



Policy for the Management and Implementation of Best Practice Guidance

National Institute for Clinical Excellence (NICE)

Joint Royal Colleges Ambulance Liaison Committee (JRCALC)

National Confidential Enquiries

National Service Frameworks (NSFs)

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The Trust will not tolerate unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups.

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Review and Amendment Log

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V.1.1	Update	June 2011	<i>Update to section 12 'References'</i>

1. Introduction

The Trust places patient safety and clinical quality at the heart of all its work. It is committed to delivering high standards of clinical quality and patient care to improve patient satisfaction and the patient experience. The values of the Trust were formally adopted in November 2008 and support the NHS Constitution, which became law in January 2009. They are reflected in decision-making at all levels within the Trust, and are summarised as follows:

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts.

It is committed to continuing to work closely with its patients, staff, commissioners and other key stakeholders to ensure it has the capacity and capability to respond positively to the growing expectations and rising needs of its patient population. To achieve this the Trust has implemented this policy to ensure that a clear process to respond effectively to NICE, JRCALC, National Confidential Enquiries and National Service Frameworks is in place and which will provide the best possible clinical care based on the best available evidence in the most cost effective manner.

Good clinical practice if properly developed, disseminated and implemented will improve the healthcare of the patient population as a whole and will support clinicians in doing their best for individual patients. The Trust receives publications incorporating good practice guidance from a variety of sources. For the purpose of this policy good practice guidance can be described as advice received that informs practice and is based upon best available evidence at that time. This policy relates only to clinical practice within the Trust and supports compliance to meet the standards set by the Care Quality Commission and the NHS Litigation Authority.

The process will be delivered within the Trust's quality governance framework (see Appendix A) to provide the necessary assurances to the Trust Board.

2. Purpose

This policy describes the systematic approach required to ensure that best practice guidance – NICE, JRCALC and National Confidential Enquiries/Inquiries and clearly:

- States the duties including leadership for all stages of the process for implementation
- Identifies all relevant documents
- Describes how the Trust will respond to requests for information
- Describes the process for disseminating relevant documents
- Outlines the process to be used to conduct an organisational gap analysis
- States how the recommendations will be actioned and how progress will be monitored
- Records the reasons for not deciding to implementing best practice guidance recommendations

- Describes how the policy links to the Trust's risk management strategy, policy and risk registers to ensure all clinical risks are managed and mitigated when introducing new and/or changes to clinical practice.

3. Scope

This policy embraces all guidance published by NICE, JRCALC, National Confidential Enquiries and the National Service Frameworks. This policy is relevant to all clinical staff within the Trust. It is acknowledged that the Trust will also receive national guidance from other external agencies such as the Care Quality Commission (CQC) and the lead Associate Director will be responsible to manage the process and reporting arrangements through the Trust's quality governance framework.

4. Definitions

For the purpose of this policy the following best practice guidance will be:

National Institute for Health and Clinical Excellence (NICE)

NICE was established and is an independent organisation responsible to provide national guidance on the promotion of good health and the prevention of ill health www.nice.org.uk

NICE guidance is integral to a standards-based healthcare system and it issues four types of guidance: **technology appraisals, clinical guidelines, public health guidance** and **interventional procedures**:

Technology appraisals

Technology appraisals provide guidance on the use of new and existing technologies including drugs, medical devices and procedures. They consider the clinical and cost-effectiveness of the technologies. The Trust is responsible for taking whatever steps are necessary to promote the uptake of recommendations.

Interventional procedures

NICE makes recommendations as to whether a procedure used for diagnosis or treatment is safe enough and works well enough to be used routinely. An interventional procedure is a procedure for diagnosis or treatment that involves making an incision to gain access to the inside of a patient's body or using electromagnetic radiation. An example is electrosurgery (diathermy and coblation) for tonsillectomy, where NICE cautions against excessive use of diathermy and highlights the importance of appropriate training for clinicians and audit of the techniques. As an Ambulance Trust it is unlikely that interventional procedures will be relevant for the range of services provided.

Clinical guidelines

Clinical guidelines recommend appropriate care and treatment of people with specific diseases and conditions. They are based on the best evidence available, taking account of clinical and cost-effectiveness.

Public health guidance

The NICE Centre for Public Health Excellence develops guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities, the wider public and voluntary sector. There are two types of public health guidance: Interventional guidance provides recommendations on activities provided

by organisations to help to promote or maintain healthy lifestyles; for example, exercise promotion. Programme guidance deals with broader activities for the promotion of good health and prevention of ill health; for example, mental health promotion or strategies to give up smoking.

NICE quality standards

NICE quality standards are a set of specific, concise statements that act as markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with the NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

Joint Royal Colleges Ambulance Liaison Committee (JRCALC)

JRCALC clinical practice guidelines set the standard of care for ambulance practice in the UK. The guidelines cover the full range of Paramedic treatments and are divided into three parts; Part 1, general guidelines, include ethical issues, pain management guidelines and drug protocols, Part 2, adult guidelines, includes cardiac arrest and arrhythmia guidelines, medical emergencies in adults, specific treatment options, trauma emergencies and obstetric and gynaecological emergencies and the treatment and management of assault and abuse and Part 3, paediatric guidelines, covers emergencies in children.

