action ("result").

Impact	Action	Result
None identified.		

(If you need to progress to a full impact assessment, please include this as an action, above.)

1. What is the main purpose of this policy?

To ensure that a standardised approach to the dissemination and implementation of nationally agreed guidance (NICE, recommendations arising from confidential enquiries) is followed across all areas in the Trust.

2. Who does it affect? Please tick as appropriate.

Carers ☐ Staff ☒ Patients ☐ Other ☐ (please specify)

3. What impact is it likely to have on different sections of the community / workforce, considering the "protected characteristics" below?

Please insert a tick in the appropriate box √

Protected Characteristics	Positive impact -- it could benefit	Negative impact -- it treats them less favourably or could do	Negative impact -- they could find it harder than others to benefit from it or they could be disadvantaged by it	Non-impact – missed opportunities to promote equality	Neutral -- unlikely to have a specific effect
Age	☐	☐	☐	☐	☒
Disability	☐	☐	☐	☐	☒
Sex *including Transgender and Pregnancy / Maternity*	☐	☐	☐	☐	☒
Race	☐	☐	☐	☐	☒
Religion / belief	☐	☐	☐	☐	☒
Sexual orientation including Marriage / Civil Partnership	☐	☐	☐	☐	☒

In identifying the impact of your policy across these characteristics, please consider the following issues:

- **Fairness -** Does it treat everyone justly?
- **Respect -** Does it respect everyone as a person?
- **Equality -** Does it give everyone an equal chance to get whatever it is offering?
- **Dignity -** Does it treat everyone with dignity?
- **Autonomy -** Does it recognise everyone's freedom to make decisions for themselves?

If you have any negative impacts, you will need to progress to a full impact assessment.

In sections 4 and 5, please copy and repeat the tables below, for each "protected characteristic" considered. Alternatively, you can use one table for more than one "protected characteristic", if the outcomes are similar.

4. **If you have identified any positive impacts (see above), what will you do to make the most of them?**

"Protected characteristic" affected:	N/A	
Issue		
Who did you ask to understand the issues or whose work did you look at?	What did you find out about?	What did you learn or confirm?
	Action as a result of above	
Action	By who?	When?

5. **If you have identified any missed opportunities ("non-impacts"), what will you do to take up any opportunities to promote equality?**

"Protected characteristic" affected:	N/A	
Issue		
Who did you ask to understand the issues or whose work did you look at?	What did you find out about?	What did you learn or confirm?
	Action as a result of above	
Action	By who?	When?

6. **If you have a identified a neutral impact, show who you have consulted or asked to confirm that this is the case, in the table below:**

Who did you ask or consult to confirm your neutral impacts? (Please list groups or individuals below. These may be internal or external and should include the groups approving the policy.)
Policy Expert Panel
Tony Williams, Equality & Diversity Manager
Governance Leads
Clinical Effectiveness Committee

If you need help with any aspect of this assessment, please contact:
Tony Williams Equality and Diversity Manager
Ext: 6942 anthony.williams1@nhs.net