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| Title: **National Clinical Guidance Policy** | Salford Royal NHS<br>NHS Foundation Trust<br>University Teaching Hospital |
| **Authors Name:**<br>Jayne Downey, Associate Director of Governance | |
| **Scope: TRUSTWIDE** | **Classification: POLICY** |
| **Replaces:** | |
| **To be read in conjunction with the following documents:**<br><br>**Clinical Audit Strategy 2009/10**<br><br>**New or modifications to clinical practice which are not part of an ethical committee approved research programme** | |

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## Policy Statement

Clinical guidelines are developed and disseminated to provide a safe, consistent and cost effective approach to the delivery of patient care. This policy supports the commitment and describes the procedures the Trust employs in ensuring that there is a systematic, effective and efficient process in place for implementing, monitoring and evaluating all National Clinical guidance relevant to the business of the organisation and for ensuring that the care and services provided are based upon relevant evidence based best practice

Implementation of National Clinical Guidance does not override the individual responsibility of health professionals to make decisions appropriate to the

circumstances of the individual patient in consultation with the patient and/or their carer. However, if a decision means that specific documented guidance is not followed for an individual patient, the reasons must be fully recorded in the patients' medical records.

## 1. Introduction

1.1. The document National Standards, Local Action, Health and Social Care Standards and Planning Framework 2005/06–2007/08 sets out the framework of standards – Standards for Better Health – improving the quality of care patients receive

1.2 Standards for Better Health forms a key part of the performance assessment by the Care Quality Commission, and are designed to improve healthcare service standards by identifying areas for improvement.

1.3 National Service Frameworks (NSFs) and National Institute for Health and Clinical Excellence (NICE) guidance are integral to this standards-based system. Under the Care Quality Commission standards NICE Technology Appraisals, Clinical Guidelines and Interventional Procedures form part of the Core Standards.

1.4 In addition, the NHS Litigation Authority (NHSLA) Risk Management Standard requires organisations to have systems in place which ensure:

1.4.1 The organisation has *approved* documentation which describes the process for ensuring that agreed best practice as defined in all NICE guidelance (where appropriate), is taken into account in the context of the clinical services provided by the organisation.

1.4.2 The organisation has *approved* documentation which describes the process for ensuring that agreed best practice, as defined in nationally agreed guidance, the National Service Frameworks, National Confidential Enquiries and other High Level Enquiries that make recommendations for patient safety, is taken into account in the context of the clinical services provided by the organisation.

1.5 The Trust will implement the following process to provide a system across the organisation that will: ensure a co-ordinated approach to the review, dissemination, and monitoring of all National Guidance. This will provide a route to ensure compliance with standard requirements and adherence to best practice is disseminated effectively.

## 2. 0 Roles and Responsibilities:

### 2.1 Board of Directors

2.1.1 The Trust Board of Directors is ultimately accountable for ensuring review and adherence to all relevant National Clinical Guidance across the organisation.

### 2.2 Chief Executive

2.2.1 The Chief Executive has responsibility for ensuring the organisation's statutory obligations are met. All NHS Trusts have a statutory obligation to implement relevant National guidance as applicable.

### 2.3 Executive Medical Director

2.3.1 The Executive Medical Director has delegated authority and responsibility for the dissemination, review, implementation and monitoring of all National Clinical guidance and recommendations.

2.3.2 Chair the Clinical Guidance Steering Group (CGSG) and ensuring gaps in assurance are reported to the Executive team and the Board of Directors as required

### 2.4 Associate Medical Directors/Director of Allied Health Professionals

2.4.1 The Associate Medical Directors support and ensure the process for review and implementation of all National Clinical Guidance is followed within their areas of responsibility.

2.4.2 Ensure that this Policy is implemented locally through the identification of a lead Clinician/Health Professional to review and implement the guidance where necessary

2.4.3 Ensure that the implementation process and compliance requirements of new guidance and national recommendations are fully embedded in the specialties of the respective clinical area/ speciality.

2.4.4 Ensure that the approval and registration processes of new techniques is fully embedded within the specialities of each respective Clinical area/speciality

2.4.5 Identify any gaps in the implementation process and communicate this to the CGSG

2.4.6 Ensure implementation plans are developed and monitored through the local Governance arrangements with the support of their local Governance manager and the Clinical Audit & National Guidance Manager.

2.4.7 Ensure clear accountability and structures are in place within their clinical areas of responsibility, so that the required time scales are met, documentation is complete and reports are provided to respective forums.