JRCALC guidelines have no legal status but are evidence of what constitutes responsible clinical practice. Any departure from usual clinical practice may be authorised via the Medical Director through the clinical advice line. All calls and advice given are recorded and monitored by the Medical Director.

National Confidential Enquiries

There are three National Confidential Enquiry agencies which investigate issues into different care settings and which provide evidence and recommendations of action to be taken to improve clinical care. The Trust by monitoring the work of these agencies will learn about weaknesses and failings in services which will support it in undertaking a gap analysis to implement measures to prevent similar mistakes being made within the organisation. The agencies work independently of the Department of Health but are part funded by the National Patient Safety Agency (NPSA).

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The purpose of NCEPOD is to support, maintain and improve standards of medical and surgical care for the benefit of the public by: reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.

Confidential Enquiry into Maternal and Child Health (CEMACH)

CEMACH aims to improve the health of mothers, babies and children by carrying out confidential enquiries on a nationwide basis and by widely disseminating findings and recommendations. CEMACH is divided into two sub-programmes: the maternal and peri-natal enquiry and the child health enquiry.

National Confidential Enquiry into Suicides and Homicides (NCISH)

NCISH examines all incidences of suicides and homicides by people in contact with mental health services in the United Kingdom and sudden deaths in psychiatric care, with the purpose of improving mental health services and helping to reduce the risk of these tragedies happening again in the future.

High Level Reports or Enquiries

High level reports or enquiries are less easy to define, and will largely be established in connection with high profile cases such as the Alder Hey Tissue Retention Enquiry, the Laming Enquiry (following the death of Victoria Climbié) the enquiry into the care provided by Mid Staffordshire NHS Foundation Trust, which result in national recommendations for standards of performance.

National Service Frameworks (NSFs)

National Service Frameworks are long term strategies which set national healthcare standards, identify key interventions and set agreed timescales for implementation. They are designed to improve the quality of health services and ensure that the same level of care is provided to all patients. The two main purposes of the NSFs are: setting clear quality requirements for care based on the best available evidence, and publishing strategies and support to assist NHS Trusts achieve these standards. One of their main strengths is that they are inclusive, having been developed in partnership with health professionals, patients, carers, health service managers, voluntary agencies and other experts. At present there are NSFs covering the following areas:

- Cancer
- Child Health and Maternity
- Chronic Obstructive Pulmonary Disease
- Coronary Heart Disease
- Diabetes
- Long Term Conditions
- Mental Health Strategy
- Older People
- Renal Services
- Stroke.

5. Duties

5.1 Trust Board

The Trust Board consists of five executive Directors (including the Chief Executive) and six non-executive directors (including the Chair) with a wide range of experience and is accountable for internal control. The Chief Executive is responsible for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives and also for safeguarding the public funds and the Trust's assets. Two other full time directorship posts also support the Chief Executive and are part of his management team. They also provide advice to the Trust Board as required.

In line with the National Leadership Council's Principles as defined within The Healthy NHS Board Principles for Good Governance (February 2010) the Trust Board will provide effective leadership in formulating the strategy for the Trust and ensure accountability by holding the Trust to account for the delivery of the strategy and

through seeking assurance that systems of control are robust and reliable and shape a positive future culture. In essence this means that the Trust Board strategy holds quality and patient safety at the heart of the organisation's vision and holds the organisation accountable through quality governance framework to assure the Trust Board that all best practice guidance received in the Trust is managed in line with this policy. This will be communicated by the Quality and Risk Assurance Committee.

5.2 Chief Executive

The Chief Executive has overall accountability for maintaining internal control and for meeting all statutory and regulatory requirements and adhering to guidance and publications incorporating best practice guidance from a variety of sources. The Chief Executive has overall responsibility for the delivery of high quality patient care and this responsibility has been delegated to the Medical Director and the Director Clinical Quality.

5.3 Medical Director

The Medical Director has overall accountability for setting the clinical standards within the Trust and is responsible for developing systems across the Trust to ensure that clinical practice is safe at all times and meets the diverse needs of the patient population. The standards of care delivered to patients will be monitored by the Medical Director via the national clinical performance indicators (NCPIs), Ambulance Framework Indicators (AFIs) from the National Operating Framework indicator documents and the clinical audit programme. The Medical Director will submit regular reports to the Trust Board to assure it that the decisions taken to implement best practice guidance have had a positive effect on the quality of patient care and have improved the patient experience.

5.4 Director of Clinical Quality

The Director Clinical Quality provides visible and effective leadership across the Trust to ensure the delivery of clinical services meet all performance standards, regulatory requirements, best practice and professional development requirements. The Chief Executive has devolved accountability to lead on the reporting requirements for the Care Quality Commission Standards, NHS Litigation Authority Standards and other standards which are part of the Trust's operational and legislative requirements to the Director Clinical Quality. Specifically the Director of Clinical Quality is the lead Executive Director accountable for managing the National Confidential Enquiries and other high level enquiry reports received by the Trust. In addition the Director of Clinical Quality will ensure that requests for data and information in relation to national enquiries are responded to in line with the Trust's Freedom of Information Policy and Caldicott principles.

5.5 Quality and Risk Assurance Committee

The Quality and Risk Assurance Committee is a non-executive sub-committee of the Board and has no executive powers, other than those specifically delegated in its Terms of Reference. As an assurance committee it may only make recommendations to the Trust Board. The Committee may establish, subject to Board approval, sub-groups to executive the delegated powers within these Terms of Reference.

