Birmingham and Solihull Mental Health NHS Foundation Trust

Review and Implementation of NICE Guidance

Policy number and category	**CG14**	**Corporate Governance**
Version number and date	**4**	**March 2021**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**May 2021**	
Next anticipated review	**May 2024**	
Executive director	**Medical Director**	
Policy lead	**Clinical Effectiveness Manager (CEM)**	
Policy author *(if different from above)*		
Exec Sign off Signature (electronic)	XXXXX XXXX	
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

The purpose of this document is to ensure a BSMHFT wide process for the review, dissemination, and implementation of NICE guidance.

Policy requirement (see Section 2)

All guidance published by NICE will be reviewed and implemented according to the procedure set out in the policy.

All staff should be aware of the NICE guidelines applicable to them.

Contents

1. Introduction:

1.1. Rationale The purpose of this document is to ensure a BSMHFT wide process for the review, dissemination, and implementation of NICE guidance.

1.2. Scope This policy applies to all staff working within BSMHFT including those in the prison healthcare services

1.3. Principles The Trust is committed to implementing evidence based practice.

2. The Policy

2.1. All guidance published by NICE will be reviewed and implemented according to the procedures set out in section 3 and 4.

2.2. All staff have a duty to be aware of the NICE guidelines applicable to them

3. The Procedure 3.1 Procedures for newly published NICE guidance 3.1.1 Identification of new guidance

Review relevance of the guidance (Implementation Stage 1)

When new NICE guidance is published the a member of the governance team will add this to the list of newly published NICE Guidelines (located in the governance shared drive) and present this list to the Clinical Effectiveness Advisory Group (CEAG).

There may be a prior review of guidelines by the Clinical Effectiveness Manager (CEM) and other members of the governance team, to offer recommendation to CEAG. If there is a large number of guidelines coming to the committee. CEAG will then review the list seeking clarification where necessary and agree which guidance is relevant to the Trust. For those guidelines that are felt to be relevant, the CEM will document this decision in the spreadsheet for newly published NICE guidelines.
For any guidance that is felt to be relevant, CEAG will agree/advise on the following:

- The priority level of the guidance according to the below criteria. (High, Medium, Resource)
- The committee, or 'Governance Home' which will hold responsibility for the Clinical Guidelines including recommendations and actions.

- Recommendations as to the profession / type of staff required to participate in the compliance assessment.
- If the committee is aware of any BSMHFT policies, guidelines or strategies that should be linked to the guidance

The CEM will document all decisions about the factors listed above in the NICE Management Spreadsheet, held by the Quality Improvement and Clinical Effectiveness Team (QICE).

Priority Levels

High priority – Any piece of NICE guidance that is considered core business for mental health services. This may be guidelines that impact large groups of service users (such as schizophrenia, depression etc.) or core activities (such as management of aggression). This will also cover guidelines that impact a smaller cohort of patients known to mental health services (e.g. Perinatal mental health). These guidelines will require a full baseline assessment with relevant clinical teams and an overall report that will go to CEAG. This may be completed In a workshop format, (Please see appendix 3) that will be facilitated by the governance team. These reports must be presented by a clinician or clinical team that were involved in the initial baseline assessment or any discussions around compliance of the guideline by the trust, a presentation date must be agreed within the workshop by a member of the reviewing group.

If a high priority guideline is returning for re-review, it will be decided at CEAG whether a full baseline is needed again. This will be dependent upon:

- Relevance- Was it that the guideline was not relevant: Is it now relevant, if not why not and if so, a baseline assessment will be needed.
- Met/Not met Criteria - did we meet it previously, have services changed, and has there been updates that may affect the criteria.

If a full baseline is not needed, a Confirmation of Compliance (CoC) sheet (Please see Appendix 2) or baseline template with the relevant recommendations may be used to confirm compliance against the guideline and this will return to be signed off at CEAG within 3 months of first review at CEAG.

The review period for new High priority guidelines will be reviewed within 6 months from review at CEAG and 2 years thereafter. This will be guided by CEAG and dependent upon the capacity within the workplan.

a. **Medium Priority**– Any piece of NICE guidance that may be related to specific directorates or teams within the Trust. Therefore, it may be seen as core business, but for a small group or one specific area. The review period for Medium priority guidelines will be 6 months from first review at CEAG and 3 years thereafter. This will be guided by CEAG and dependent upon the capacity within the workplan.

b. **Resource Guidelines**– Any piece of NICE guidance that may not directly relate to services the Trust offers but could be used as a resource for clinicians to refer to. This guidance will be held in the trust, on the Clinical Effectiveness connect page for resource or reference, but not assessed on compliance or adherence. If required, a member of the CEAG committee will disseminate this as a resource to relevant parties, and it will be included in a monthly NICE newsletter. This priority level will also include guidelines relating to physical health where the onus is on the trust to support users to access the required support, for example guidance on obesity or tuberculosis. These guidelines will be brought back for relevance updates every 3 years, directly to CEAG.

c. **Technology appraisals guidance** (TAG's) are recommendations on new and existing medicines and treatments within the NHS. The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's technology appraisals and must make sure it is available within 3 months (unless otherwise

specified) of its date of publication. TAG's will therefore be reviewed within 3 months of issue. The review period will be as for medium guidelines.

