NICE IMPLEMENTATION

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GUIDANCE IS ONLY USEFUL IF IT IS PUT INTO PRACTICE

‘Nurses are at the forefront of driving change because they see our guidance as a way to improve care for their patients’

At NICE we are well aware that there is little point in us developing guidance if no one puts it into practice. That is why we have spent a great deal of time and energy over the last few years establishing a team of people dedicated to supporting frontline practitioners in implementing that guidance.

Initially, we spent a lot of time listening to what our stakeholders had to say about implementation. We held workshops to find out what barriers you have to overcome before you can put our recommendations into practice. We also talked to a lot of people about what sort of practical tools and support would be of use in overcoming these hurdles.

We then spent time working on what we had been told. We built a team of people who come from a wide range of backgrounds and experience – people who have worked in nursing, pharmacy and management – who understand what it is like to have to take a piece of paper and translate it into changes in everyday practice.

I am constantly amazed at how much the team have achieved in such a short time. In just a couple of years we have gone from having almost no implementation support tools at all, to offering a full complement with each piece of guidance that we publish. In addition, we have produced a large number of generic support tools that cut across all our guidance-producing programmes – things like our forward planner and the evaluation and review of NICE implementation evidence (ERNIE) database.

The best part of my job, however, is not counting the number of support tools we have produced, but hearing how they are used and about the huge number of innovative implementation projects that are going on across the whole of the NHS. So many of these projects are led by nursing staff, and it is these people who are often at the forefront of driving change because they see our guidance as a way to improve care for their patients.

I hope that you enjoy reading this supplement and that it gives you a greater insight into the work that we do. Most of all I hope you will find inspiration in the case studies of nurse-led implementation projects that are featured here.

Dr Gillian Leng, MD, FFPH, FRCP
Implementation director, NICE
HOW NICE MAKES DECISIONS ON TREATMENTS AND DRUGS

AUTHOR Kathryn Godfrey, BSc, is clinical editor, Nursing Times.

NICE recommendations can be controversial. Kathryn Godfrey explains why NICE was originally set up and its role in making decisions about individual drugs and treatment.

The National Institute for Health and Clinical Excellence, commonly known as NICE, has the job of deciding which drugs and treatments can be provided on the NHS in England and Wales. Using the expertise of doctors, nurses, patients and carers, it also produces evidence-based guidance that is designed to help healthcare professionals promote good health and prevent and treat ill health.

NICE was established in 1999 with one of its main aims being to tackle the ‘postcode lottery’ of healthcare, that is, when the availability of treatment is dependent on where the patient happens to live. Originally set up as the National Institute for Clinical Excellence, it merged with the Health Development Agency in 2005. NICE is a special health authority, which is accountable directly to the NHS chief executive and the health secretary. Its chairperson is a clinical pharmacologist, Professor Sir Michael Rawlins, and the chief executive is former trust chief executive, Andrew Dillon.

Although specifically focused on England and Wales, NICE does have indirect influence on the rest of the UK. In 2006 the Department of Health, Social Services and Public Safety (HPSS) in Northern Ireland decided to link to NICE. The HPSS now studies any guidance issued by NICE and decides if it should be accepted for Northern Ireland.

In Scotland the equivalent body is the Scottish Medicines Consortium (SMC), which conducts appraisals of new drugs. It tends to report more quickly than NICE, whose appraisals are more in depth. If a later appraisal by NICE comes to a different conclusion than that of the SMC then the NICE guidance will usually be adopted in Scotland.

With regard to producing clinical guidelines, the Scottish equivalent is the Scottish Intercollegiate Guidelines Network (SIGN). In order to avoid duplicating guidelines, the two bodies – NICE and SIGN – work together.

AREAS OF ACTIVITY
NICE has four main areas of activity in the NHS in England and Wales. The first, and the one that causes the most controversy, is producing guidance on the use of new and existing treatments in the form of technology appraisals. The appraisals look at the evidence regarding the clinical and cost effectiveness of a treatment and recommend whether, and in what circumstances, it should be used in the NHS. The appraisals mainly cover drugs but they do also cover other areas such as procedures, medical devices and screening.

The second is to produce guidance on the care and treatment of specific conditions in the form of clinical guidelines. The third area covered is interventional procedures that consider whether particular diagnostic or treatment procedures are safe and effective for routine use. NICE also produces guidance on the promotion of good health and the prevention of ill health but these only apply in England.