**2.5 Director of Clinical Effectiveness**

2.5.1 The Director of Clinical Effectiveness will ensure that the Care Records based structured documentation and other decision supporting mechanisms are developed to assist in the implementation of prioritised guidelines; and that all prioritised National Guidance and recommendations are integrated within the Clinical Audit Strategy, so that process and outcomes monitoring is implemented through the Clinical Audit Committee in a co-ordinated manner ensuring compliance with National Guidance is complete

**2.6 Deputy Director of Nursing**

2.6.1 The Deputy Director of Nursing will ensure all National Clinical Guidance and recommendations relating to the effective delivery of Nursing care are reviewed, implemented and monitored as necessary liaising closely with the Clinical Audit & National Guidance Manager in ensuring compliance is documented and maintained.

2.6.2 Ensure that any identified gaps in assurance have an action plan in place and progress reported to the Executive Nurse and the Clinical Guidance Steering Group through close liaison with the Clinical Audit & National Guidance Manager

**2.7 Director of Pharmacy**

2.8.1 The Director of Pharmacy will ensure all National Clinical Guidance and recommendations relating to the use of Medicines are reviewed by the Medicines Management Group, ensuring compliance or gaps in assurance are documented and evidence maintained

2.8.2 Ensure any identified gaps in assurance have an action plan in place and progress is reported to the CGSG through close liaison with the Clinical Audit & National Guidance Manager

**2.8 Associate Director of Governance & Quality**

2.8.1 The Associate Director of Governance & Quality is responsible for consistently implementing the organisational arrangements for Governance throughout the Trust, with operational responsibility for ensuring National Clinical Guidance and recommendations are reviewed, implemented and monitored as necessary.

2.9.2 The Associate Director of Governance & Quality will ensure systems are in place to support the dissemination, review, implementation and monitoring of all National Clinical Guidance and recommendations.

2.8.2 Ensure compliance with all relevant external assessment standards in relation to the review, implementation and monitoring of all National Clinical Guidance and recommendations.

2.8.3 Ensure the contents of this policy is administered and adhered to locally, reporting any gaps in assurance to the Clinical Effectiveness Committee.

### 2.9 Clinical Audit & National Guidance Manager

2.9.1 The Clinical Audit & National Guidance Manager will ensure all national guidance is disseminated to the relevant Clinicians as identified by the CGSG.

2.9.2 Liaise with the local Governance Managers to ensure action plans are developed in conjunction with identified leads and monitored to completion.

2.9.3 Ensure a process of horizon scanning is in place and reported through the CGSG to the Associate Directors of Operations for planning purposes.

2.9.4 Act as the responsible officer for overseeing the full implementation of this policy including developing clear structures within the Audit department for collating all relevant information for dissemination, maintaining evidence of compliance, advising the CGSG of any gaps in assurance.

### 2.10 Designated Leads

2.10.1 Designated leads will normally be a clinician, health professional or manager whose service would be affected by the guidance they are designated to review and implement.

2.10.2 Designated leads are responsible for co-ordinating a baseline assessment including developing an action plan in conjunction with their local Governance Manager; and identifying any cost implications. They will have responsibility for regular reporting on progress of implementation and identifying any barriers to implementation to the Clinical Audit & National Guidance Manager.

2.10.3 If guidance cannot be implemented fully, partially or within the agreed timescales, a risk assessment must be carried out and documented within the relevant Risk Register as per Trust policy.

## 2.11 All Staff

1.11.1 All staff have a responsibility to be aware of all National Clinical Guidance which may have an impact upon on their clinical area. Within this policy they have responsibility to support the Review, implementation and monitoring processes conducted by designated Leads.

1.11.2 Once a guideline has been endorsed by the CGSG and implemented within the Trust, health professionals are expected to take it fully into account when exercising their clinical judgment.

1.11.3 However, the Guidance does not override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and/or their guardian or carer. If such a decision means that the guidance is not followed for an individual patient, the reasons must be fully recorded in the patients' medical records.

## 2.12 Clinical Effectiveness Committee

2.12.1 The Clinical Effectiveness Committee will receive six monthly reports from the CGSG on progress in implementing all National Clinical Guidance relevant to the organisation.

2.12.2 The Clinical Effectiveness Committee will review and where appropriate endorse exception reports for National Clinical Guidance that is not considered appropriate to be fully implemented, cannot be implemented within required timescales, and /or that do not have the required resources.

## 2.13 Clinical Guidance Steering Group

2.13.1 The Trust has established a designated group to review, monitor and ensure compliance is maintained with all National Clinical Guidance and recommendations relevant to the Trust, reporting any gaps in assurance to the Clinical Effectiveness Committee including those Guidelines/Recommendations which are not considered appropriate to be fully implemented, cannot be implemented within the required timescales and /or that do not have the required resources.