A key function of the Committee is: "To lead on the development and monitoring of quality and risk systems within the Trust to ensure that quality, patient safety and risk management are key components of all activities of the Trust." The Committee plays a pivotal role in the assurance processes linked to the monitoring of the implementation of best practice guidance and providing assurance to the Trust Board.

In addition it will scrutinise performance of the Trust's risk management processes to ensure that the Trust's top twenty risks are mitigated to reduce the risk of harm to patients and improve patient safety.

5.6 Clinical Quality and Safety Group (CQSG)

The CQSG is responsible to review key clinical information across the range of services provided by the Trust and to support the delivery of safe, effective and appropriate patient care. In particular it will receive reports on:

- Clinical incidents (to include serious incidents)
- Clinical audit, patient surveys and research
- Summary of complaints and PALS
- Safeguarding information and requirements
- Infection prevention and control information requirements
- Medicines management information and requirements.

In addition the CQSG will receive reports from the working groups specifically from the Clinical Development and Effectiveness (CDE) Group and the CAPE Group in regard to national guidance, best practice relating to NICE, JRCALC, National Confidential Enquiries and NSFs. It will set and monitor clinical standards within the Trust based on best practice or specialist clinical opinion. It will scrutinise patient safety performance, clinical performance, review clinical practice and commission audits to confirm that the implementation of best practice based on best available evidence has improved clinical effectiveness and the patient experience. It will monitor plans which have been implemented to address deviation from expected clinical performance, review patient experience feedback and seek assurance on action plans to address any shortcomings. The CQSG will also receive the clinical risk register at each of its meetings to monitor clinical risks and ensure mitigations are progressed to reduce the risks to patients. All risks scored above 15 are escalated to the Risk Management Group which will inform the Audit Committee, Quality and Risk Assurance Committee and the Trust Board of any concerns.

5.7 Clinical Development and Effectiveness Group

The Clinical Quality and Safety Group has delegated responsibility to the Clinical Development and Effectiveness Group to monitor and evaluate external guidance to inform clinical the development agenda (e.g. NICE, JRCALC, National Confidential Enquiries and NSFs). This Group is chaired by the Trust's Consultant Paramedic and the membership covers multi-disciplinary areas with representation of all professions. The Group will:

- Ensure an organisational gap analysis takes place when best practice guidance is issued and received by the Trust; Any risks identified during the course of conducting the gap analysis or implementing the action plan are escalated to the appropriate risk register which will be monitor by the Trust's Risk Management Group
- Maintain a register of all external guidance that has been assessed and record whether or not a recommendation will be made to implement the guidance
- Review and agree dissemination and implementation plans, and submit to the CQSG for approval
- Submit the approved actions to the CAPE Group to monitor uptake and to receive audit information.

5.8 Consultant Paramedic

The Consultant Paramedic is the nominated Trust lead for the dissemination, implementation and monitoring of best practice guidance. All guidance received via

the Trust's Medical Director will be passed to the Consultant Paramedic for assessment adhering to any identified timescales for implementation if necessary. The Consultant Paramedic will utilise the CIRIS system to horizon scan and forward plan for any external guidance published. The benefits of using CIRIS in managing this process allow a vast amount of information to be stored on one system including guidance, the gap analysis, associated audits, reports, action plans. In addition any new national guidance is immediately available to system users. All external guidance will be disseminated to the key governance groups as identified in the quality governance framework and uptake will be monitored by the CQSG. In addition the Consultant Paramedic will liaise with the Training and Education Lead to ensure that all relevant best practice guidance is considered built into all future training programmes.

5.9 Associate Director Clinical Quality

The Associate Director Clinical Quality who is also the Chair of the Clinical Audit and Patient Experience (CAPE) Group will place on the CAPE Group agenda all NCEPOD reports to review and to consider the recommendations which have been based on the findings of the investigation. All recommendations applicable to the Trust will be discussed and agreed and added to the CAPE action log to ensure that the appropriate action is taken by the relevant line managers.

NCEPOD recommendations are usually directed at service provision at both local and national level. The recommendations as well as identifying remedial action also include examples of good practice to encourage others to change practice. All good practice recommendations highlighted by NCEPOD will be recorded on the CAPE action log and proposals to change clinical practice will be submitted to the Clinical Quality and Safety Group.

The Trust is committed to improving the standards of patient care and will continue to use clinical audit as a means of identifying remedial action and for highlighting areas of good practice.

5.10 Clinical Lead

The clinical lead is responsible for considering the relevance of the NICE, JRCALC and National Framework documents for the Trusts and to take the appropriate action through the Trust's Quality Governance Framework. In addition, the clinical lead is responsible for undertaking a benchmarking exercise against current activity (gap analysis) and to identify any obstacles to implementation.

The clinical lead must record the findings of the gap analysis in an action plan and monitor the progress against this to ensure the Organisation is responding appropriately.

6. Process for Identifying Relevant Documents (including horizon scanning)

Best Practice Guidance is received into the Trust via a number of routes including the Chief Executive, the Medical Director, the Director of Clinical Quality, the Consultant Paramedic, the Central Alerting System Officer and the Associate Directors, Clinical Services. All staff listed above receive notification of best practice reports but also horizon scan relevant websites as well as receiving the information via the DH CAS system and the Trust's CIRIS software system. These routes therefore ensure that

the Trust can be alerted to the arrival of any new report. All new guidance is registered on the CAS and/or CIRIS databases.

