Leicestershire Partnership NHS Trust

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

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

Key Words:	NICE, Guidance, Agreed Best Practice	
Version:	9	
Adopted by:	Trust Policy Committee	
Date this version was adopted:	12 July 2022	
Name of Author:	Head of Clinical Quality Governance/NICE & Effectiveness Officer	
Name of responsible Committee:	Clinical Audit NICE and QI Committee (CANQI)	
Please state if there is a reason for not publishing on website:	N/A	
Date issued for publication:	July 2022	
Review date:	December 2023	
Expiry date:	1 July 2024	
Target audience:	All LPT staff	
Type of Policy	Clinical ✓	Non-Clinical ✓
Which Relevant CQC Fundamental Standards?	R9, R12,R14, R15, R17 & R18	

Contents

Version control and Summary of Changes

History of former organisations' policies		
LPT		November 2010 (no policy ref. number)
LCRCHS	Version 2	November 2009 CHSQCD002
LCCHS	Version 1	February 2010 LCCHSCP182
Version number	Date	Comments (description change and amendments)
Version 1.0	Dec 2011	Harmonisation of former organisations' policies
Version 2.0	Feb 2012	Comments incorporated received from key staff.
Version 2.1	8 Feb 2012	Policy approved at the Senior Clinical Quality Group subject to minor amendments.
Version 2.2	14 Feb 2012	Gone to Quality Assurance Committee for ratification.
Version 3.0	May 2013	Revised policy
Version 3.1	15 Aug 2013	Policy approved at Policy Group meeting subject to minor amendment in readiness to be adopted at the next QAC meeting.
Version 4.0	17 Jun 2016	Elena Relph & Julie Warner – Grammatical and reference amendments. Fern Barrell – Risk register and CEG involvement clarification. Jude Smith - Confirmation of Clinical Directors' financial involvement. 360 Assurance – approval of BAT when compliant (see 6.7 point 2)
Version 5.0	1 Aug 2016	Circulation list updated and sent to additional Clinical Directors (no additional comments received by deadline of 19 August 2016).
Version 6.0	Dec 2016	Reference to NHS Litigation Authority (NHSLA) removed from section 13 and appendix 4.
Version 7.0	Jun 2018	Amendments made due to movement of responsibility from CQETL to HOP.
Version 8.0	Sept 2020	Amendments made due to appointment of Associate Director for Quality Improvement and as a result of actions required in 360 Assurance Clinical Audit and NICE report.
Version 9.0	June 2022	Amendments made due to change of role from Associate Director of Quality Improvement to Head of Clinical Quality Governance. Removal of references to other nationally agreed best practice including National Confidential Enquiries as these are dealt with via alternative routes. Amendments following introduction of the NICE review group. Updates to appendix 2 to include consideration of risk

For further information contact: WeImproveQ team at lpt.WeImproveQ@nhs.net.

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

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

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

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

Definitions that apply to this Policy

Best practice guidance	This policy refers to clinical guidance documents and any high level enquiry documents that make recommendations for patient safety.
Nationally agreed	Documents that have been published by national organisations which have an official advisory or regulatory role for the National Health Service.
NICE	**The National Institute for Health and Care Excellence (NICE)** is the independent organisation responsible for providing national guidance on treatments and care for people using the NHS in England and Wales.
CG	NICE **Clinical Guideline** - guidance on the appropriate treatment and care of people with specific diseases and conditions.
NG	NICE Guideline – Replaced CG in January 2015 as a means to identify new clinical guidance.
IPG	NICE **Interventional Procedures Guidance -** on procedures used for diagnosis or treatment that involves incision, puncture, entry into a body cavity, electromagnetic or acoustic energy.
TAG	NICE **Technology Appraisal** –Guidance on the use of new and existing medicines and treatments.
PH	NICE **Public Health** guidance provides guidance on the promotion of good health and the prevention of ill health. These are: “Public Health Intervention Guidance” and “Public Health Programme Guidance”
QS	NICE **Quality Standards -** A concise set of statements designed to drive and measure high-priority quality improvements in a particular area of care and to achieve improved quality of care in local settings. General Public and People receiving health care services, can access information about the quality of services and care they should expect from their health care provider

DAP	NICE **Diagnostics Assessment Programme -** (DAP) focuses on the evaluation of innovative medical diagnostic technologies in order to ensure that the NHS is able to adopt clinically and cost-effective technologies rapidly and consistently.
MTG	NICE **Medical Technologies Guidance -** considers a single medical device or diagnostic technology which provides equivalent or enhanced clinical outcomes for equivalent or reduced cost.