2.13.2 The Clinical Guidance Steering Group (CGSG) will note any National Clinical Guidance that is fully implemented within the Trust and formally endorse the guidance as a Trust Clinical Guideline.

2.13.3 The CGSG will ensure evidence of implementation is recorded and an audit plan registered with the Clinical Audit Committee

2.13.4 Instances of intentional non-compliance or partial compliance agreed by the Clinical Effectiveness Committee will be reviewed by the CGSG to ensure appropriate Trust guidelines are in place or, if not, to highlight the need for their development. A risk assessment must be completed in these instances and documented within the Groups Risk Register as per Trust Policy.

## 2.14 Medicines Management Group

2.14.1 The Medicines Management Group will review each guideline and NICE Technology Appraisal relevant to Medicines Management and consider its appropriateness. The Director of Pharmacy will report the outcome to the CGSG and ensure in close liaison with the Clinical Audit & National Guidance Manager that the progress and evidence of implementation is documented within the Trust's National Guidance database

## 3.0 Purpose and scope of document

3.1 This policy has been developed to provide a framework for managing all National Clinical Guidance relevant to the services provided by Salford Royal Foundation Trust.

3.2 This includes guidance produced and disseminated by the following organisations:

3.2.1 National Institute for Health and Clinical Excellence (NICE)
3.2.2 National Service Frameworks
3.2.3 Care Quality Commission (CQC)
3.2.4 National Confidential Enquiries (NCEPOD/CEMACH/CISH)
3.2.5 Royal Colleges
3.2.6 Independent Inquiries (Shipman Inquiry)
3.2.7 National Patient Safety Agency Rapid Response Reports (clinical)
3.2.8 Any other relevant reports

3.3 The policy outlines the core principles for a collective approach to planning, enabling the consistent dissemination, implementation and evaluation of all National Clinical Guidance. (Appendix 1)
This policy provides a framework for the receipt, dissemination, implementation, audit and monitoring arrangements as well as the exception reporting.

3.4 The key objectives of the policy are to:

3.4.1 Identify the overall responsibilities for the consideration of relevant National Clinical Guidance within the Trust.

3.4.2 Identify the key structures for implementation including dissemination, review and reporting arrangements.

3.4.3 Provide a fully transparent structure that complies with internal and external review processes.

3.4.4 Ensure that new surgical or other invasive procedures are only introduced into practice after due consideration of all the relevant issues relating to appropriate training, business planning, capital and revenue investment, and safety.

3.5 This policy is applicable to all Clinical Groups and staff across the Trust and gives responsibilities to individual clinicians and managers on specifically relevant guidance issued.

3.6 It should be noted that for the implementation of interventional procedures these must be carried out in accordance with the Trust policy:

*'New or modifications to clinical practice which are not part of an ethical committee approved research programme'*

3.7 The above policy does not relate to doctors in training, as their competencies are developed and assessed as part of a programme of training overseen by their consultant and clinical tutor.

## 4.0 Definition and Terminology

4.1 The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on treatments and care. It produces guidance for health care professionals, patients and carers, to help them make decisions about treatment and health care.

4.2 NICE Guidance is issued in a number of forms, as detailed below, and can be found on the NICE website (www.nice.org.uk):-

### 4.2.1 Clinical Guidelines including Cancer Service Guidance

Appropriate treatment and care of patients with specific diseases and conditions within the NHS in England and Wales. Healthcare organisations should ensure they take into account NICE Clinical Guidelines when planning and delivering care, as appropriate.

### 4.2.2 Technology Appraisals

Use of new and existing medicines and other treatments within the NHS for example medicines, medical devices, diagnostic techniques, health

promotion activities and surgical procedures. Technology Appraisals must normally be implemented and funded within three months from the date of their issue (unless specifically exempted).

### 4.2.3 Public Health Guidance

Cover broad aspects of disease prevention or health promotion. There are two types of public health guidance:-

- Public Health Intervention Guidance
- Public Health Programme Guidance

### 4.2.4 Interventional Procedures

Cover the safety and efficacy of surgical procedures.

Interventional procedures do not fall within the remit of this policy. The following Trust Policy should be read in conjunction with this policy.

'New or modifications to clinical practice which are not part of an ethical committee approved research programme'

## 4.3 National Service Frameworks

National service frameworks (NSFs) are long term strategies for improving specific areas of care. They set measurable goals within set time frames.

NSFs:

4.3.1 set national standards and identify key interventions for a defined service or care group

4.3.2 put in place strategies to support implementation

4.3.3 establish ways to ensure progress within an agreed time scale

4.3.4 form one of a range of measures to raise quality and decrease variations in service, introduced in The New NHS and A First Class Service.