- CEAG will review the applicability of all non-medical TAGs. Those that may be applicable will be sent to the most appropriate Governance Home, or designated individual, who should report back to CEAG within 4 weeks if this is applicable to us. If this is applicable, the response should also detail if we have plans to implement, or the reasons why we are unable to implement (in which case this will be escalated to Trust CGC). The report should be fed back by a relevant clinician who holds expertise in medicines and treatments. These conversations will be facilitated by Clinical Governance Facilitators.
- The Area Prescribing Committee will retain responsibility for pharmacological TAGs. Any positive medicines TAGs (i.e. recommendation for using the TAG in the NHS) are considered monthly at the Area Prescribing Committee, who place on to the formulary, which is followed by BSMHFT staff. PTC will provide quarterly exception and assurance reports to Trust Clinical Governance Committee about any pharmacological TAGs that have not been implemented.

3.1.2 Dissemination of new guidance The Clinical Effectiveness Manager (CEM) will:

- Bring all new guidance to CEAG (as defined in Stage 1)
- Issue guidance deemed applicable to BSMHFT to Governance Homes and individuals identified as having relevant knowledge (As directed by CEAG). As part of this, the responsibilities and clear time scales for return of information will be detailed by CEM and updated in the NICE workplan.
- Send a Quarterly update via email to Trust Clinical Governance Committee (CGC)

Clinical Leads will:

- When assigned a guideline, be responsible for allocation of leads or groups within their service areas for compliance confirmation or baseline assessment completion. These groups/meetings will be facilitated by Clinical Governance Facilitators (CGFs), but reports will be fed back to Clinical Effectiveness Group (CEAG) via Clinicians, leads or Clinical Leads.

3.1.3 First review of new guidance

High Priority guidance

- After CEAG has designated Clinical leads or relevant leads within Governance home/s, the relevant parties (clinical teams with facilitation from CGFs) will be required to complete the baseline assessment (see section 4) of a new high priority guidance. If applicable, a workshop will be facilitated with relevant clinicians and teams to allow for wider scope and clinical input. The workshop format is listed in appendix 3. If there is no baseline available (In the case of Quality statements or Guidelines that do not have a baseline assessment), the recommendations and standards will be reviewed and discussion will guide compliance- which will create percentages depending on how many there are and how many are met/not met.
- If after or during review, clinical teams feel that the guideline is wrongly placed in priority- this will need to go back to CEAG for re-allocation or rejection of the notion. However, if the teams feel that wider review is needed form other teams that CEAG did not suggest these teams can be contacted by the Governance team to facilitate further review, before returning to CEAG.
- Upon returning to CEAG, if a piece of guidance is felt to be 'Met', this will be sufficient assurance for compliance for CEAG to close the guideline on the NICE tracker (Held by the governance team). In this case the normal 2 yearly

review timeline can be put in place on the NICE tracker. CEAG will then offer recommendations and feedback to Trust CGC on the guideline and any actions that are in place. Disputes with 'Met' guidelines will be considered in exceptional circumstances.

- If a piece of guidance is felt to be 'Partially met', there must be actions brought to CEAG by clinicians that are presenting the feedback. Alternatively, evidence that actions are already in place to mitigate the compliance gaps must be presented, this will allow CEAG to agree that this is sufficient assurance for compliance. From this, they may feel it is appropriate to set the default review period as 2 years or advise that the guideline needs to be reviewed sooner in order to monitor progress against the actions. If so, this will be clearly documented in CEAG minutes and on the NICE Management Spreadsheet held by QICE. Leads must be assigned to each action or review where applicable. Alternatively, if the part that is not met is not relevant, it may be signed off.
- If a piece of guidance is felt to be 'Not met', the baseline assessment report (If applicable) must return to CEAG within 3 weeks of completion. This must be presented by a clinician or member of the discussion panel or teams that have been involved. The group will review the actions, reasons why it is 'Not Met' and discuss whether this needs to return to other teams or services. This guideline will need to be reviewed within 6 months and return to CEAG to sign off.
- High Priority guidelines should be reviewed at least every 2 years.

Medium Guidelines

- The relevant governing body or designated individual should provide CEAG with assurance on general compliance level using the 'Overview Compliance' triaging form (appendix) – Feedback must be given by the reviewing team/Individual in CEAG.
- If the individual deems the guideline is wrongly placed (priority) or needs to go to another reviewer/s, this will need to come through CEAG as a quick 'Approval of Journey' – Once approved the same process will apply.
- As above, if compliance is Met, the guidance should be returning to CEAG for sign off and CEAG will offer Trust Clinical Governance Committee advice on recommendations or present findings.
- If it is 'partially met' there must be actions on the action table on the Overview of Compliance sheet, or these must be agreed within CEAG by clinicians that are presenting the feedback. Alternatively, evidence that actions are already in place to mitigate the compliance gaps must be presented, this will allow CEAG to agree that this is sufficient assurance for compliance and the Guideline can be closed by the QICE team. The actions will be monitored by the committee and the leads.
- If it is 'Not met', The committee will review the actions, reasons why it is 'Not Met' and discuss whether this needs to return to other teams or services for a full baseline assessment or whether it is not applicable to the trust. This guideline will need to be reviewed within 6 months and return to CEAG to sign off.
- Medium should be reviewed at least every 3 years

3.2 Procedures for reviewing NICE guidance applicable to BSMHFT

3.2.1 Monitoring compliance

- Full Baseline Assessment Review: For new medium guidance that does not have sufficient assurance following compliance overview exercise. For all high priority guidance established on the work plan.
- Gap analysis review: If a piece of guidance has maintained a consistently high compliance rate over the last 2-3 reviews, before starting review process QICE can take this to CEAG to ask for approval to complete a 'Gap analysis review' instead of a full baseline assessment. This review must be completed in conjunction with relevant clinicians and professionals, as directed by CEAG, and supported by a member of the governance team. The review period for this review will be 3 months.
- CEAG will be interesting in gaining assurance through the below Questions:
    - Is this guidance relevant to the Trust?
    - If yes, are we compliant?
    - If we are, what are we doing to evidence this?
    - If not, is it relevant/important that we are not (i.e., some guidelines may apply to primary care settings- therefore it may not be relevant for us to implement)
    - If we are not meeting them/partially meeting them, but they are relevant, what are we doing to bridge the gap?