1.0. Purpose of the Policy

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

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

2.0. Summary and Key Points

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

3.0. Introduction

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

4.0 Scope of the policy

This policy covers the implementation and monitoring of NICE guidance for best practice within LPT. It sets out a coordinated process to identify and disseminate relevant documents. In addition, it covers conducting an organisational gap analysis and monitoring of the implementation process.

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

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

4.1 National Institute for Health and Care Excellence - (Technology Appraisals, NICE Guidelines and Quality Standards).

NICE guidance is:

- Intended to improve the outcomes for people who access health service providers.
- Produced by health and social care professionals, patients and the public.
- Evidence based guidance and advice for health, public health and social care practitioners.
- Transparent in its development, consistent, reliable and based on a rigorous development process.
- Evaluated, weighing up the cost and benefits of treatments to ensure money is well spent.
- Internationally recognised for its excellence.

- Issued as NICE (formerly clinical) guidelines, quality standards, interventional procedures guidance, public health guidance, medical technologies guidance, diagnostic guidance and technology appraisals.

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

4.2 NICE Guidelines

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

4.3 Technology Appraisals

- Are guidance on the use of new and existing medicines and treatments.
- Assess the clinical and cost effectiveness of health technologies.
- Have stated timescales associated with them and must be implemented within three months of their publication.

4.4 NICE Quality Standards

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

4.5 Public Health Guidance

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

4.6 Care Quality Commission (CQC)

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

5.0 Duties within the Organisation

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

5.1 The Chief Executive

- Is accountable for the implementation of this policy and ensuring that LPT has a process for the consideration, dissemination and implementation of all NICE guidance.

5.2 LPT Trust Board

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

5.3 Medical Director

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

5.4 The Head of Pharmacy (HoP)

- Will work with the NICE and Effectiveness Officer (NEO) and Directorate Governance leads to agree which NICE guidelines are relevant to the Trust and to provide a rationale for those not relevant to LPT.
- Receive medicines related NICE guidance from the NEO and establish relevance for each Directorate.
- Contribute to the completion of baseline assessment tool (BAT) as required.
- Work in collaboration with the Medical Director and Clinical Directors to assess financial implications (Appendix 1).

5.5 Clinical Directors

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

5.6 NICE review group

Members of the NICE review group will work with the NEO to:

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

5.7 Quality Assurance Committee (QAC)

Will assess assurances received from the CEG related to the implementation of Guidance.

- Ratify decisions not to implement Guidance.

5.8 Clinical Effectiveness Group (CEG)

- Will receive assurance reports from the NEO/Head of Clinical Quality Governance.
- Approve decisions not to implement Guidance and report their decisions to QAC.
- Ensure that identified risks related to non-compliance are escalated to QAC and recorded on the risk register.

5.9 Clinical Audit, NICE and Quality Improvement Committee (CANQI Committee)

- Have oversight of the progress of NICE implementation work within the Trust.
- Receive reports from the NEO giving a review of the number of outstanding actions and action plans in place to address non-compliant recommendations, the number and stage (not started, incomplete, complete) of NICE baseline assessment tool completion, details of guidance that has been escalated due to lack of progress and guidance that has been closed as fully compliant or partially compliant.
- Monitor completion of NICE BATs within the 18-month timeframe following publication (see section 6.1).
- Agree and monitor NICE Quality Improvement activities including monitoring and clinical audits.
- Ensure compliance with Technology Appraisals is confirmed within 3 months of publication.

5.9 Directorate sub-groups of Clinical Governance Groups

- Ensure that NICE is a standing agenda item on the relevant directorate sub-group of the directorate Clinical Governance Group.
- Approve compliance with the guidelines once fully reviewed and adequate evidence provided, noting this in the minutes of the meeting.
- Disseminate guidance to appropriate services throughout the directorate.
- Respond to exceptions highlighted by the NEO regarding confirmation of relevance, evidence of dissemination.
- Identify risk associated with the implementation of guidance and update risk register as appropriate.
- Oversee implementation of action plan within BAT.
- Identify NICE related clinical audits in partnership with NEO and consider whether Clinical Audit is the appropriate means of confirming compliance with NICE guidance or if there are other means of assurance.
- Ensure that confirmation of compliance with NICE guidance is completed within an appropriate timescale.