## 4.4 National Confidential Enquiries

4.4.1 The Enquiries are three independent organisations, each with a different history and organisational arrangements. However, the Enquiries exist for a common purpose

4.4.2 To investigate the contribution of deficiencies in care to serious adverse patient outcomes

4.4.3 To identify areas where clinical practice needs to be improved and to make appropriate recommendations for changes that will improve outcomes for patients.

4.4.4 There are three Enquiries:

- The Confidential Enquiry into Maternal and Child Health (CEMACH)
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

### 4.5 Care Quality Commission

4.5.1 The Care Quality Commission is the independent regulator of health and social care in England. It's aim is to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere.

## 5.0 Implementation Plan

5.1 Agreement of the Terms of Reference for the Clinical Guidance Steering Group were approved by the Clinical Effectiveness committee in January 2008

5.2 The first meeting of the CGSG was arranged for February 2008 and this policy was agreed by the group for ratification by Clinical Effectiveness Committee in March 2008

5.3 A timeline for review was established indicating from when a gap analysis of retrospective guidance/ recommendations relevant to the organisation were to be reviewed.

5.4 The Clinical Audit & National Guidance Manager in conjunction with the pharmacy department and local Governance Managers undertook the Trust-wide retrospective gap analysis to establish which guidance/ recommendations have been reviewed, implemented and audited and those which require a review from the date agreed by the CGSG

5.5 A report of the findings was provided to the CGSG and the Clinical Effectiveness Committee in July 2008. This included the actions required to ensure compliance is established and maintained.

5.6 The policy has been made accessible to all staff via the Trust's Synapse web page

5.7 Promotion of this policy is included within local Governance/risk groups

5.8 All new guidance/recommendations or reports relevant to the local clinical group are to be included within the agenda for local Governance/risk groups

5.9 Progress of compliance, non-compliance and implementation is to be reported through local Governance/Risk arrangements

## 6.0 Monitoring, Evaluation and Review

6.1 The CGSG will monitor compliance with all disseminated guidance through a planned programme of work, based upon disseminated guidance and documented action plans.

6.2 A bi-annual report to the Executive Clinical Effectiveness committee will be prepared by the Clinical Audit & National Guidance Manager providing an overview of the Trust's compliance, together with more detailed action plans for all instances of non compliance.

6.3 The Trust Board will receive a summary schedule as part of a bi-annual integrated Governance report.

6.4 Any intentional non compliance will be reported to the Clinical Effectiveness Committee, for endorsement or review.

6.5 The CGSG will monitor this policy through an initial 6 month review of the effectiveness of the processes documented. The policy will then be subject to an annual review or as defined by the CGSG.

6.6 Feedback of compliance with the policy will be included with the bi-annual report to the Executive Clinical Effectiveness Committee

6.7 All relevant implemented guidance will be subject to a planned programme of audit and must be included within the specialties audit programme and registered with the Clinical Audit Department in line with the trust's Clinical Audit Strategy 2009/10.

## 7.0 References

7.1 National Institute for Clinical Excellence (2005): "How to put NICE Guidance into Practice"

7.2 Department of Health (2004): “Standards for Better Health”

7.3 Healthcare Commission (2005): “Assessment for Improvement: The Annual Health Check”

7.4 National Standards, Local Action Health and Social Care Standards and Planning Framework 2005/06–2007/08

7.5 Managing the Financial Implications of NICE Guidance, Audit Commission, September 2005

7.6 Department of Health (1997) National Service Frameworks

7.7 NHS Litigation Authority Risk Management Standard (April 2009)

**Appendix 1**

## Procedure for Implementing National Clinical Guidelines and Recommendations

### 1.0 Receipt and Recording

1.1 All reports received in to the organisation are to be forwarded to the Clinical Audit & National Guidance Manager who will ensure all new guidance/national reports are recorded on a master database and disseminated to members of the Clinical Guidance Steering Group prior to the next available meeting.

1.2 The CGSG will determine the relevance of the document to the organisation and will identify the most appropriate 'Designated Lead' to review and implement the guidance or recommendations. This information will be included within the guidance database

### 2.0 Dissemination to 'Designated Leads'

2.1 The CGSG will carry out an initial assessment of the guidance to identify whether it is relevant to the Trust and if so to identify an appropriate 'Designated Lead".

2.2 Following the meeting, the Clinical Audit & National Guidance Manager will ensure the guidance/report is disseminated to the designated lead, local Governance Manager, and ADO.