Anyone can propose a subject for all of the NICE work programmes. Healthcare professionals and members of the public can email suggested topics to NICE, although the final decision about what it addresses is determined by the Department of Health and the Welsh Assembly.

TECHNOLOGY APPRAISALS
Each technology appraisal takes around 12–18 months and is undertaken by a committee of some 15–20 experts, which includes clinicians, academics, researchers, managers and patient representatives.

When developing guidance NICE takes into account both clinical evidence and cost effectiveness. As part of the process, the committee asks for expert advice and opinion from health professionals, patients and patient organisations, as well as from pharmaceutical companies.

WHO SHOULD USE THE GUIDANCE
Healthcare professionals are expected to take NICE guidance into account when deciding how patients should be cared for. This was not the case in the early years of NICE – at this time the situation was unclear, with some trusts continuing to argue that they could not afford those treatments recommended by NICE, thereby continuing the postcode lottery.

However, since January 2002, trusts in England and Wales have been expected to provide funding for treatments recommended in technology appraisals within three months of the guidance bring published. Despite this target, there is still some variation in the speed of implementation.

Doctors can go against NICE recommendations if they feel that an individual case warrants it. The Medical Defence Union advises its members that the guidance can be rejected if the decision taken is ‘reasoned and reasonable’ and advises that the rationale should be documented in the patient’s notes.
Sharing best clinical practice

**AUTHOR** Caroline Rapu, PGDip, MBA, is project manager, RCN NICE Portfolio

As core users of NICE guidance it is vital that nurses help its development, inform its content in the interest of patients and share best clinical practice through implementation.

RCN members provide professional input to ensure that the guidance includes the nursing perspective. RCN members work in two ways – as a collaborating centre that develops guidelines on behalf of NICE and as a stakeholder contributing to the development of NICE guidelines.

The RCN hosts the National Collaborating Centre for Nursing and Supportive Care, which is one of the seven centres commissioned by NICE to develop its clinical guidelines. We developed the following guidelines: pressure ulcer management; and managing violence behaviour in inpatient settings and emergency departments. We are currently working on osteoporosis, irritable bowel syndrome and peri-operative hypothermia guidelines.

As a stakeholder, the RCN contributes to the development of guidelines and reviews draft guidelines for implementation. Nurses are involved in a variety of ways, such as scoping a guideline, submitting evidence on the topic being reviewed and reviewing draft guidelines prior to their publication. They are also members of the guideline development groups and are involved in finalising clinical questions, interpreting evidence reviews, meta-analyses, consensus procedures, cost-effectiveness reviews, developing recommendations, and implementation.

We believe that a good guideline is one that is widely implemented. We support conferences and study days promoting NICE guidance and nominate members who work in the relevant fields to assist NICE in developing implementation support tools.

Recently our members contributed to the development of the following implementation support tools: clinical guidelines on the prevention of venous thromboembolism (deep vein thrombosis) for patients undergoing surgery; and managing eczema in children.

We welcome nurses with expertise to participate in this work. For further information email caroline.rapu@rcn.org.uk.

**CONTROVERSIAL DECISIONS**

In the past a major criticism of NICE has been that it takes too long to approve new drugs and treatments and, for some patients, particularly those with life-threatening or terminal disease, that delay is unacceptable. More recently limitless resources and NICE is involved in the management of these by considering the cost-effectiveness of various treatments. Inevitably patient groups feel strongly and lobby hard when treatments are not made available. This occurred with one of NICE’s earliest decisions in 2000 when it decided not to recommend beta-interferon for patients with multiple sclerosis.

In 2002 another treatment received media coverage: NICE draft guidance suggested that the drug imatinib would be limited to people in the advanced stages of chronic myeloid leukaemia. However, by the time the full guidance came out its use had been extended to all stages of the disease.

The trastuzumab (Herceptin) case is the one that has had the most press coverage. After heavy lobbying by patients and pharmaceutical companies, the then health secretary Patricia Hewitt announced during the appraisal process that Herceptin would be made available to women with early breast cancer who could benefit from it. NICE went on to recommend Herceptin in August 2006.

NICE has only made an outright decision not to recommend a treatment on a handful of occasions. Most recommendations from technology appraisals provide a restricted yes, allowing drugs or treatment to be used for a specific subset of patients.

However, although many may feel that NICE guidance is excluding them from the treatments they need, a recent report suggests that NICE may, in fact, be allowing more treatments through than the NHS can afford.