3.2.2 Process of Baseline Assessment Construction

- A member of the clinical governance department will be identified to support the review of the guideline. This work will be done in conjunction with the relevant Governance Home and any individuals with specialist knowledge of the guideline content, as directed by CEAG or Clinical Leads. The member of the clinical governance department will facilitate the review, but ownership and reporting must be led by clinicians and teams as directed by CEAG. Medium Priority guidelines
- Triaging process (please refer to Appendix 2) for medium guidelines will provide CEAG with a better understanding of general compliance. This will enable more effective prioritization and allocation of resources for actions that come from this process. (A baseline assessment will not be used for medium guidelines, unless a 'Not met' response is deemed, and it is decided at CEAG that we should be meeting it.

  High Priority Guidelines

    - Information regarding previous assessments, serious incidents, risks, Clinical Audit, and such information will be gathered by the QICE team. They will collate this to facilitate conversation with clinicians and relevant reviewing teams (As directed by CEAG or Clinical Leads).
    - Information such as local guidelines and policies will be brought and considered by clinicians and reviewing teams.
    - The baseline assessment will be facilitated by the QICE teams in workshops, Governance home committee meetings or 1:1 meeting's, depending on the scope and reach required for the guideline. (Please see Appendix for workshop template). Clinicians will be given or agree a CEAG meeting date to attend and feedback the report below.
    - The information will be collated in the baseline tool, but also a short summary which will be put together by the CGF facilitating the guideline review. This report will be sent to CEM/Relevant clinician or reviewer that was highlighted to feedback the findings in CEAG, along with a CEAG date.
    - The report will contain the following information (See template in appendix4):
    - Name of CGF facilitating the compliance assessment
    - Names and positions of contributors to the compliance assessment
    - Sources used to collect the data indicating compliance level
    - Dates of approval from Governance Home and presentation to CEAG for assurance
    - Number of standards applicable to BSMHFT

- Compliance rate against the standards applicable to BSMHFT
- A summary of good practice
- A summary of not met/partially met practices
- An action table that denotes if there are any actions to mitigate against noncompliance or if the non-compliance needs to be escalated. Any actions listed will also list the person responsible for monitoring this action.
- 3 key messages that highlight urgent actions/work (if relevant) that can be used as a basis for discussions at CEAG.
- The Clinicians will be sent this report and will be required to feedback at the planned CEAG or next available CEAG meeting.

3.2.3 Process of Gap Analysis

- The process of Gap analysis largely follows that of a Baseline assessment. However, in this case the CGF will look through the 2-3 previous reviews for areas
  of consistent non-compliance and areas of compliance that have reduced over the recent reviews. The subsequent data collection/reviews will only focus on those gaps identified.
- These reviews will be in conjunction with clinical individuals and teams, as directed by CEAG.
- When the findings are written up, it will be clearly documented if a gap analysis was completed instead of a baseline assessment.
- These will be reported back to CEAG by clinical teams/reviewers.

3.2.4 Review of findings and Action Plans

- The findings of any reviews should be taken to the relevant Governance Home to agree this is a reflection of practice. The Governance Home has responsibility for allocating relevant actions to gaps in compliance and flagging gaps that cannot be actioned. Actions and responsibility will be documented on the 'Overview of Compliance' form, or report.
- Following discussion in the Governance Home, the findings of the compliance assessment and associated action plan will be presented at CEAG. CEAG are responsible for agreeing that there is sufficient assurance of compliance with NICE guidance and/or appropriate action plans in place to address any gaps in compliance. CEAG will advise of a time period in which they will require an update on progress of actions, this will be fed back to the Governance Home and monitored by a clinician or professional that was involved In the review process, these actions will be facilitated by a CGF, who will feed back to CEAG where necessary. (The clinician or members of reviewing team must be present at this CEAG meeting to assign or take back actions). The QICE team may decide (On guidance from CEAG) that a guideline can be closed on the NICE Spreadsheet but monitored by internal processes.
    - The Ulysses action module will be used to track actions- whilst the actions will be put on the module by a member of the Governance team, actions will be managed and overseen by local areas/ or relevant committees.
- If any gaps have been escalated from the Governance Home to CEAG, this should be further escalated to Trust CGC and CEAG should advise if the CEM needs to log a risk on the BSMHFT risk register. Trust CGC must then discuss the gaps and feedback recommendations to CEAG, who will escalate to relevant teams and directorates. The time frame of 9 months for medium and 6 months for high must be considered in this process.