2.3 The email will inform the identified person of their role as the Trust's 'designated lead' and include a copy of the summary guidance and a request to reply outlining:

2.3.1 the current level of compliance and how this has been assessed and assured

2.3.2 the action required to achieve compliance (a comprehensive action plan will be required, which must include any resource implications. Leads will be encouraged to utilise the NICE costing templates where available.)

2.3.3 timescales for review and implementation.

2.3.4 audit requirements

2.4 The reply should be returned to the Clinical Audit & National Guidance Manager within 3 months of dissemination.

2.5 If a Technology Appraisal relates to the use of medicines, the Director of Pharmacy will ensure the guidance is reviewed by the Medicines Management Group and report back to the CGSG with the outcome of the review and an action plan as necessary.

2.6 If the guidance relates to more than one specialty, the appropriate Associate Director of Operations will be asked to nominate someone responsible for leading the implementation across the Trust.

## 3.0 Baseline Assessment

3.1 An initial assessment of the current status is required to form a baseline. This will be lead by the Clinical Audit & National Guidance Manager. The designated lead will assess the extent to which there is compliance with the guidance and if not, identify the barriers to implementation, taking into consideration the service and resource implications

3.1.1 The types of issues that might be considered can be seen below:-

**Service issues**

Will major changes in practice be required?
Will protocols need to be updated?
What patient/public involvement issues apply?

**Resource issues**

Will there be capacity or resource issues associated with the required changes?
What will the impact be on prescribing costs – will these increase or decrease?
Will there be any additional costs, both in terms of implementation and into the future when following the guidance?
Do potential costs need to be built into business planning?

**Workforce issues**

Will there be any workforce implications?
Will there be any training needs for staff?
Will people be receptive to change?

**Risk**

Are there any potential risks to implementing this guidance?
Are there any risks identified that need to be entered onto the local or Corporate Risk Register.

**Management Issues**

What is the proposed implementation plan?
How will the comprehensiveness of implementation be monitored?
What might some of the barriers be to implementation?
Where does implementation of the guidance fit in relation to other priorities?
Can the guidance be implemented within an appropriate/required timescale?
Should any information be made available to the public?
What might the impact be on commissioning?

## 4.0 Development of an Action Plan

4.1 The designated lead in conjunction with their local Governance Manager where appropriate will develop an action plan for achieving full implementation of the guidance/ recommendation. If the guidance is not being adopted a detailed report is required explaining the reasons for not implementing the guidance and what alternative action has been agreed.

4.2 All action plans for achieving compliance will be included in the Group service review and performance managed by Associate Directors of Operations (ADO). To assist with this process a summary schedule from the Clinical Audit & National Guidance Manager will be sent to the ADO's on a quarterly basis

4.3 Key milestones within the action plans will be discussed at the Group's local Governance meeting. Any progress is to be reported to the Clinical Audit & National Guidance Manager for inclusion on the guidance database and reviewed at the next available CGSG meeting.

4.4 Outstanding requests for position statements and action plans will be followed up after three months, and notified to CGSG for action accordingly. Until a position statement is received by the CGSG, the status will be maintained as "under review."

## 5.0 Implementation

5.1 When the Trust is able to achieve compliance against each National Clinical Guideline/ Technology Appraisal or Recommendation as required, it will be reported to the CGSG which will formally endorse it as a Trust Clinical Guideline.

5.2 Similarly, all instances of intentional non-compliance will be reviewed by the CGSG to ensure appropriate Trust guidelines are in place.

## 6.0 Monitoring and Reporting

6.1 The Clinical Audit & National Guidance Manager will liaise with the Director of Pharmacy and the designated lead to ensure that the master database is kept updated with respect to guidance/appraisals and recommendations under review.

6.2 A six monthly report will be prepared by the Clinical Audit & National Guidance Manager, for the Clinical Effectiveness Committee, providing an overview of the Trust's compliance, together with more detailed action plans for all instances of non-compliance.

6.3 Any intentional non compliance will be reported to the Clinical Effectiveness Committee for endorsement. Definitions used for reporting purposes can be seen below.

## 7.0 Audit

7.1 All guidance and implemented recommendations will be included within the relevant annual audit programme as indicated within the Trust Clinical Audit Strategy 2009/10

## 8.0 Definitions for Reporting Purposes

### 8.1 Under Review

In the process of being reviewed by the designated lead to establish the Trust's current position against the guidance/recommendation and developing an action plan for achieving compliance.

### 8.2 Compliant

The Trust is fully compliant with the Guidance i.e. doing what the Guidance indicates we must do: not doing anything the Guidance indicates we should not do: considering or having considered a course of action which the disseminating organisation has recommended is considered.

### 8.3 Partially Compliant

The Trust is working towards full compliance and an action plan has been developed with timescales for review.