5.10 Head of Clinical Quality Governance

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

5.11 NICE and Effectiveness Officer (NEO)

- Oversee and co-ordinate the Trust NICE guidance implementation procedure.
- Identify new NICE guidance published on the NICE website on a monthly basis.
- Work with the Head of Clinical Quality Governance, Head of Pharmacy and NICE review group to agree which guidance is relevant to the Trust and to provide a rationale for guidelines which are not relevant to LPT.
- To receive a response from the NICE review group on the relevant/non-relevant guidance within two weeks of the initial review by the HoP.
- Receive names of individual(s) to review NICE guidance from the NICE review

group.

- To send the relevant BAT to the nominated individual(s) to complete, providing support if necessary.
- Collate completed BATs and Quality Standard compliance templates from each Directorate.
- Collate evidence of dissemination of guidance from each Directorate.
- Inform NICE review group of areas which require action plans, cross-referencing with other divisions to avoid duplication of effort.
- Collate evidence of implementation by updating the Guidance Activity and Compliance Statements section of AMaT (Audit Management and Tracking) with details of progress towards implementation, identifying high priority and significant recommendations and acting accordingly.
- Support directorates to identify and deliver NICE related quality improvement projects (including clinical audits).
- Provide status reports to each Directorate sub-group (subgroups of Directorate Clinical Governance Groups). To include clinical audit, cost implications and exceptions at each stage, e.g., confirmation of relevance, completion of BATs, evidence of dissemination and implementation.
- Where the baseline assessment reveals a need for additional financial investment/resource ensure the procedure in Appendix 1 is followed.
- Provide assurance reports for the Commissioners in line with the Quality Schedule.
- To be aware of areas of risk which potentially are to be re-assessed e.g., where NICE guidance has been revised, new services or areas of organisational risk/serious incidents, via the Head of Pharmacy, Clinical Quality Governance Lead and the Clinical Effectiveness Group (CEG).
- Provide assurance reports for all guidance to CANQI and exception reports to CEG.
- Maintain the Guidance Activity and Compliance section of AMaT, detailing the stages of the implementation procedure and related correspondence, including rationale for non-relevant guidance.

5.12 Responsibility of Clinical Staff

- All staff have a professional responsibility to implement relevant guidance and make evidence-based decisions about treatment and health care.

Consent

- Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.
- In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

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

6.0 Process for Identifying and Dissemination of Relevant Documents

6.1 NICE guidance

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

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

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

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

The NEO, Head of Pharmacy, Head of Clinical Quality Governance and Directorate Clinical Quality Governance Leads then monitor baseline assessment tools, in terms of delivery and follow up. It expected that the initial review of the BAT will be completed within 3 months of publication and the final position of compliance to be completed with 18 months of publication.

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

6.2 Quality Improvement including Clinical Audit

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

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

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

The BAT lead and the NEO will consider relevant NICE guidance for inclusion in the Clinical Audit Forward Plan. NICE produces clinical audit tools and Quality Standards to inform clinical audits.

Where other quality improvement methodologies are more appropriate, action will be taken and assistance provided where necessary, see Appendix 2. Quality Improvement (including clinical audit) project support will be provided through the QI design huddle and the use of LifeQI and/or AMaT.

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

7.1 Resource and financial implications
It is recognised that implementation of guidance will often have a financial impact.

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

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

8.0 Process for ensuring that recommendations are acted upon throughout the organisation
Regular reports from the Head of Clinical Quality Governance /NEO outlining performance and exceptions in terms of dissemination, action planning, implementation, quality improvement or clinical audit, will be reported to:

- Directorate Clinical Quality Governance Leads/Directorate sub-groups (Appendix 3)
- Clinical Audit, NICE and Quality Improvement Committee (CANQI) (Appendix 3)
- CEG (Appendix 3)
- Quality Assurance Committee (Appendix 3)
- Commissioners (Appendix 3)

9.0 Process for documenting any decision not to implement NICE recommendations
Any decision not to implement National Guidance must be approved by the Clinical Effectiveness Group and ratified by the Quality Assurance Committee.