3.2.5 Documents to be sent to clinicians to initiate review

In order to ensure clinical teams/reviewers have the correct information when reviewing NICE guidelines, the clinical governance team will send the following documents prior to meeting or commencing the review:

- If medium: Compliance Overview Sheet (See appendix) , Flow chart for reviewing (See appendix), workshop template for guidelines (If relevant) – this will be saved in the NICE medium folder held by QICE, and hyperlink of guideline.
- If High: Baseline tool that will be used or workshop template- this will be save in the NICE high priority folder held by QICE, flow chart for reviewing high priority guidelines (See appendix) and any previous reviews that have been completed (if relevant).

3.3 Clinical Audit/ Other resource

Where relevant, Clinical Audit, service evaluation, Quality Improvement and Trust data may be used to evidence compliance against recommendations for guidelines. The governance team may also use the audit platform to inform Audits, based on 'Not met' or 'Partially Met' Nice guidelines. Every 6 months the Governance team will highlight the top 3-5 Audits that can be led by 'Not met' or 'Partially Met' NICE guidelines. These will be disseminated to teams through CEAG or via direct enquires to the Governance team.

3.4 Updated guidance

- Periodically, NICE review existing guidelines and publish updates based on up to date evidence. These updates may impact the whole guideline or smaller sections of standards within a guideline.

3.4.1. Identifying and reviewing updated guidance

- The CEM will be responsible for completing a monthly check for updated guidelines. This will be done in the same way as pulling the list of all new guidelines, however the CEM will be able to establish which updates are relevant to BSMHFT based on guidance already in the NICE Management Spreadsheet and consultation with the chair of the Clinical Effectiveness Committee. The NICE Management Spreadsheet will be updated to reflect that a piece of guidance has been updated in a certain month, these will be sent out via e-mail or put on the Clinical Effectiveness Connect page for committee members to review relevance, whether priority needs to change, and where it will need to go if any additions or changes to the old review/teams.
- If the updated guidance is mapped to a trust policy, the CEM will notify the Compliance Facilitator who will contact the relevant policy lead. The policy lead will be asked for a response within 2 weeks about whether the policy remains in line with NICE guidance, an amendment is needed, or the policy needs to be reviewed.
- The CEM will send an email to the Subject Matter Experts (SME),CGFs and Governance Home for the pieces of guidance that will be updated containing notification that the guideline has been updated and what the update covers. This email will ask for a response from the SME and Governance Home within 4 weeks. The SME and Governance home are responsible for indicating if current practice is compliant with the update.
- If the SME and Governance Home (and Policy Lead if relevant) feel current practice is not in line with this update, they will be responsible for providing a statement around action that will be taken to achieve compliance or highlighting that the gap in compliance needs to be escalated. This statement will need to be returned by using the 'Overview of Compliance' sheet (See appendix 2).
- This will be presented at CEAG by the SME or clinician, CEAG will then agree that the response is sufficient to indicate compliance, or sufficient assurance has been received that actions are ongoing or that escalation of gaps are needed.
- If we are compliant with the update, this will reset the 24 months review timer from the point the update was assessed. This will be done as standard, unless CEAG/ or SME advise that there is a need to complete a full baseline or gap analysis review of the guidance in line with the initial review plan. Reasons for this may include: to keep in line with trust strategy, awareness of a recent linked serious incident relating to the guidance, or wider concerns about compliance with the wider guideline.

3.5 Workplan Review

- The CEM will provide a summary to CEAG of guidelines due to be reviewed within the next 12 months, on the annual work plan. This will be reviewed annually in CEAG from November 2020. As part of this summary CEAG will provide confirmation of the appropriate Subject Matter Experts, teams and Governance Home to link in with and any policies and guidelines that are applicable to the guidance.
- Flexibility with review date: If a new piece of guidance has been released within the last 24 months and is directly related to the guidance in question (e.g. an accompanying quality standard) as part of the 18 month CEAG check, CEM will ask if CEAG feel the review date can be postponed following adequate assurance of compliance with the new/updated guidance. This conversation will be clearly

documented in CEAG minutes and the NICE Management Spreadsheet will be updated accordingly.

3.6 **Committee Ownership:** The Clinical Governance Committee is accountable for the implementation and review of NICE guidance.

The Clinical Effectiveness Advisory Group will manage the day to day running of the implementation and review of nice guidance.

3.7 **Recording decisions not to implement recommendation from NICE guidance:**

3.7.1 **Full NICE guidance:** If a decision is made not to implement a full piece of NICE guidance this will be presented to CEAG. CEAG are responsible for approving the rationale and completing a risk assessment for non-implementation. If necessary, the risk register should be updated. This will be documented in the same way a compliance review is.

3.7.2 **Select standards within NICE guidance:** If a decision is made not to implement standards within a piece of NICE guidance this will be highlighted, alongside the rationale for this decision, in the baseline assessment (If applicable). The decision not to implement will be validated by the Clinical Effectiveness Advisory Group and escalated to the Clinical Governance Committee (Via Quarterly report) for ratification. The Clinical Effectiveness Manager will log risk identifying numbers on the QICE team guidelines tracker, as guided by reviewing clinicians.

3.8 Implementation

3.8.1 As part of action plans the trust should consider using the implementation tools provided by NICE

3.8.2 If it becomes apparent that some gaps in compliance cannot be addressed easily, the CEM should contact the Subject Matter Experts (SMEs), Governance Home and relevant Improvement Advisor to inform them of the compliance gap and ask them to initiate the discussion around using QI methodologies to tackle the compliance gap.