Resources that may help identifying relevant documents are:

- www.nice.org.uk
- www.3e.co.uk
- www.dh.gov.uk
- www.cemach.org.uk
- www.cas.dh.gov.uk
- www.dmrc@MHRA.gsi.gov.uk
- www.jrcalc.org.uk

The Clinical Development and Effectiveness Group with its multi-disciplinary membership will review all clinical best practice guidance issued and record whether or not it is relevant to the Trust. The CDE Group will then present a report to the CQSG for a decision to be made. All decisions made by the CQSG will be reported to the Executive Management Group for final sign off.

7. Process for Disseminating Relevant Documents

The Chief Executive will disseminate best practice guidance documents to the relevant lead Executive Directors. NICE, JRCALC and National Framework documents will be passed to the Medical Director who will pass them on to the Consultant Paramedic. National Confidential Enquiries and reports of high level enquiries will be passed to the Director of Clinical Quality, who will appoint a responsible lead to consider the relevance of the document for the Trust and to take the appropriate action through the Trust's Quality Governance Framework (Committee and Groups which are described above). In all occasions this will be communicated through discussion with the nominated lead and followed up with an email.

The Trust suggests that the lead managers utilise the slide sets which have been developed by NICE to support discussions with a variety of audiences to assist in the local dissemination of the guidance. Slide sets can be tailored for local Trust presentations and include background notes for the presenter. It should be noted that the slides contain key messages and may not always cover all the recommendations approved for action.

Slide sets can be accessed at:

www.nice.org.uk/usingguidance/implementationtools/slidesets/slide_sets.jsp

8. Process for Conducting an Organisational Gap Analysis

The responsible clinical lead and/or working group will assess the extent of the Trust's compliance with each of the recommendations made in the report and determine the actions required.

The types of issues that might be considered are:

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?

Will there be additional costs, both in terms of implementation and for future practice?

Will a business case or PID be needed to ensure that potential costs are approved and built into next year budgets and service planning?

Workforce Issues

Will there be any workforce implications?

Will there be any training needs for staff?

Will staff be receptive to the required changes?

Risk

Are there any potential risks to implementation?

Are there any reasons not to implement recommended practice?

Are there any risks identified, which need to be entered onto the relevant risk register

Management Issues

What might some of the barriers be to implementation?

Where does implementation fit in relation to other priorities?

Can the recommendations be implemented in appropriate/required timescales?

Should any information be made available to the public?

Following the gap analysis, the outcome must be formally recorded on the template for an

Action Plan following an Organisational Gap Analysis (Appendix D). In some cases, however, the responsible clinical lead and/or working group may need to produce a more detailed action plan.

A record of progress against the action plan must be clearly documented and securely retained. The action plan in respect of NCEPOD recommendations should be submitted to the Clinical Quality & Safety Group and the Associate Director Clinical Quality so that it can be monitored at the CAPE Group and also referred to in the Trust's Quality Account.

To complete the gap analysis the Trust suggests that it should utilise the NICE support tools which will provide the necessary direction by using a step by step approach to identify any gaps. One of the NICE support tools to complete the gap analysis can be viewed in Appendix C.

9. Process for Ensuring that Recommendations are Acted Upon

Clinical Audit and Patient Experience Group (CAPE)

The Clinical Quality and Patient Safety Group (CQSG) has devolved responsibility to the Clinical Audit and Patient Experience (CAPE) Group to provide assurance that all aspects of service provision which relate to and/or impact on the patient's experience are monitored, and measured to benchmark clinical practice so action can be taken as and when necessary to improve the standard of patient care and ultimately the

patient's experience. The CAPE Group is responsible for maintaining an action log of all recommendations received through best practice guidance and clinical audit and patient survey results. It will provide a bi-monthly report on the progress of the action log to the CQSG so that they can monitor any barriers to completing the action on time and to monitor any resultant clinical risks. The report will also be placed on the agenda of the QRAC to provide assurances to the Trust Board that the policy and systems are working effectively in managing and implementing best practice guidance. The CAPE group have the responsibility for reporting progress up and for disseminating information down to line managers so that recommendations are acted upon.

The Responsible Clinical Lead will report bi-monthly or upon completion of the action plan to the CAPE group. The report will contain:

- Progress against each recommended action/ action plans
- Details of any barriers to achievement of original time scales
- Details of the reasons for any departure from recommended practice
- Details of risks placed on the Trust's corporate, directorate and/or department risk register
- Details of the Trust's compliance against newly published reports.

Following presentation at the CAPE Group the CAPE action log will be presented to the Clinical Quality and Safety Group; a copy of the progress report will also be presented to the Risk Management Group and the Quality Risk and Assurance Committee.

The progress of risks placed on the Trust's risk registers will be monitored by lead managers using the 4 Risk software system.