In evidence that was submitted to the House of Commons select committee enquiry on NICE this year (Appleby et al, 2007) a joint report by City University and the King’s Fund said that the body may be judging value for money at too high a level, compared with other treatments within the NHS.

NICE uses a variety of economic equations in order to judge whether a treatment is cost-effective, including a Quality Adjusted Life Year (QALY), which indicates the benefits gained from treatments and drugs in terms of quality of life and survival. The report authors suggest that NICE may be setting its QALY level too high.

**CONCLUSION**

NICE has to make some controversial decisions about funding treatments. These may not be popular with the public but its remit is to provide guidance as to the best possible care based on current evidence.

Nurses need to be aware of this function when they are implementing guidance, talking to patients about their care and also when they are reviewing their practice against NICE guidance. This supplement will explore how nurses can become involved in the development of NICE guidance or implementing guidance to assess, improve and challenge existing practice.

NURSES’ INPUT IS VITAL TO GUIDELINE DEVELOPMENT

AUTHOR Clare Lomas, BSc, BA, RGN, is news reporter, Nursing Times.

Clare Lomas explains how guidelines are developed and why nurses need to be actively involved in this process.

NICE issued its first guidance in April 2001. It has now published over 430 pieces (Box 1) and is in the process of developing many more.

Using the expertise of doctors, nurses, patients and carers, the evidence-based guidelines are designed to help healthcare professionals promote good health, and prevent and treat ill health.

Probably the guidance most relevant to nursing practice is the clinical guidelines. To date, NICE has published 64 clinical guidelines, ranging from the management of hypertension to the assessment and prevention of falls in older people. NICE’s clinical guidelines do not replace the knowledge and skills of healthcare professionals but set out recommendations on the most appropriate treatment and care of people with specific diseases and conditions.

Nurses can use NICE clinical guidelines to help develop standards for best practice, in education and training, to improve communication between patients and healthcare professionals, and to help patients make informed decisions.

DEVELOPING GUIDELINES

NICE considers topics for guidance from the Department of Health, healthcare professionals, patients, carers and the public (Box 2). If nurses want to suggest a topic they can complete a form (Box 2). If nurses want to suggest a topic they can complete a form that can be obtained by calling or emailing NICE, or they can download it from the NICE website at www.nice.org.uk. NICE reviews each of the suggestions received, which are then assessed according to the DH’s selection criteria. This takes into account the morbidity and mortality of the disease, the cost to the NHS, inappropriate variations in practice and the urgency for guidance to be produced. The final decision on which topics are referred to NICE lies with the DH.

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Guideline development groups

Once a topic has been selected, a National Collaborating Centre (NCC) is commissioned to prepare a scope, which details what the guideline will and will not cover. The NCC also sets up an independent guideline development group (GDG) to look at all the available evidence and makes recommendations to produce a draft guideline.

Consultation and stakeholders

A consultation period then follows where registered stakeholders – healthcare professionals and groups representing patients and carers – can comment on the draft guideline. Nurses who are not registered stakeholders can provide comments but NICE recommends that, because they work very closely with registered stakeholder groups, any comments or suggestions that nurses want to make should be made via the relevant organisation.

Information of how to register as a stakeholder can be found on the NICE website.

There is always at least one public consultation period on a draft guideline. This usually lasts for two months and an independent guideline review panel is responsible for making sure that all stakeholder comments have been taken into account.

Box 2. Process of guideline development

- Developing NICE guidelines takes about two years.
- NICE considers topics for guidance from the Department of Health, healthcare professionals, patients, carers and the public.
- Once a topic has been selected, a National Collaborating Centre (NCC) is commissioned to prepare a scope – what the guideline will and will not cover.
- The NCC sets up an independent guideline development group (GDG) to look at all the available evidence and makes recommendations to produce a draft guideline.
- A consultation period then follows where registered stakeholders can comment on the draft guideline.
- There is always at least one public consultation period on a draft guideline.
- At the close of the consultation process the GDG finalises the guideline recommendations and the NCC then produces the final guidance.
- The guidance is then formally approved by NICE and the official guidance issued to the NHS.

Box 1. Types of NICE guidance

- Technology appraisals;
- Clinical guidelines;
- Intervention procedures;
- Public health guidance.
At the close of the consultation process the GDG finalises the guideline recommendations and the NCC produces the final guidance. It is then formally approved by NICE and the official guidance is issued to the NHS.