### 8.4 Non-Compliant

The Trust is not working towards full compliance. For example, if the evidence is considered by a body of clinicians to be out of date; drugs that were not licensed at the time of the issue of the Guidance have now been licensed, or lack of funding is making it impossible to implement.

A risk assessment must be carried out and included within the local risk register or Corporate Risk Register as Trust per policy and reported to the CGSG and Clinical Effectiveness Committee

**8.5 Not Applicable**

The guidance/report recommendations do not apply to the services provided by Salford Royal Foundation Trust.

**Appendix 2**

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|---|---|
| **Title: Clinical Guidance Steering Group - Terms of Reference** | Salford Royal NHS<br>NHS Foundation Trust<br>University Teaching Hospital |
| **Authors Name:**<br>**Jayne Downey Associate Director of Governance** | |
| **Scope: Trust Wide** | **Classification: Trust Organisation Structure and Minutes** |
| **Replaces: Issue 2** | |
| **To be read in conjunction with the following documents:** | |

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| **Officer responsible for archive: Associate Director Corporate Governance** | | |

## 1.0 Definition (Constitution)

This Clinical Guidance Steering Group is a sub-committee of the Executive Governance Clinical Effectiveness Committee and has been established to co-ordinate the effective implementation of nationally agreed guidance and recommendations.

## 2.0 Purpose and Powers (Duties)

The purpose of the Steering Group is to promote the Trust's National Clinical Guidance implementation process, ensuring an organisational gap analysis is conducted, that change is implemented appropriately and that lessons are shared throughout the organisation. An essential requisite of the group is to monitor the effectiveness of these processes.

The Clinical Guidance Steering Group will report progress and concerns to the Executive Clinical Effectiveness Committee.

## 3.0 Frequency of Meetings

The Steering Group will meet on a monthly basis.

## 4.0 Membership

The membership of the committee is as follows:

- Executive Medical Director (Chair)
- Associate Medical Director-Medicine (Deputy Chair)
- Associate Medical Director-Surgery
- Director of Clinical Effectiveness
- Deputy Director of Nursing and Governance
- Director of Pharmacy
- Associate Director of Governance & Quality
- Clinical Audit & National Guidance Manager

## 5.0 Chairmanship

The Chair of the Committee is held by the Executive Medical Director

## 6.0 Quorum

A quorum will consist when the Chair or Deputy Chair of the Committee and any 4 members of the group are in attendance.

## 7.0 Conduct of Meetings

The meetings will follow the following format:

1. Notes of previous meeting
2. Matters arising
3. Identification of new national guidance and appropriate dissemination
4. Review of national guidance implementation reports, including gap analysis and action plan
5. Identification of lessons to be shared across the organisation
6. Review of effectiveness of process
7. Any other Business
8. Date and Time of Next Meeting

## 8.0 Reporting

The Clinical Guidance Steering Group will report to the Executive Clinical Effectiveness Committee on a six monthly basis.

## 9.0 Roles and Responsibilities

### 9.1 Chief Executive

The Chief Executive has overall responsibility for compliance with this document.

### 9.2 Executive Medical Director

The Medical Director has delegated responsibility for the implementation of National Clinical Guidance and Recommendations within the Trust and will specifically ensure that all documents received by the Trust are effectively disseminated to relevant area leads.

### 9.3 Clinical Audit & National Guidance Manager

The Clinical Audit & National Guidance Manager is responsible for ensuring all national guidance is disseminated to the relevant Clinicians as identified by the CGSG and will liaise with designated lead and local Governance Manager to ensure action plans are developed and monitored to completion, reporting any findings to the CGSG.

### 9.3 Group Clinical Directors and Associate Directors of Operations

Are responsible for ensuring that clinical practice is carried out in accordance with national guidance and any deviations identified through the Trust's Risk Assessment processes.

### 9.4 Designated leads and Governance Managers

Are responsible for receiving national clinical guidance from the Executive Medical Director, ensuring appropriate effective review and discussion at a local forum is instigated.

To undertake a gap analysis and ensure a robust action plan is developed and shared with the Clinical Audit & National Guidance Manager and CGSG. The action plan must be up to date and within the agreed timescales.

## 10.0 Implementing Change

The action plan developed from the gaps analysis will be monitored locally and by the steering group to ensure effective implementation.