Information required for implementing the recommendations:

- Names of management leads responsible for implementing the action plan,
- Date by which the action plan will be implemented,
- Any barriers to implementation that cannot be resolved by the management lead
- Management Lead to be sent a schedule of CAPE Group meeting dates
- Where the Trust is not compliant with Best Practice Guidance, the Management Lead should assess the risk using the Trust's risk scoring matrix and consider it for inclusion on the relevant risk register,

10. Process for Documenting any Decision Not to Implement NICE Recommendations

Best Practice Guidance is received into the Trust via a number of routes including the Chief Executive, the Medical Director, and the Director of Clinical Quality, Central Alerting System Officer, Medicines management group and CIRIS. All Best Practice guidance will be:

- Registered on to the Trust's Guidance Database, CIRIS,
- Reviewed by the Clinical development and effectiveness group to make an initial assessment of the guidance and its relevance to the Trust,
- Where the Best Practice guidance is deemed not appropriate for implementation by the CDE Group, the nominated management lead will present a paper to the Medical Director and/or Director of Clinical Quality at CQSG who will consider the recommendation not to implement the guidance and will make a decision. The

decision will be noted at CQSG and will be reported by the chair (Medical Director and/or Director of Clinical Quality of CQSG) to the Executive Management Team

- The Paramedic Consultant will report all Best Guidance that the Trust has decided not to implement to the CAPE Group so that a record can be made and included in the Trust's Quality Account.

These decisions should be reviewed periodically by the CDE Group as changes to service provision or the introduction of new service lines may lead to previously inapplicable guidance becoming relevant to the Trust.

11. Process for ensuring the organisation respond to requests for data

The Trust maintains a central log spreadsheet for ensuring that the Trust responds to all requests for data. In line with appendix B, all requests for data will be forwarded to the Associate Director of Clinical quality who will update the central log spreadsheet. Once the request for data has been responded to, the central log spreadsheet must be updated by the Associate Director of Clinical Quality to this effect.

In addition to the central log spreadsheet, any requests for data which are received by the Chief Executive will be discussed at the next available EMT meeting. An action is recorded within the EMT minutes to follow up on the organisations response to the request for data. This will continue to be a recurring action until the organisation has responded to the request for data and the central log spreadsheet has been updated.

12. Equality Impact Assessment

The Equality Act 2010 (the Act) replaces the previous anti-discrimination laws with a single Act. On 5 April 2011, the public sector Equality Duty came into force. This Duty requires the Trust to play their part in making society fairer by tackling discrimination and providing equality of opportunity for all. Therefore the Trust must consider the needs of all individuals, in shaping policy, in delivering services, and in understanding how different people will be affected by decisions made by implementing this policy. All decisions taken will be documented and the Committee's and Lead Managers will consider whether the decisions taken continue to provide services that are appropriate and accessible to all and that they meet different people's needs. The new Equality Duty replaces the three previous public sector equality duties – for race, disability and gender.

The new Equality Duty covers the following protected characteristics:

- age
- disability
- gender reassignment
- pregnancy and maternity
- race – this includes ethnic or national origins, colour or nationality
- religion or belief – this includes lack of belief
- sex
- sexual orientation

It also applies to marriage and civil partnership, but only in respect of the requirement to have due regard to the need to eliminate discrimination.

The new Equality Duty is designed to reduce bureaucracy while ensuring public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all. **The Equality Duty does not impose a legal**

requirement to conduct an Equality Impact Assessment. Nor is there is any practical need to conduct one. Compliance with the Equality Duty involves consciously thinking about the three aims of the Equality Duty as part of the process of decision-making. That will entail understanding the potential effects of the organisation's activities on different people, but there is no prescribed process for doing this. Keeping a simple record of how decisions were reached will help the Trust show how it has considered the Equality Duty.

13. Monitoring Compliance with the Policy

The Associate Director of Clinical Quality will monitor the implementation of this policy including the minimum requirements of the NHSLA Risk Management Standards and will provide assurance to the CQSG and QRAC through an annual report. If on-going monitoring identifies an adverse trend an exception report will be submitted at the next scheduled meeting.

What	How	Frequency	By whom	Evidence
a. Duties, including leadership for all stages of the process	Job descriptions Audit CIRIS	Annual	Associate Director Clinical Quality	Audit reports
b. Process for identifying relevant documents	CIRIS Internet	Bi-Monthly	Consultant Paramedic	CIRIS reports
c. Process for disseminating relevant documents	CQM Intranet	Bi-Monthly	Medical Director	Clinical Quality Matters bulletin Clinical updates
d. Process for conducting an organisational gap analysis	Audit / Review	Annual	Audit resource	Completed gap analysis documents
e. Process for ensuring that recommendations are acted upon throughout the organisation	Audit / Review	Annual	Audit resource	CAPE action log
f. Process for documenting any decision not to implement JRCALC and NICE recommendations	Audit / Review	Annual	Audit Resource	Notes of CDE and CQSG Groups CIRIS report
g. Process for ensuring that the organisation responds to requests for data	Audit / Review	Annual	Audit Resource	FOI Policy and Publication Schedule Data Quality Policy and Implementation Plan

14. References

National Quality Board: NICE Quality Standards. (2010)

The NHS Constitution: The NHS belongs to us all. (2010)

The National Institute for Health and Clinical Excellence (NICE) website provides the full list of NICE guidance, quick reference guides, resources to support implementation, and further information: www.nice.org.uk.