10.0. Training needs
There is no training requirement identified within this policy.

11.0. Monitoring Compliance and Effectiveness

The Head of Clinical Quality Governance will audit this document by means of a review of the records maintained by the NEO on an annual basis against the following standards:

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

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

Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual/Group	Frequency of monitoring
How the organisation identifies which NICE guidelines are relevant to its services	NEO records	The NICE guidance is reviewed monthly by the Head of Pharmacy and NEO who identify guidelines relevant to services within the directorates. This is then validated by the NICE review group.	Head of Pharmacy	On a monthly basis
How action plans are created to address any shortfalls. **Including recording decisions not to implement NICE guidelines**	AMaT and BAT's	Plans to address shortfalls are developed by the BAT lead or Trust- wide via CEG. Decision not to implement are made by CEG and verified by QAC.	Divisional Clinical Governance Leads Medical Director, Chair of Senior Clinical Quality Group and QAC	As above
How action plans are developed to address any shortfalls	Process for conducting an Organisational Gap Analysis	Monitoring via the Head of Clinical Quality Governance/NEO/ Quality & Data Analyst outlining	Divisional Clinical Governance Leads CEG and	Annually

Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual/Group	Frequency of monitoring
		performance and exceptions in terms of action planning and implementation or clinical audit	additional exception reports as required. Escalate gaps to QAC.	

12.0. Link to standards
This policy links to Care Quality Commission (CQC) standards:

9. Person centred care
12. Safe care and treatment
14. Meeting nutritional and hydration need
15. Premises and Equipment
17. Good governance
18. Staffing

13.0. References and Bibliography
The policy was drafted with reference to the following:

Learning how to learn – compliance with Patient Safety Alerts in the NHS
https://webarchive.nationalarchives.gov.uk/20130105045549/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4115784.pdf

High Quality Care For All

First Class Service: Quality in the NHS:1998

HSC 2003/011 - The interventional procedures programme: working with the National Institute for Clinical Excellence to promote safe clinical innovation

Legal Context of NICE guidance. (2004) www.nice.org.uk
National Quality Board: NICE Quality Standards. (2010)

NICE - what we do

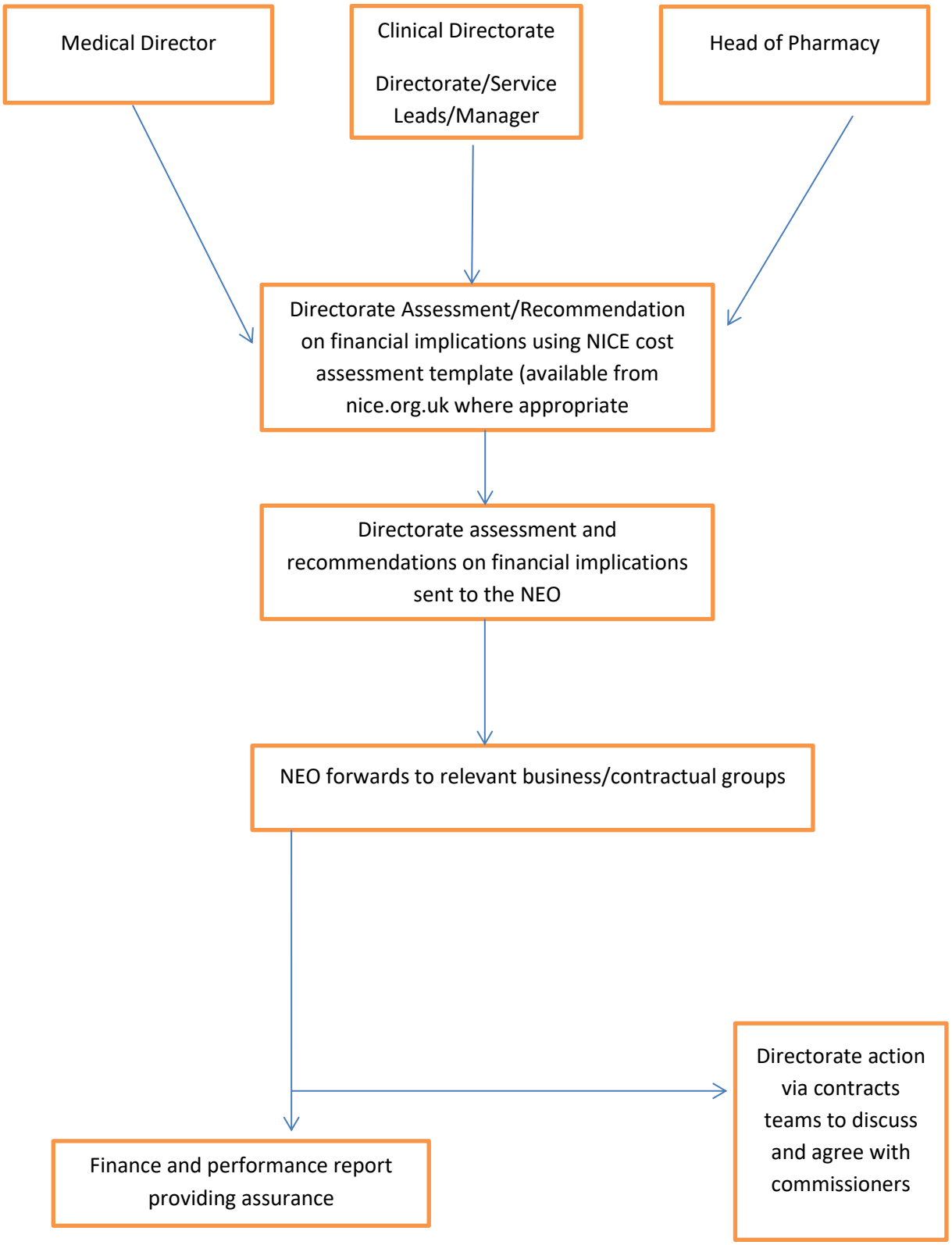
Practical steps to improving the quality of care and services using NICE guidance
NICE 2018