3.9 Sharing learning

3.9.1 The CEM/QICE team will maintain NICE pages on the intranet which will come under the wider Clinical Effectiveness connect page. These pages will list guidelines relevant to our organization, guidelines coming up for review, and general compliance with guidelines.

3.9.2 As the final stage of the NICE review process, there should be a regular update (e.g. Monthly/quarterly) of NICE work circulated to Governance homes and Local CGCs. These updates should list new NICE guidance, guidance that has recently been reviewed (including summary compliance), Resource guidelines, and guidance that is due to be updated.

3.9.3 There will be a monthly NICE newsletter circulated through the trust for resources, and key NICE guidelines that were reviewed and those that are due for review in the coming months.

3.10 Escalation process for not getting involved

3.10.1 Responsibility of various individuals (SME, Governance Homes, Clinical leads) have been listed previously.

3.10.2 If there is consistently poor engagement from individuals or Governance Homes, this will be escalated to the AD of Governance as a risk that lack of engagement will compromise the reliability of NICE compliance reviews. If this

lack of engagement continues, this will be escalated to Trust CGC to raise aware of the risk.

4 Responsibilities

Post(s)	Responsibilities
All Staff	**All Clinicians** have a duty to be aware of NICE guidance and ensure their practice reflects the recommendations. They also have a duty to actively be involved in the review process where requested or directed by CEAG. This requires attendance to CEAG committee meetings to present and discuss guidelines they have reviewed.
Policy Lead	**The Clinical Effectiveness Manager** will have lead management responsibility for the co-ordination of NICE guidance review and implementation and the review. The CG Manager will report quarterly to the Clinical Governance Committee.
Executive Director	**The Medical Director** will have executive responsibility overall for this policy
Clinical Leads	**All clinical Leads** will have responsibility to delegate guidelines that are assigned to them, to leads within their team. They will also be responsible for attending CEAG to feedback or delegating a representative to do this. They will also ensure action plans are regularly tracked and updated.

The following committees and departments will support the above to carry out their duties

4.4 **The Quality Improvement & Clinical Effectiveness Team** will maintain a database of all newly published NICE guidance, which will contain:

The full title
Date of publication
Date of distribution within BSMHFT
Whom this guideline is to be escalated to
Priority level assigned by CEAG

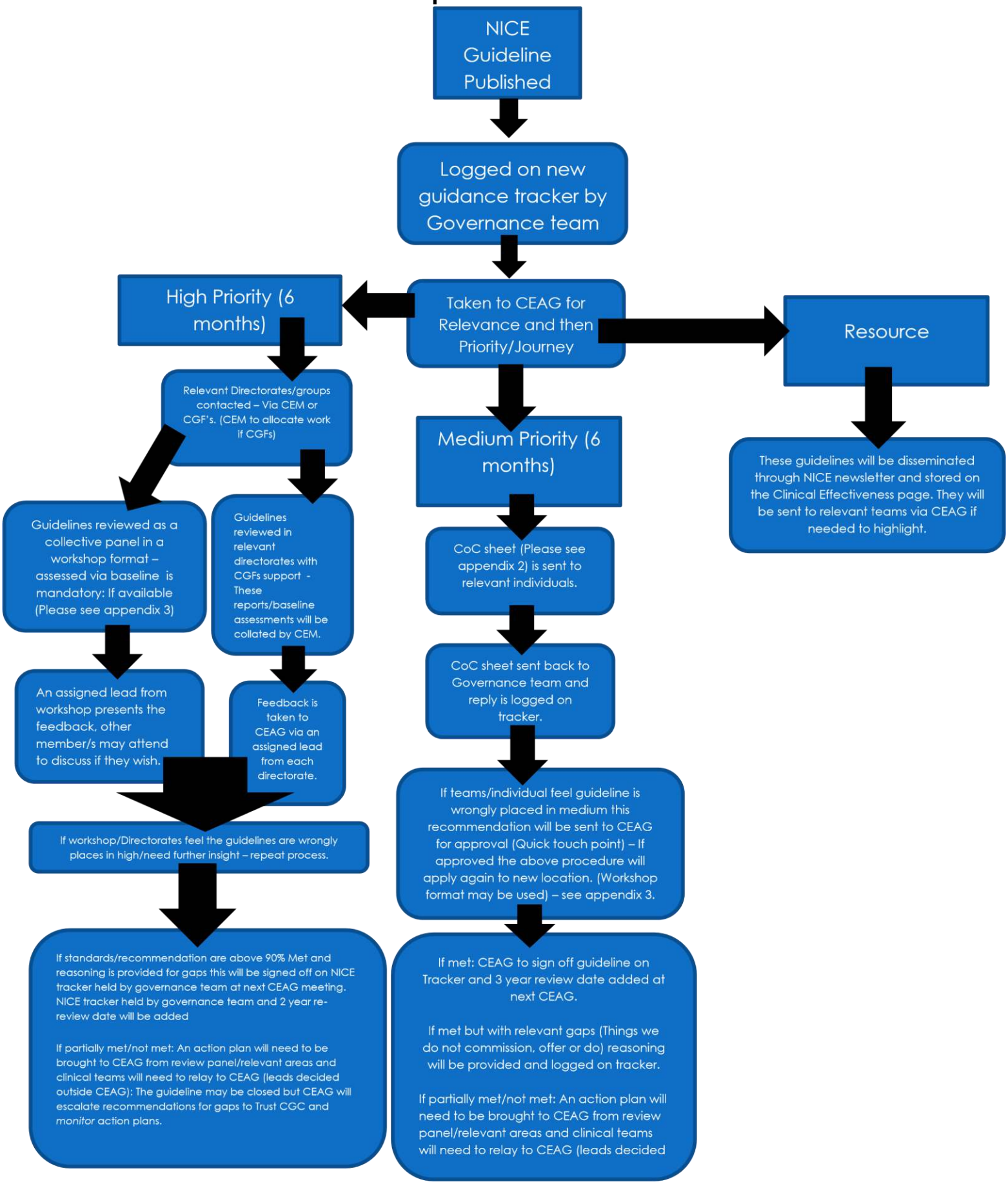
4.5 **The Quality Improvement & Clinical Effectiveness Team** will maintain a database of all NICE guidance applicable to BSMHFT, which will contain:

The full title
Date of publication
Date initially taken to CEAG
Priority level assigned by CEAG
Name of relevant governance forum of 'Governance Home'
Date of distribution to relevant governance forum/home
Names of topics leads needed to be involved
Date of last contact with topic lead/governance forum
Date of completion of most recent compliance review
Actions required to complete guideline review
Sign off date and status

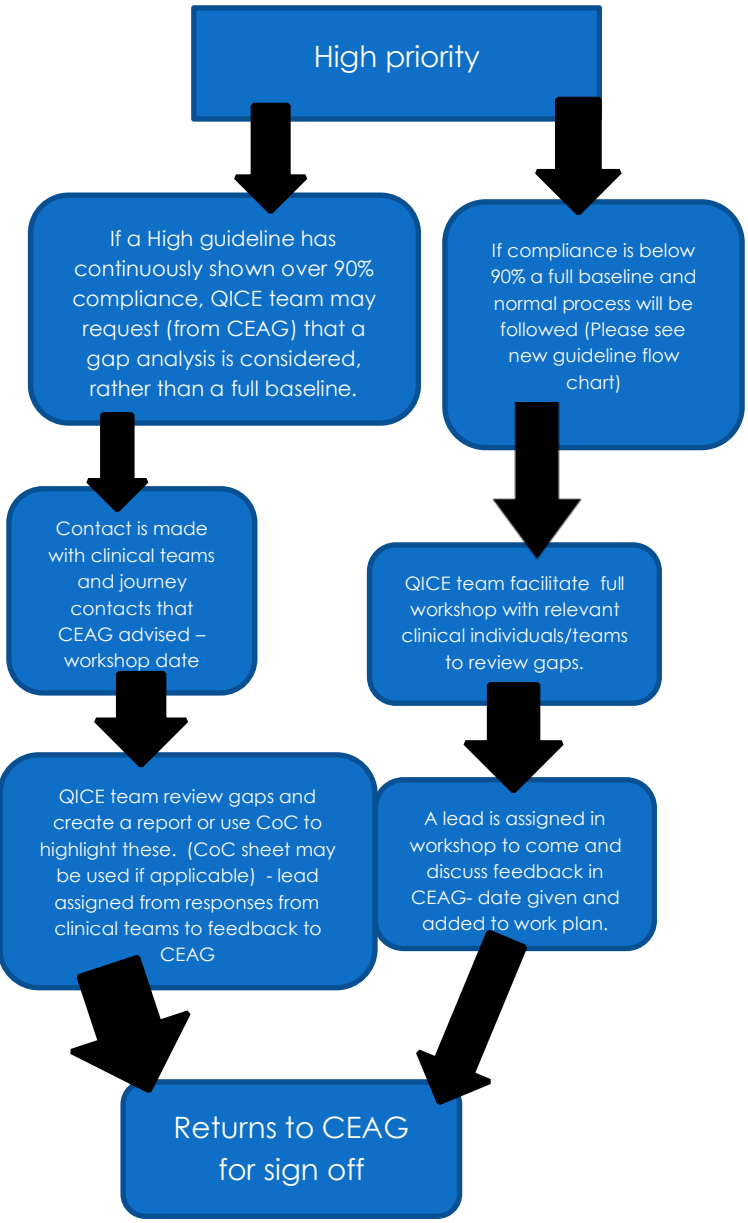
Risk status
Actions taken by QICE team

4.6 **The Pharmacological Therapies Committee** will ensure that all relevant NICE guidance is incorporated into any prescribing guidance produced.

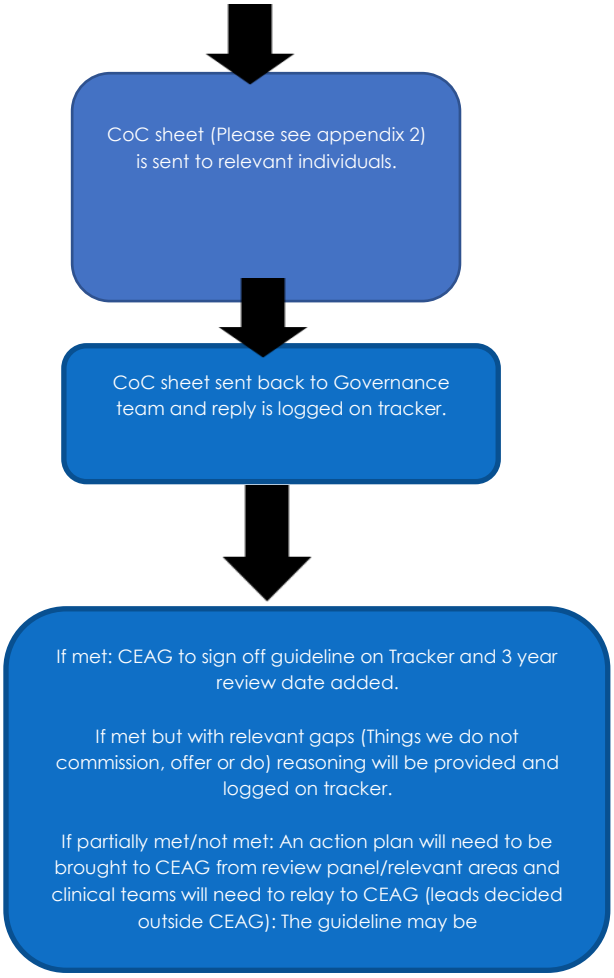
NICE Review and Implementation Procedure in BSMHFT