How to put NICE guidance into practice: A guide to implementation for organisations. (2008)

Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Pre-Hospital Clinical Practice Guidelines (2006) www.jrcalc.org.uk

The Equality Act (2010)

Confidential Enquiry into Maternal and Child Health (CEMACH). London: RCOG Press. www.cemach.org.uk

Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), London: RCOG Press. www.cemach.org.uk

NCEPOD, encompassing both the Report of the National Confidential Enquiry into Patient Outcome and Death and the former Report of the National Confidential Enquiry into Perioperative Death. London. NCEPOD. www.ncepod.org.uk

National Health Service Frameworks. London. Department of Health. www.dh.gov.uk

Bristol Royal Infirmary Enquiry (2001). *Learning from Bristol. The report of the Public Inquiry into children's heart surgery at Bristol Royal Infirmary 1984 – 1995.* London. The Stationery Office. www.bristol-inquiry.org.uk

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The Shipman Enquiry (2004). *Fifth report – Safeguarding patients: Lessons from the past – proposals for the future.* London. The Stationery Office. www.the-shipman-inquiry.org.uk

Francis Roberts Enquiry into Mid-Staffordshire Foundation Trust. www.midstaffsinquiry.com

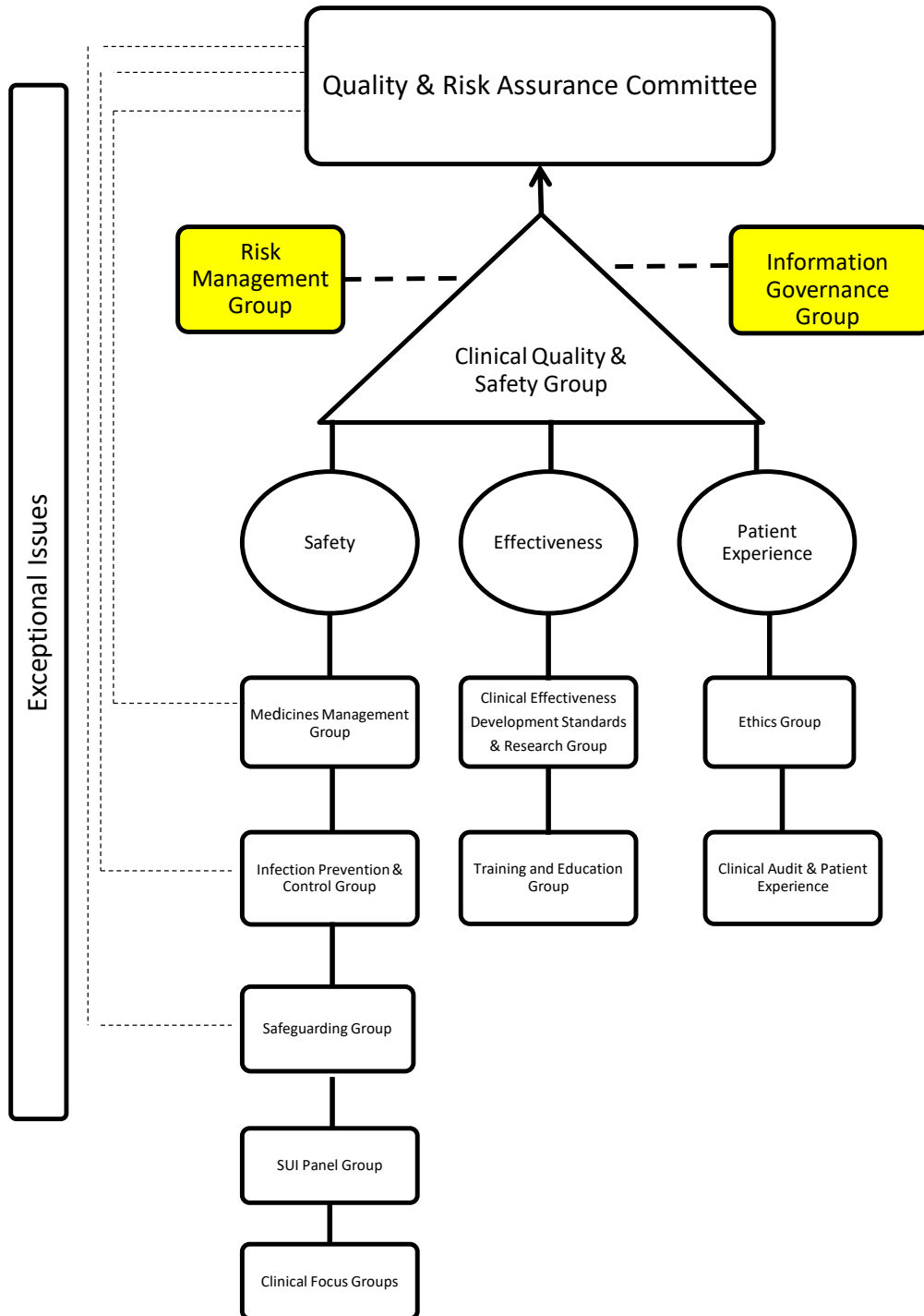
15. Associated Documentation

This policy should be cross referenced to other related Trust document(s):