Principles for putting evidence-based guidance into practice NICE 2018

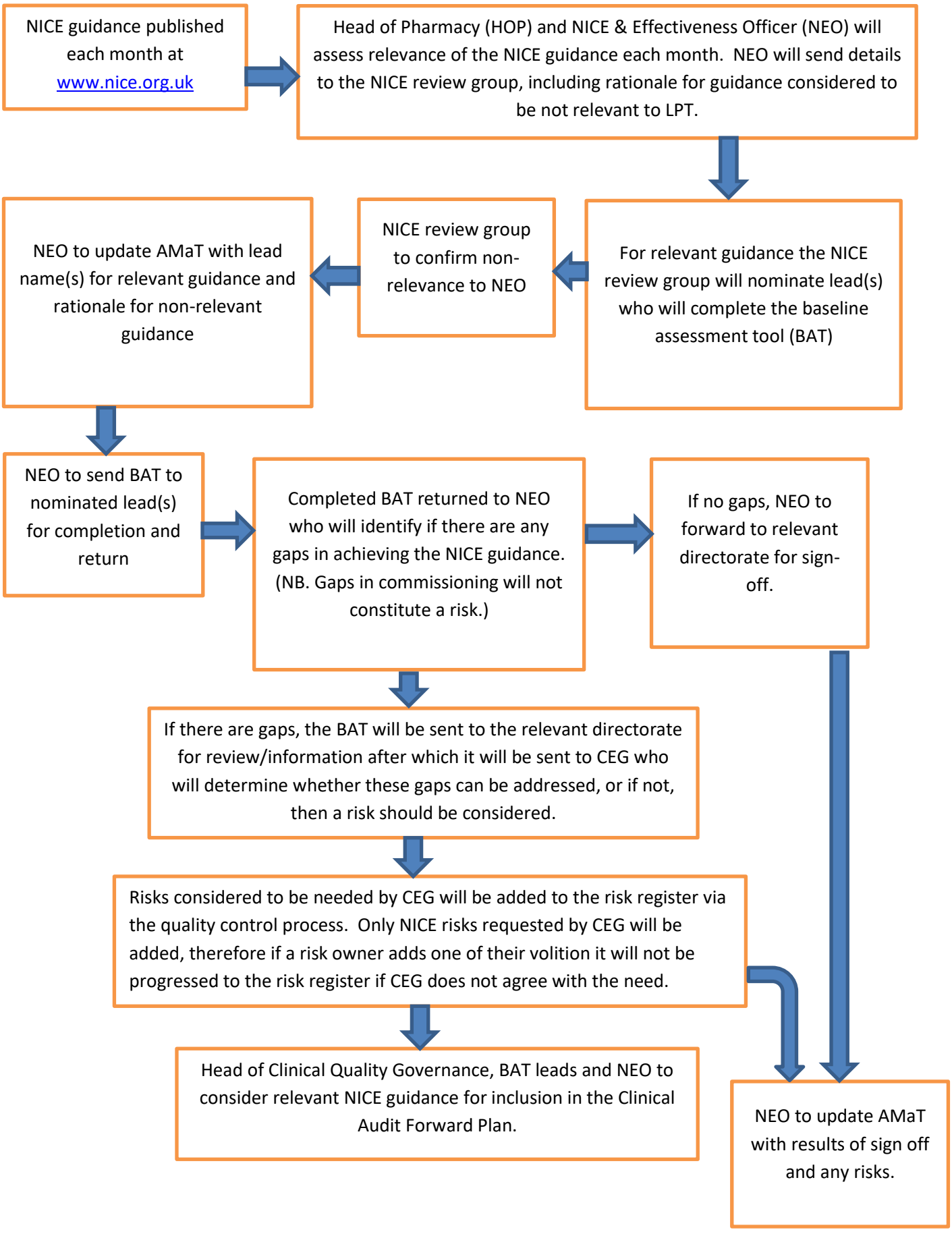
The Health Foundation. (2009) Rising to the challenge: Using evidence about what works to improve quality and save money. London: The Health Foundation.