## 11.0 Ensuring that Best Practice is Shared Throughout the Organisation

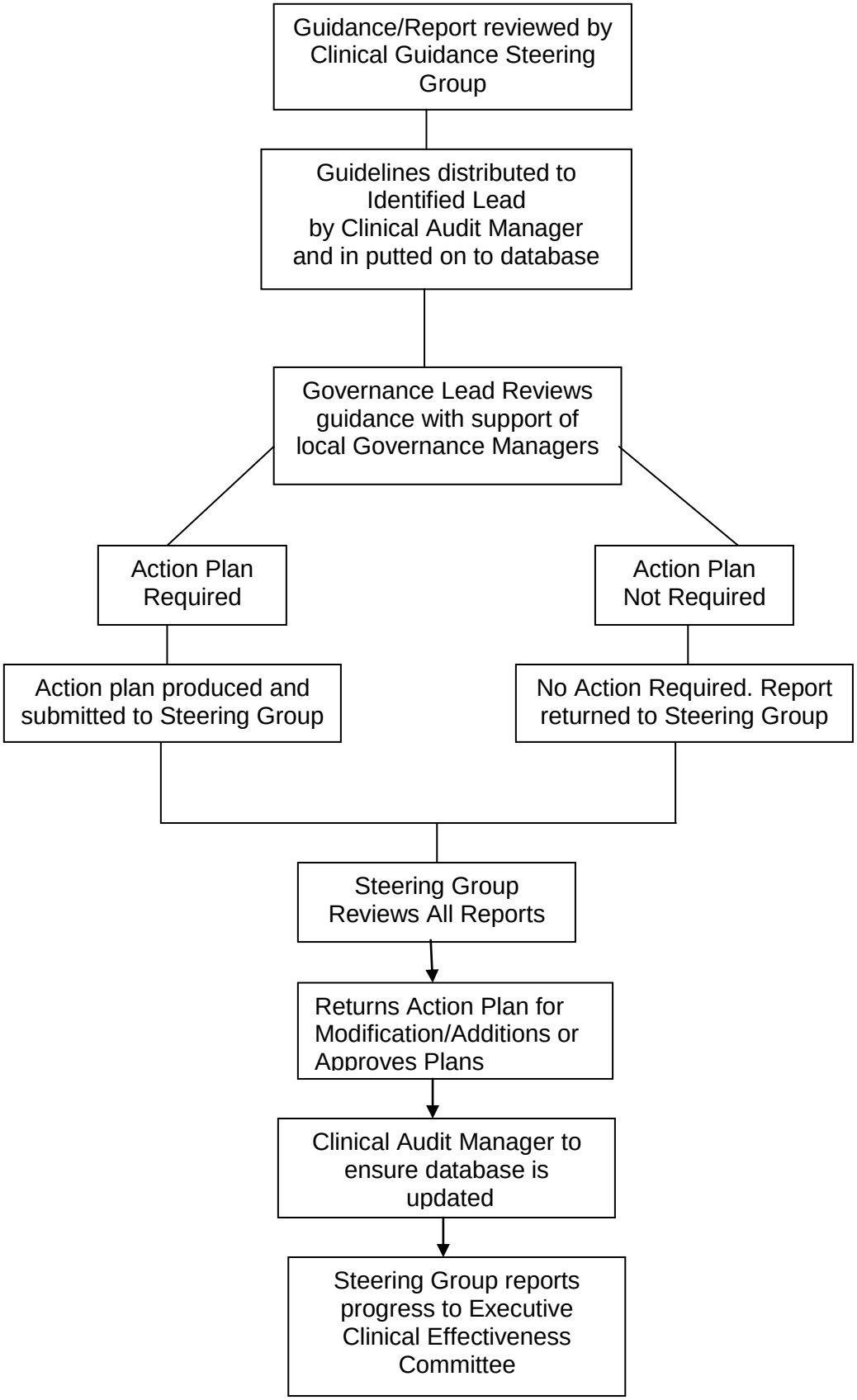
The steering group will review all action plans and ensure lessons are shared throughout the organisation. A comprehensive report will be made to the

Executive Clinical Effectiveness Committee and members will ensure that key examples of best practice are disseminated appropriately.

## 12.0 Monitoring Effectiveness

The Clinical Effectiveness Committee has monitoring arrangements in place to ensure the effectiveness of this process. The Trust's clinical audit strategy prioritises national clinical guideline audits in the development of clinical audit forward plans for all areas of the Trust; this includes NICE guidelines, National Service Frameworks (NSF) and National Confidential
Enquiry reports. The Clinical Audit Committee will provide an annual clinical audit report to the Clinical Effectiveness Committee