SHORT CLINICAL GUIDELINES

In July 2007, NICE introduced the first of its short clinical guidelines, on the recognition of and response to acute illness in adults in hospital. Developed using the same methods as regular clinical guidelines, short guidelines are produced within a shorter time period – usually 9–11 months – to help the institute respond faster to urgent NHS issues relating to specific parts of a care pathway.

NICE aims to produce at least two of these types of guidelines per year, and these shorter guidelines will also be used to help update the guidelines already in existence.

ROLE OF NURSES IN GUIDELINE DEVELOPMENT

Nurses have a key role to play in the development and implementation of NICE guidelines. Where guidance is particularly relevant to nursing practice, nursing groups, such as the Leg Ulcer Forum or the UK Association of Diabetes Nurses, may be consulted or involved in the guideline process.

In order to ensure their views are taken into account throughout the consultation process, nursing organisations can register as stakeholders. Individual nurses, who have a specialist interest in an area where a guideline is being developed, can apply to be a part of the guideline development group.

Implementing NICE guidance can be a challenging process, so NICE has set up a programme to help nurses and other healthcare professionals put the guidelines into clinical practice. This includes advice on costing tools, audit criteria and education tools (see p10).

Nurses can also apply to join the external reference group, which supplies NICE with informal feedback on implementation support tools. Information on how to join these groups, and other ways in which nurses can help implement NICE guidance and promote best practice can be found on the NICE website.

Being part of the guideline development group

Dianne Crowe has been a gynaecology specialist nurse practitioner at Hexham NHS Trust in Northumberland for nine years. During this time she has been instrumental in leading a number of nurse-led initiatives, including setting up a one-stop clinic for abnormal uterine bleeding.

As a member of the RCN gynaecology steering group, Ms Crowe was invited to apply to join the guideline development group (GDG) on the NICE clinical guideline on heavy menstrual bleeding. She was accepted by NICE and the group first met in January 2005.

‘It was a big commitment to make but the subject is of special interest to me so I was glad to be part of the group,’ says Ms Crowe.

Being on the GDG meant she had to attend meetings in London every month, with teleconferences in between, and undertake specific reading and allocated work.

‘It meant some very early starts; when going to London I would be up at five in the morning and not get home until midnight,’ she says. ‘But in the current climate, where nurses are taking on a lot of the jobs that medics used to do, I felt it was essential for nurses to have a voice.’

Each time the group met they would look at specific parts of the topic. This involved examining current clinical practice, patient education and the latest research. They would then make recommendations based on the best available evidence. Part of Ms Crowe’s role as the only nurse on the group was to give presentations on examples of good clinical practice to the other members of the GDG.

‘In my presentation on patient information and education, I was able to demonstrate how nurses and doctors working in partnership in specialist clinics, such as our one-stop abnormal uterine bleeding clinic, were able to impact on patient outcomes,’ she says.

‘Seeing patients in a dedicated clinic – right environment, right staff and right equipment – can maximise their healthcare experience and deliver the right message. Our hysterectomy rate at Hexham has steadily reduced by 60% over the last 7–8 years as a result of high-quality patient information and a dedicated team. I clearly demonstrated the theory-to-practice gap, in that it is the “how” or the “process” that has a great impact on patient care.’

Ms Crowe says she was given the opportunity to have a lot of input into the guideline development, and it was a good opportunity to learn and share new ideas on clinical practice.

‘Although it can be quite daunting at first, inputting ideas became easier as time went on,’ she says. ‘We had a fantastic group chairperson who was really keen for the nurse and patient representatives to have their say.’

Being on the development group also meant that Ms Crowe was able to see first hand how changes were made in response to stakeholder comments and new evidence.

‘The group always took account of what the stakeholders had to say, and subtle changes were made all along the line. It was great to be the nursing link because, although you have to go with the evidence, it is possible to get carried away. You have to remember to bring it back and relate the practical points to patient care.’

Although it does involve a lot of commitment, Ms Crowe says she would recommend being on a GDG to other nurses. ‘Even if it was only in small ways, such as how things were worded, I do like to think that my input made a difference,’ she says. ‘Nurses can give a different slant on things and are essential in plugging the gap between theory and practice.’

The final NICE clinical guideline on heavy menstrual bleeding was published in January 2007 and is due for review in January 2011.
NICE LEADERSHIP

TAking THE LEAD ON IMPLEMENTATION

AUTHOR Adrian O’Dowd, MA, is freelance medical writer.