NICE Re-Review and Implementation Procedure in BSMHFT



Medium priority



5 Development and Consultation process consisting of:

Consultation summary	
Date policy issued for consultation	January 2021
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	
Clinical effectiveness advisory group	September 2020
Quality Improvement and Clinical Effectiveness Team	December 2020
PDMG	March 2021

6. Reference documents

- Policy Development and Management Policy (includes Clinical Guidelines)
- New Clinical Procedures policy
- How to put NICE guidance into practice – Pub NICE December 2005 ISBN 1-84629114-3

7. Bibliography

None

8. Glossary

CEAG: Clinical Effectiveness Advisory Group
QICE: Quality Improvement and Clinical Effectiveness
CEM: Clinical Effectiveness Manager
CoC Sheet: Confirmation of Compliance Sheet
Governance home- Relevant directorate or committees

9. Audit and assurance

9.1 The above procedures will apply to all new guidance from the date of implementation of this policy. All guidance issued prior to this will have a baseline assessment and be reviewed but not within the stipulated timescales.

9.2 The Clinical Effectiveness Manager will maintain a database on all the relevant NICE guidance, their publication and review dates, the level of compliance, and at what stage of the implementation process they are at, as defined on the previous page.

9.3 Every 6 months the Clinical Effectiveness Advisory Group will receive a report on the implementation of the NICE guidelines and if the implementation process has been in line with the stages set out on the previous page, to ensure it is compliant with the policy.

9.4 The Clinical Governance Committee will receive quarterly reports from the Clinical Effectiveness Group, this will include a list of all relevant new NICE guidance and a summary of the guidance reviewed in the previous 3 months.

9.5 Monthly progress reports to Contracts

9.6 Attendance will be monitored at Clinical Effectiveness Advisory Group to monitor involvement of all service areas.

9.7 The Trust Board will receive an Annual NICE implementation report as part of its Board program approved by the Clinical Governance Committee. This report will include dates that Clinical Governance Committee reports were submitted.

9.8 In order to provide assurance that all of the work has led to a better understanding of how effective the care we provide is and gaps are acted on, the trust CGC report will include a summary of the gaps identified, actions agreed, progress and information about any issues the TCGC needs to consider.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement
Where recommendations from guidelines can't be met they will be escalated to the CGC	Head of Quality and Effectiveness / Chair of CEAG	Report to the Clinical Governance Committee	Quarterly	Quarterly report to the Trust CGC

10 Appendices

Appendix 1- Equality Analysis Screening Form

CG 14 Review and Implementation of NICE Guidance

Title of Proposal	**XXXX XXXX**	**Role or title**	**Clinical Effectiveness Manager**
Person Completing this proposal	**Corporate**	**Service Area**	
Division	**30/09/2021**	**Date completed**	**11/01/2021**
Date Started			

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation. The purpose of this document is to ensure a BSMHFT wide process for the review, dissemination and implementation of NICE guidance

Who will benefit from the proposal?

All staff will be aware of the NICE guidelines which are applicable to them. This policy ensures that best practice in care is implemented.

Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity?	*Promote good community relations?*
Eliminate discrimination?	*Promote positive attitudes towards disabled people?*
Eliminate harassment?	*Consider more favourable treatment of disabled people?*
Eliminate victimisation?	*Promote involvement and consultation?*
	Protect and promote human rights?

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics**
Age	**Yes**			
Including children and people over 65**.** Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	**Yes**			
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	**Yes**			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex?. Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships	**Yes**			

People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters

Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?

Pregnancy or Maternity **Yes**

This includes women having a baby and women just after they have had a baby. Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?

Race or Ethnicity **Yes**

Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees. What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	**Yes**			
Including humanists and non-believers. Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	**Yes**			
Including gay men, lesbians and bisexual people. Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	**Yes**			
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights	**Yes**			
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
No negative impact identified.				
How will any impact or planned actions be monitored and reviewed?				

How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Equality and Diversity Lead Bina Saini The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

Appendix 2- Template Compliance Confirmation Form

Dear

Please find attached NICE guideline XX. The Clinical Effectiveness Group have assessed that this guidance has elements which are partially applicable to the trust and your advice is being sought as to the trusts compliance with these elements. Please read the guidance and provide an overall indication of compliance and please highlight any areas of non-compliance or concern.

Please provide the information below by the (4 weeks), when it will be reported back to the Clinical Effectiveness Group. You will be required to attend the meeting to feedback. Invite will be sent upon receipt of completed form.

Yours Faithfully

Dr Rowe

Deputy Medical Director

NICE Reference No. ……

Title of Guidance……..