**National Guidance Implementation process**



## Endorsed by:

| Name of Lead Clinician/Manager or Committee Chair | Position of Endorser or Name of Endorsing Committee | Date |
|---|---|---|
| Dr S Waldek | Chair, Clinical Effectiveness Committee | 07/01/2008 |
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| Record of Changes to Document - Issue number: 4 | | | | |
|---|---|---|---|---|
| Changes approved in this document by - | | | Date: | |
| **Section Number** | Amendment (***shown in bold italics)*** | Deletion | Addition | Reason |
| Front page and throughout document | Assoc Director of Governance & Quality | | | Change in job title |
| Front page and throughout document | Clinical Audit & National Guidance Manager | | | Change in job title |
| 1.2 and where necessary in document | Care Quality | Healthcare | | Change of organisation name |
| 1.3 | | and the implementation of Clinical Guidance forms part of the Developmental Standards | | Change in CQC standards |
| 1.4.1 | | The organisation has *approved* documentation which describes the process for ensuring that agreed best practice as defined in the National Service Frameworks and 'High Level Enquiries' that make recommendations for patient safety is taken into account in the context of the clinical services provided by the organisation. | The organisation has *approved* documentation which describes the process for ensuring that agreed best practice as defined in all NICE guidelance (where appropriate), is taken into account in the context of the clinical services provided by the organisation. | Change in NHSLA wording |

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| 1.4.2 | | The organisation has *approved* documentation which describes the process for ensuring that agreed best practice as defined in the National Service Frameworks and 'High Level Enquiries' that make recommendations for patient safety is taken into account in the context of the clinical services provided by the organisation. | The organisation has *approved* documentation which describes the process for ensuring that agreed best practice, as defined in nationally agreed guidance, the National Service Frameworks, National Confidential Enquiries and other High Level Enquiries that make recommendations for patient safety, is taken into account in the context of the clinical services provided by the organisation. | Change in NHSLA wording |
| 3.2.7 | | National Patient Safety Agency (NPSA) Rapid Response Reports | | Addition |
| 4.2.4 | | (2006) | | Policy updated |
| 4.5 | | | | |
| | | | | |
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| | | | | |

# Diversity & Equality Screening Questionnaire

**The Trust is legally required to ensure that all new policies and documents are assessed for their impact both positive & negative on equality target groups ;**
**religion/beliefs, disability, age, gender, religion & sexual orientation & transgender.**

**When undertaking this assessment you must consider the impact this policy could have on the equality groups listed above.**

**If you wish to discuss any aspect of this assessment process please contact the Equality Advisor, HR dept.**

| |
|---|
| Have you been trained to carryout this assessment:? YES/NO<br>If 'yes' continue with the assessment, if 'no' arrange to have the training first. |
| **Name of policy, document or leaflet;** |
| **1 Whom is this document or policy aimed at ?** |
| **2 Is this document a specific user group? if yes, why ?**<br><br>**How will you ensure that this policy is cascaded to the target group ?** |
| **3 Is there any evidence to suggest that different groups have different needs in relation to this policy or document (positive or negative) ?** |
| **4 If you a revising a policy are any the changes to this policy likely to impact on any groups?** |
| **5 Have you undertaken any consultation/involvement with service users or other groups in relation to the new policy ?**<br><br>**If yes, what format did this take? face/face or questionnaire?**<br><br>**Were service users who may require additional support (e.g. visually impaired) involved ?** |

| | |
|---|---|
| | **Have any amendments been implemented as a result of this exercise?** |
| **6** | **Are you aware if a request has been made for the policy to provided in alternative formats?**<br><br>**If yes, how/was this achieved?** |
| **7** | **Could any individual/group be affected differently by the application of the document?** |
| **8** | **Does the document require any decision to be made which could result in some individuals receiving different treatment or care to other individuals ?**<br><br>**On what basis would this decision be made ?**<br><br>**Could this impact on any particular group ?** |
| 8 | **Are you aware of any complaints from service users in relation to the application of this policy ?**<br><br>**If yes, how was the issue resolved ?** |

9 **Looking at the above points does this indicate that any of the groups listed below have different needs, experiences or priorities groups in relation to the document ?**

| | **Yes** | **No** | **Don't know** |
|---|---|---|---|
| Age | | | |
| Disability | | | |
| Gender | | | |
| Marital Status | | | |

| | | | |
|---|---|---|---|
| Racial group | | | |
| Religious belief | | | |
| Sexual orientation | | | |
| Transgender | | | |
| Low Income | | | |

Any additional comments

**If any impact have been highlighted by this assessment, you will need to** ;

- contact T Horrocks, Equality Advisor, HR dept
- additional work may have to be undertaken ;

- if necessary, gather further data to establish the level of impact

- consult with relevant service users

- determine if the impact of the policy is justifiable or has to be eliminated

- investigate why there was an adverse impact

- complete action plan outlining what action you propose to undertake to reduce or
eliminate the adverse impact or justify

- publication of findings