Dr Gillian Leng, implementation director at NICE, believes that nurses are vital for successfully implementing NICE guidelines. In an interview with her, Adrian O’Dowd finds out how nurses can become more involved in the implementation process.

Mention guidelines, guidance or official recommendations and many nurses might groan at the thought of more bureaucracy. But when it comes to NICE, putting its guidance into practice can mean a world of difference to patients and their care.

NICE produces some 15 new clinical guidelines every year, as well as technology appraisals and public health guidance, which have a significant impact on the NHS and how it looks after patients. But all this good work means little if the guidance is not implemented properly and actually used by staff.

A team within NICE is dedicated to making sure implementation of guidelines happens and is supported. Its head, Dr Gillian Leng (pictured), NICE implementation director since 2004, knows that making sure nurses are involved is the secret of success.

After qualifying and spending time as a junior doctor, Dr Leng spent a year in general practice, then got into research in Edinburgh and was involved in the Cochrane Collaboration. She formally trained in public health and worked as a public health consultant at Bedfordshire Health Authority before joining NICE in 2001 as guidelines programme director.

‘I did a lot of work with Cochrane and it is a very rigorous organisation but it stops short of providing guidance for practitioners whereas NICE has the opportunity to do that,’ says Dr Leng.

Her interest in evidence-based practice stems from differences of opinion she would encounter from medical colleagues: ‘My interest goes back to studying medicine where I was aware that there often wasn’t evidence for what was being practised and [there was] variation in what different doctors would recommend,’ she says.

Her current role is to support the use of NICE guidance throughout the NHS and beyond. As she says: ‘That’s about best patient care and best practice and the philosophy is ensuring that NICE guidance is core to what organisations see as improving quality of care and patient safety.’

The need for such support emerged after NICE held a series of workshops in 2003 with NHS staff when, in Dr Leng’s words: ‘Increasingly, people were looking to NICE to provide some implementation support.’

Her work can be summarised under three themes:

• Motivating and inspiring people to implement guidance (through working with others such as the Department of Health, Healthcare Commission, royal colleges and patient organisations);
• Practical support (through costing tools, commissioning guides and ‘how to’ guides);
• Evaluating recommendation uptake to ascertain what is and is not working, and any barriers.

At the heart of this process are nurses. As Dr Leng says: ‘I have involved nurses at every stage of work that has developed. They were invited to the original workshops and I think they have a key role in helping us work through what the barriers to implementation are.

‘Nurses are very good implementers and good practically on the ground, on the wards or wherever else, in getting things done. ‘For example, we have an external reference group that has nurse membership and we have planning meetings when guidance is coming out for consultation and we always make sure we have nurses around the table at that point.’

Dr Leng also directly employs several nurses on her team and says: ‘I am working with the RCN on drawing up a memorandum of understanding to identify how we work together and what the RCN can do in terms of their education and training programmes, [and] routes of dissemination to support implementing our guidance.’

Some of the nurses working at
NICE will be involved with draft guidance to identify the key issues, implementation barriers and useful areas of support. Dr Leng also has a team of six implementation consultants, including two with a nursing background, covering England. ‘They are there to provide advice, support and information rather than hands-on input on a day-to-day basis,’ she says. ‘They are busy people and have been out and about for a year now and during that time, we’ve seen increasing contact from staff in the NHS.’

The benefits of NICE’s guidance are clear, Dr Leng believes: ‘It’s about providing best practice in line with best evidence and therefore best patient care. If you are following NICE guidance, patients should be receiving optimal care. ‘NICE produces guidance that I genuinely think is as good guidance as you possibly can get in terms of the robust process that we go through, the evidence that is reviewed, [and] the people that are consulted and are involved in developing it. ‘If the guidelines are implemented nationally, then there will be less variation in care too, so a patient can be sure that wherever they go, they will receive the same level of care and there won’t be “postcode prescribing” going on.’

But barriers do exist, she admits: ‘There are potentially a huge number of barriers and one of those that comes to my attention most frequently is clinical resistance. It tends to be around specific recommendations that for some reason people feel might not be appropriate or surprises them. ‘Our recommendations are evidence based and it’s difficult for clinicians to be aware of all the evidence in a particular field so, if sometimes the evidence suggests something that clinicians might not be expecting, it can present a bit of resistance. ‘But clinicians are also the best at driving change so it’s important that we work with them during the development process.’

A lack of organisational support can also hinder implementation. ‘You can have a clinician wanting to take change forward but they might find that the management structures are not supportive. That is becoming less of an issue than it used to be because most organisations have processes in place to implement NICE guidance.’