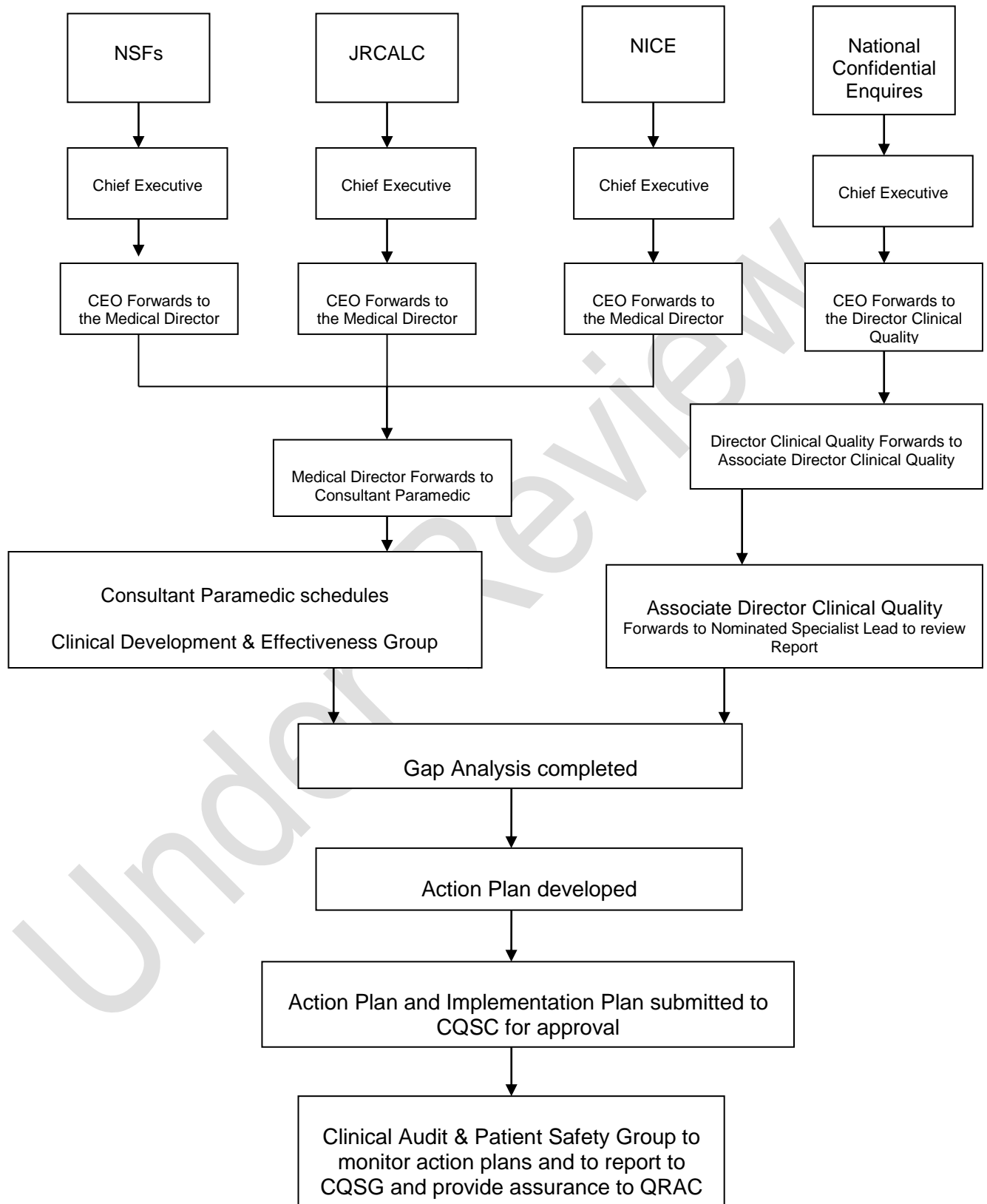
- Risk Management Policy
- Risk Register
- Quality Governance Strategy
- Clinical Strategy
- Trust Board Committee Governance Structure including Terms of Reference