14.0 Associated documentation
Clinical Audit policy.

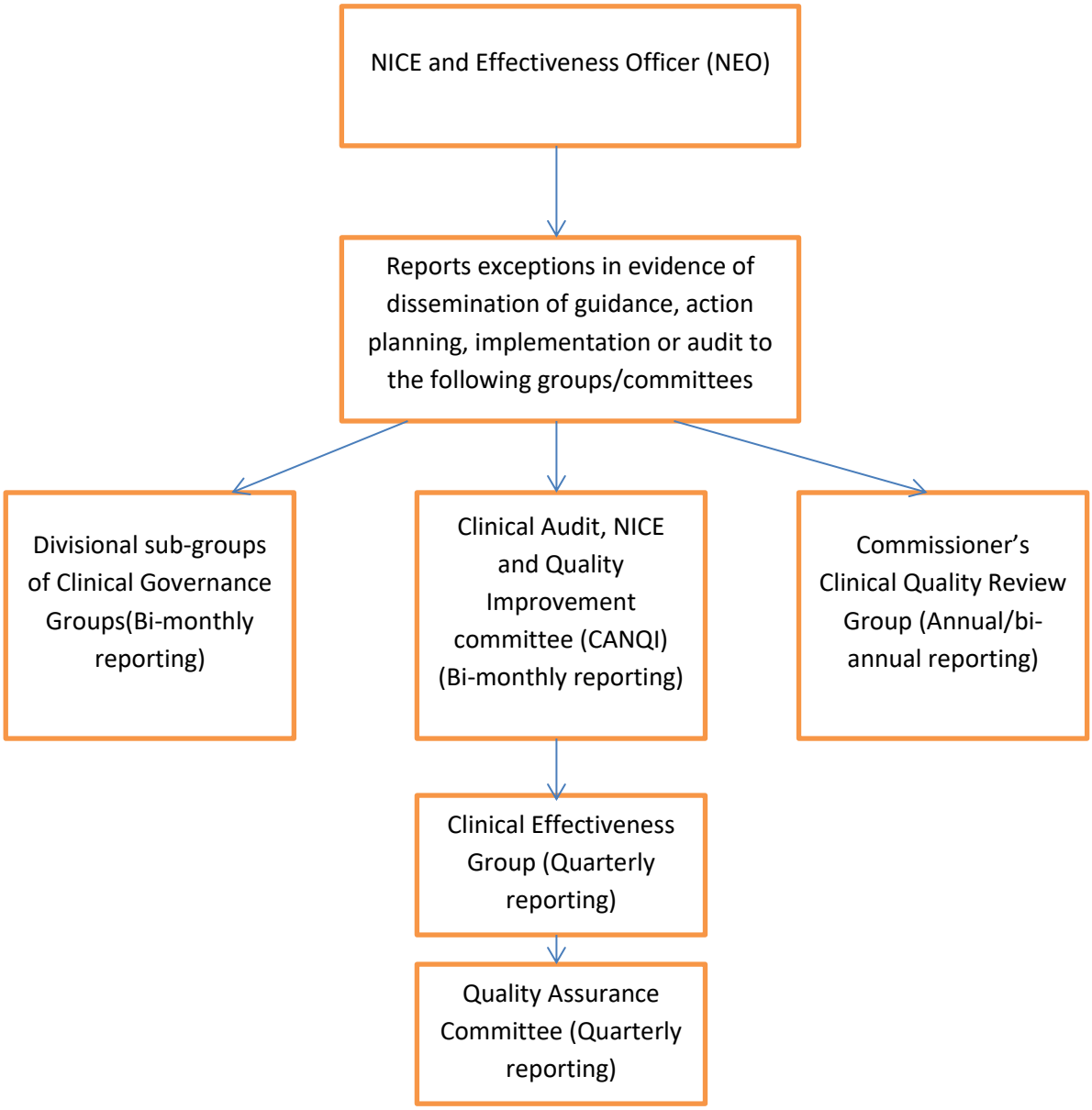
Appendix 1: Financial decisions in relation to cost implications.