Resources are a perennial problem and Dr Leng adds: ‘People will always say there isn’t enough money. ‘But there has been an Audit Commission report that looked at financial planning for implementation of NICE guidance and it was very clear where organisations were planning ahead on an annual basis to put money aside to implement our guidance and improve patient care.’ In these organisations the resources were not the barrier they were in other places, where forward planning did not occur.

NICE now has a forward planner on its website that highlights what is coming out in the future with costs to make it easier for organisations to plan ahead. Evaluation of how well guidance is being implemented is carried out using the ERNIE (Evaluation of Reviews of NICE Implementation Effectiveness) system as well as external sources – local audits, research, feedback from the Healthcare Commission and patient organisations.

NICE published a booklet on how to implement its guidance in 2005 and a new guide will be published in December. The new guide will focus on overcoming barriers to change. Copies can be obtained at the NICE conference or from NICE’s website.

There are many sources of help for nurses – NICE’s implementation team, the implementation consultants and NICE’s website. ‘It should be clear on the website how they can get in touch with the implementation team and we very much welcome that contact,’ says Dr Leng. ‘We’ve always got new guidance topics coming out and the more feedback we can get from the field the better. ‘They can also contact their local implementation consultant who will be able to put them in touch with other people working in that field if that is helpful.’

Locally, nurses can play their part by becoming involved in clinical governance or clinical governance committees. ‘On a more day-to-day basis at ward level, I’ve seen some excellent examples of nurses either involved in developing protocols or monitoring on a regular basis, feeding back to staff how well they are implementing guidance or any change,’ she says.

‘I would love them to do more on a local basis. Nurses are great at getting things done.’

Dr Leng concludes: ‘I think nurses can find it difficult to ensure every guideline is implemented as it is hard on an individual level and you do need overarching support from the organisation, but they can be very powerful voices to ensure that organisational support is forthcoming.’
A Practical Approach to Implementing Guidelines

**Author** Ann Shuttleworth, BA, is clinical editor, Nursing Times.

Ann Shuttleworth describes the practical support and tools that are available to help nurses implement NICE guidelines.

Since it was set up in 1999 NICE has changed the face of the NHS. The information it disseminates helps to ensure that all patients have access to care based on the latest evidence, and that NHS funding decisions on treatments are consistent across England and Wales. It has also helped to eradicate the wide variations in care that were common when clinical practice was often governed by the preferences of individual practitioners.

Meeting the recommendations of NICE guidance can help NHS organisations ensure they achieve the requirements set out in the Department of Health’s Standards for Better Health – the core and developmental standard covering NHS healthcare provided in England. The extent to which they do this is assessed by the Healthcare Commission in its annual health check.

**Why Implement NICE Guidance**

While NHS organisations are expected to take all guidance from NICE into account, they are only required to provide funding and resources for medicines and treatments recommended in technology appraisals within three months of publication.

There is no mandatory funding requirement attached to other types of guidance as the time it takes to implement guidance will vary between organisations, depending on their practice. It will also vary between guidelines depending on resources needed to implement the guidance and the change required to current practice. As such it would be difficult to apply one timescale to all guidelines.

Guidance offers organisations an opportunity to examine their performance and check how well they are complying with best practice. NICE does not undertake primary research but pulls together evidence that is already available that most health professionals will not have time to read and digest themselves.

‘It is often about sharing information we already have rather than disseminating completely new information,’ says Mary McClarey, head of clinical effectiveness and research at Plymouth Teaching PCT and formerly a non-executive board member for NICE. ‘For example, the recent guidelines on caring for acutely ill patients in hospital stressed the importance of not transferring patients in the night unless it is unavoidable. The importance of this simple principle is often overlooked, but being moved in the night can be extremely disorienting and distressing for patients, particularly if they are confused.’

**Disseminating Guidance**

While there are still many conditions and treatments awaiting guidance, the institute has already produced a vast body of work. Last year it produced over 80 pieces of guidance and it looks set to produce a similar number this year.

It is vital that this information is disseminated effectively so that it reaches the people who need to put it into practice. Each NHS organisation has a person with overall responsibility for ensuring guidance is acted upon – often the clinical governance manager will be sent all new material, while those responsible for implementing

‘Nurses are best able to see where care standards are inadequate’

**Box 1. Tools for implementation**

- A team of implementation advisers support organisations putting guidelines into practice;
- Implementation slide sets are available on the NICE website;
- Costing tools are available to help PCTs work out the costs of implementing particular guidelines;
- A forward planner sets out forthcoming guidance;
- ‘How to’ guides;
- E-alerts to inform organisations of new guidelines and appraisals;
- Into Practice – an electronic bulletin aimed at those responsible for implementing NICE guidance;
- Best practice advice.