Appendix A – Quality Governance Framework

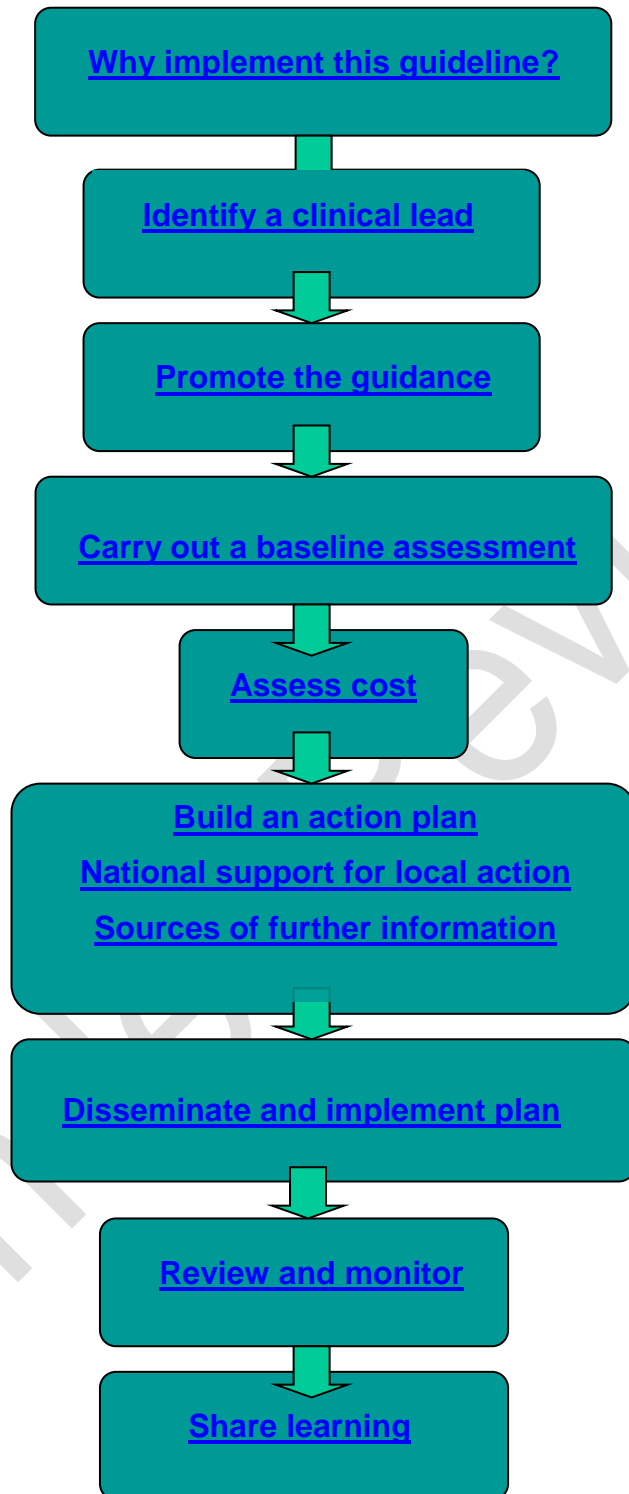
Committee Structure for the Clinical Directorate



Appendix B - Process Flow Chart for Managing the Dissemination, Implementation and Monitoring of Best Practice Guidance



Appendix C - Nice Tool to complete Gap Analysis



Appendix D - Template for an Action Plan Following an Organisational Gap Analysis

Recommendation <i>(detail all recommendations from the guidance)</i>	Compliance (Yes/No/Partial)	Action Required	Responsibility and Timescales	Monitoring Arrangements	Date Action Completed

Under Review

Appendix E - External Clinical Guidance Impact Assessment

This form is to be completed by clinicians who are reviewing external clinical guidance to inform the development of practice. The form should be submitted to a member of the Clinical Development and Effectiveness Group once complete.

Guidance Title:

Author:

Publication Date:

Summary of guidance (200 words):

Key recommendations relevant to ambulance service care with rationale and assessment of what we are already doing:

Recommendation	Ref Number / Page Number	Relevant to ambulance clinical practice (Yes / No)	Rationale for decision	Is this already current practice?

For areas where you have identified that a change in practice is required please enter information below:

Development Required

Area requiring development / Recommendation	Development required (including where possible resource implications)	Priority

Policy for the Management and Implementation of Best Practice Guidance

Area requiring development / Recommendation	Development required (including where possible resource implications)	Priority

Form Completed by:

Date Completed:

Under Review

EXAMPLE: External Clinical Guidance Impact Assessment

This form is to be completed by clinicians who are reviewing external clinical guidance to inform the development of practice. The form should be submitted to a member of the Clinical Development and Effectiveness Group once complete.

Guidance Title: Preventing unintentional injuries among under-15s (quick reference guide)

Author: National Institute for Health and Clinical Excellence

Publication Date: November 2010

Summary of guidance (200 words):

This guidance is a summary of three NICE guidance documents:

- Strategies to prevent unintentional injuries among under-15s
- Preventing unintentional injuries among under-15s in the home
- Preventing unintentional injuries among under-15s: road design

Key recommendations relevant to ambulance service care with rationale and assessment of what we are already doing:

Recommendation	Ref Number / Page Number	Relevant to ambulance clinical practice (Yes / No)	Rationale for decision	Is this already current practice?
Establish a national injuries surveillance resource	7 / pg. 9	Yes	We will be required to contribute information to the surveillance.	Yes - safeguarding register already established.
Developing policies for public outdoor play and leisure	12 / pg. 19	No	We have no play areas for under 15s	

For areas where you have identified that a change in practice is required please enter information below:

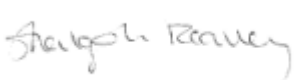
Development Required

Area requiring development / Recommendation	Development required (including where possible resource implications)	Priority
Establish a national injuries surveillance resource (Recommendation 7)	<ul style="list-style-type: none"> • Confirm with surveillance centre what information they require for the ambulance service (safeguarding lead) • Ensure system in place to pass information (may require IT investment) • Write clinical information to staff to ensure consistent collection of data 	Medium

Form Completed by:

Date Completed:

Appendix F Equality Impact Assessment Summary

Executive Summary Page for Equality Impact Assessment:	
Document Reference:	Document Title: Policy for the Management and Implementation of Best Practice Guidance
Assessment Date: July 2011	Document Type: Policy
Responsible Director: Sheilagh Reavey	Lead Manager: Jill Moseley & John Martin
Conclusion of Equality Impact Assessment: There are no adverse effects of this policy on any group	
Recommendations for Action Plan: None	
Risks Identified: None	
Approved by a member of the executive team:	
Name: Sheilagh Reavey	Position: Director of Clinical Quality
	Date: July 2011