Statement of Compliance

Fully Compliant ☐ Partially Compliant ☐ Non-Compliant

If not fully compliant:

The trust **will** implement the guidance as detailed in the action plan below ☐

The trust is **unable** to implement the guidance, please give detail below ☐

The trust does **not intend** to implement the guidance, please give detail below. ☐

Details regarding non-compliance;

Areas the Trust does well in/ previous progress made:
Areas of the guideline not met by the Trust/things to be aware of:
Actions the Trust needs to take in order to meet this guideline: (only if the guideline is partially or not met)
Risk level (If the guideline is partially or not met, please indicate using the risk matrix below the current risk this could have)

Name …… Date……

Severity	Likelihood				
	1- Rare	2- Unlikely	3- Possible	4- Likely	5- Almost Certain
5- Catastrophic	Score 5	Score 10	Score 15	Score 20	Score 25
4- Major	Score 4	Score 8	Score 12	Score 16	Score 20
3- Moderate	Score 3	Score 6	Score 9	Score 12	Score 15
2- Minor	Score 2	Score 4	Score 6	Score 8	Score 10
1- Insignificant	Score 1	Score 2	Score 3	Score 4	Score 5

APPENDIX 3- Workshop Guide

Workshop Guide

In order to facilitate a successful workshop it is important to prepare well and be aware of the content of the workshop, what you bring to the table, what the participants need (In this case clinical individual/s and teams) bring to the workshop and what outputs are expected from both parties. This Workshop guide will:

Help you prepare for a NICE guideline review workshop
Describe and outline the pre-workshop checklist for both clinical individuals/teams (Here by noted as the reviewers) and the facilitator
Explain the workshop template
Describe the format and offer tips on starting and facilitating discussion
Offer note taking tips
Talk about roles and responsibilities

Preparation beforehand and Roles Within

This section will talk about preparation from a facilitator perspective, but also the reviewer's perspective. It is important for both sides to have a clear understanding of what the workshop is about and what is expected.

Facilitator

The role of a facilitator is to support the conversation and take notes on the views and discussions that occur within the workshop. Preparation will include:

- Creating the workshop template (INSERT LINK) – medium use obesity example and high regular
- Sending the pre-workshop checklist to the reviewers (Below)
- Setting up the meeting and sending it to all relevant parties
- Sending out the guidelines and report at least a week prior to the workshop (This may be extended if several are reviewed in one workshop)
- Post workshop: Liaise with CEM/Corporate CGF to ensure updates, dates and actions are logged on internal tracker
- Post CEAG feedback: CEM/Corporate CGF to liaise with teams if the guideline is to go elsewhere or if further clarification is needed.

Reviewers

The role of the reviewers is to be aware of the guidelines and any links they may have to local trust policies or guidelines, this allows for meaningful conversation and a wider scope of the work that is being done. Most of the preparation will be outlined in the workshop checklist for reviewers below. They are also responsible for guiding and leading discussion within workshops about the guidelines.

Pre-workshop

☐ Review and consider relevant/related local policy
☐ Review and consider relevant/related local guidelines
☐ Review presentation
☐
☐
☐

During the workshop

☐ Generate relevant conversation around guidelines relevance, met or actions
☐ Assign a lead to present information to next relevant CEAG: governance team to offer dates if applicable
☐
☐
☐
☐
☐

Post workshop

☐ Designated lead to feedback to CEAG
☐ Designated lead to disseminate actions if applicable
☐
☐
☐
☐
☐
☐
☐

Ongoing actions

☐ Be aware of action required (If applicable)
☐ Review actions in a timely manor and feedback to CEAG to escalate if needed
☐
☐
☐
☐

Workshop template

The workshop template is designed to allow for guidelines recommendations and standards to be presented to staff in a collective manner, but also to allow for themes, shared learning and outcomes (met, partially met, not met) to be displayed.

The workshop

In order to successfully facilitate conversation in a workshop it is important to be aware of how many recommendations there are and if pre-work will be required or the work will be done in the workshop. This may require some pre-reading. Whilst it is important to offer and support a rich conversation, the clinicians must offer and guide direction in regards' to whether practice meets what the guidelines demand. Therefore, prereading of guidelines for clinicians and reviewing panel is vital.

Note taking tips

Create a pre-meeting plan of how notes will be organized: Link to baseline if high and link to recommendations if medium.

Back your notes up wit ha recording if possible (Teams recording option, Dictaphone, etc.)

Be succinct in what you capture to ensure efficient note taking not word for word transcription.

Organize notes towards an action

Capture Key points

Reflect on what you have written

Use symbols and abbreviations to assist better note taking

NICE medium workshop template.pp

,

The above template may be used for workshops

Appendix 4- Report Template for High Priority Guidelines

Name of CGF facilitating the compliance assessment:
Names and positions of contributors to the review:
Date Approved/Taken to local CGCs
Date Presented at Clinical Effectiveness Committee:

NICE Guideline: (INSERT NUMBER AND TITLE)
Desc (Taken from NICE Site)

Sources used to collect the data indicating compliance level: E.g. Clinical teams, groups, policies, etc.

Number of standards applicable to BSMHFT:
Compliance rate against the standards applicable to BSMHFT:

Good Practice Summary
(Brief summary)

Not met/Partially Met Summary
(Brief summary)

Actions	Responsible individual/Team

3 key messages that highlight urgent actions/work (if relevant) that can be used as a basis for discussions at CEAG.