**SUPPORT FOR IMPLEMENTATION**

NICE’s work extends beyond simply producing and disseminating guidance. The institute has a team of 30 implementation advisers and consultants, from a range of clinical and managerial NHS backgrounds, which supports organisations in putting the guidance into practice.
‘We take very seriously the need to support organisations in implementing NICE guidance. There is no point in putting all the effort into producing it if nothing is done with it,’ says Gillian Leng, implementation director at NICE, who manages the implementation team.

**Tools**

The implementation advisers develop tools to support organisations in implementing guidelines as well as advice on the practicalities of putting guidelines into practice.

The tools include slide sets, which can be downloaded from the NICE website, that offer an overview of the guideline concerned. In addition, costing tools are available to enable PCTs to work out the likely costs of implementing guidelines and technology appraisals. The costings are based on populations and incidence of particular conditions but can be tailored to reflect local circumstances. Knowing the likely costs, along with the impact of implementation in reducing future healthcare needs enables services to make business cases to have implementation funded by their PCT.

For example, the tool on the use of alteplase in the treatment of ischaemic stroke works out the incidence of the condition, how many people are likely to need the drug, depending on whether implementation targets are achieved and, from that, potential savings, for example from reduced hospital stays.

‘One of the barriers to implementation of NICE guidance is that there is often a perception that they will be very expensive,’ explains Ms Lucy Betterton, associate director of external communications at NICE. ‘The costing tools enable services to see exactly what costs are involved – and what savings are likely in the future.’

Other implementation support can be seen in Box 1.

The implementation team has also set up a shared learning database on NICE’s website. This enables practitioners to share examples of good practice in implementing guidelines – and enables others to learn from problems encountered.

‘We don’t just want people to share their experiences if they went well,’ says Ms Betterton. ‘It can be as valuable – and often more – if they can say “don’t do it this way because this is what happened to us”. Problems can be learning experiences in many cases.’

**Implementation consultants**

The implementation team does not simply produce information and tools. It also has six regionally based implementation consultants from a range of NHS backgrounds, whose job is to engage with NHS organisations in their regions, offer practical support in implementing NICE guidance and ensure they are aware of the tools developed by the team (see Box 1).

‘We’re the local face of NICE,’ says Jayne Chidgey-Clark, implementation consultant for the South West region – one of two consultants from a nursing background. ‘We’re not experts on all the individual guidelines, but we can advise on general issues related to implementation. If people have more specific difficulties we can get advice from the development team for that particular guideline.’

Organisations can also give the consultants feedback on NICE guidance and other materials. ‘It might be something relatively small, like “can you look at how this is phrased, because it wasn’t quite clear to us”, or a suggestion to improve one of the implementation tools,’ says Dr Chidgey-Clark.

She emphasises that NICE wants nurses to engage with it and to get involved in shaping its future directions. They can do this by contacting their NICE consultant directly or through the governance manager or NICE lead in their trust.

‘Nurses can have a real influence’

Mary McClarey says Plymouth Teaching PCT takes an active approach to disseminating information on NICE guidelines and technical appraisals, and ensuring they are acted upon.

‘We send out the quick reference guide for each guideline or appraisal to the relevant clinicians in a monthly bulletin. They are asked to assess how well they are meeting the key recommendations and to reply within a month – they can also ask for help at this point.’

The PCT also organises workshops that give clinicians the opportunity to look at guidelines and how to meet them. Where appropriate, other organisations may also attend, such as acute trusts, social services and GPs. Commissioners have also attended some events, which Ms McClarey says is helpful as they can often move money around to where it can be used most effectively.

‘These events put nurses in a powerful position,’ says Ms McClarey. ‘They can say how any suggestions made will affect patient care, so they can have a real influence on how guidelines are implemented.’

Ms McClarey believes that while NICE was initially very medically oriented, its focus has now shifted.

‘Latterly its agenda has broadened out considerably and its work is much more relevant to nurses than it once was,’ she says. ‘In fact the last seven sets of guidelines have been extremely relevant to nurses. Many of the recommendations are around the environment of care and how it should be delivered.