Appendix 2: NICE Guidance, Relevance, Compliance, Risk, Dissemination & Clinical Audits



Appendix 3*:* Exceptions, assurance and reporting to Divisional sub-groups of Clinical Governance Groups, Clinical Effectiveness Group, Quality Assurance Committee and Commissioners



Appendix 4

The NHS Constitution

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

Shape its services around the needs and preferences of individual patients, their families and their carers	✓
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for patients	✓
Help keep people healthy and work to reduce health inequalities	✓
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓

Appendix 5 - Stakeholders and Consultation

Key individuals involved in developing the document

Designation
Head of Quality & Professional Practice
Director of Corporate Affairs
Associate Director for Quality Improvement
Clinical Audit Assistant
Clinical Audit Officer
NICE & Effectiveness Officer

Circulated to the following individuals for comment

Designation
Medical Director
Head of Pharmacy
Divisional Clinical Governance lead for Adult Mental Health and Learning Disability
Divisional Clinical Governance Lead for Adults Community Health Services
Head of Nursing, CHS
FYPC Clinical Governance and Quality Lead
Head of Research and Development
Clinical Effectiveness Lead
Quality and Data Analyst
Project Officer, Clinical Practice
Clinical Audit Officer
Clinical Director, Adult Mental Health Services
Clinical Director, Learning Disability Services
Clinical Director, Families, Young People and Children's services
Clinical Director, Community Health Services
Pharmacy Services Manager/Clinical Quality and Effectiveness – Trust Lead

Appendix 6

Due Regard Screening Template

Section 1	
Name of activity/proposal	The policy outlines the system and processes for the dissemination, implementation and monitoring of NICE guidance throughout LPT. National "best practice" guidance enables staff to make evidence-based decisions about treatment and healthcare.
Date Screening commenced	1 February 2022
Directorate / Service carrying out the assessment	WeImproveQ team
Name and role of person undertaking this Due Regard (Equality Analysis)	Heather Darlow, Head of Clinical Quality Governance
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To establish a policy and procedure for NICE guidance.	
OBJECTIVES: To disseminate, implement and monitor NICE practice.	

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

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

Section 4			
If this proposal is low risk, please give evidence or justification for how you reached this decision:			
The policy outlines the system and processes for the dissemination, implementation and monitoring of NICE guidance throughout LPT. National "best practice" guidance enables staff to make evidence-based decisions about treatment and healthcare.			
Signed by reviewer/assessor	Heather Darlow	**Date**	1 June 2022
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 7

PRIVACY IMPACT ASSESSMENT SCREENING

Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment. **The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	Dissemination, implementation and monitoring of National Institute for Health and Care Excellence (NICE) guidance		
Completed by:	Heather Darlow		
Job title:	Head of Clinical Quality Governance	**Date**	1 June 2022

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

If the answer to any of these questions is 'Yes', please contact the Head of Data Privacy **Tel: 0116 2950997 Mobile: 07825 947786 Lpt-dataprivacy@leicspart.secure.nhs.uk** **In this case, adoption of a procedural document will not take place until approved by the Head of Data Privacy.**	
IG Manager approval name:	
Date of approval:	

Acknowledgement: Princess Alexandra Hospital NHS Trust