‘The other significant standard-setting programme nurses are engaged with is Essence of Care, and they can draw on evidence from NICE guidance to measure how well, or otherwise, basic care is being delivered.’
IMPLEMENTING GUIDELINES FOR SUSPECTED CANCER

AUTHOR Victoria Hoban, BA, is freelance journalist.

When nurses at a walk-in centre in Manchester identified a gap in the service for people with suspected cancers, they adapted NICE guidance to address this. Victoria Hoban reports.

Nurse-led walk-in centres across the UK have played a crucial role in appropriately streaming patients to primary care, alleviating the pressure on the A&E four-hour wait target and developing the skills of nurses. As new services, they can also highlight gaps in patient care that may have been overlooked.

This was the case with the Primary Care Emergency Walk-in Centre in central Manchester. Soon after the nurse-led service opened in February 2005, anecdotal evidence revealed that patients were presenting with symptoms of suspected cancer. This was then substantiated by a three-month audit.

At the time, there were no systems to refer patients on to the urgent suspected cancer pathway. Instead, decisions on patient management depended on individual clinicians. The team has now implemented a system based on the NICE referral guidelines for suspected cancer (NICE, 2005), which is successfully ensuring patients at risk no longer slip through the net, including those not registered with a GP.

IDENTIFYING THE PROBLEM

Soon after the walk-in centre opened, it became apparent to the primary care emergency service nurses there that patients were presenting with symptoms of suspected cancer but the processes for referring such patients were inconsistent.

Patients with suspected cancer were either referred back to their GP or to A&E. The former was undesirable as some patients at the centre were unregistered or, if they were registered, had attended the centre on the basis of patient choice and may not have wished to see their GP. Directing the patient to A&E was often inappropriate as patients were often not acutely ill and did not need urgent investigation. Referral could also have adversely affected the four-hour wait target in A&E.

‘Patients were being admitted for diagnostic tests, which is not always appropriate,’ says Rachael Walsh (pictured), lead nurse assessor at the Primary Care Walk-in Centre. ‘If we referred unregistered patients to a GP, it might take up to a month for an appointment. With suspected cancer, time is precious.

‘There is an assumption that every patient has a GP. Unregistered patients were therefore extremely vulnerable.’

The nurses decided to consider using the NICE (2005) referral guidelines for suspected cancer.

‘We felt NICE guidance was best practice and we wanted equal referral pathway for all patients,’ explains Ms Walsh. However, the existing guidance for suspected cancer did not include specific advice for walk-in centres, so she and her team had to consider adapting it.

‘The guidance says that the referral form has to be done by the patient’s own GP or dentist. But this isn’t always possible, and it isn’t always appropriate to refer to the consultant.’
IMPLEMENTATION
Ms Walsh and her team took their findings to the cancer lead in the PCT, who liaised with other UK cancer leads and with the Department of Health policy team for referral guidance and liaison. It was discovered that, although the cancer referral process in walk-in centres had been identified as a problem, it had not been addressed.

A mini audit was conducted between March and June 2007 to assess how many patients fit this category and to understand something about presenting symptoms. During this period, 13 patients presented with symptoms of suspected cancer – hardly an insignificant number.

The team contacted the local cancer collaborative and cancer network, which accepted the project as a test site. They also set up a project group of stakeholders including booking managers at the referral booking and management centre (RBMC) and the local medical council.

The project group decided to implement the NICE (2005) referral guidelines for suspected cancer at the walk-in centre in the same format as for general practice and dentistry.

To achieve this, thorough preparation was needed. It was necessary to:
- Explore the feasibility of implementing the referral guidance at the walk-in centre;
- Implement a standardised process of referral for all patients, regardless of GP registration status; and
- Implement an immediate GP registration process for unregistered patients.

Intense work was undertaken with Patient Data (which registers patients with a GP) at the strategic health authority to establish a system of immediate GP registration. This was to ensure ongoing care is provided following a serious diagnosis.

They also persuaded the RBMC to accept patients who were not registered with a GP.

‘They are now happy for nurses from the emergency centre to refer patients which is a big achievement,’ says Ms Walsh.

‘This has resulted in us building up stronger networks with primary care services and there is better continuity of care.

‘It is also a way of empowering nurse clinicians at the centre while also reducing the four-hour waits in A&E, as we don’t have to wait for a clinician.’

EVALUATION
Following six months of detailed project work, the NICE referral guidance for suspected cancers was implemented at the walk-in centre on 20 August 2007.

This entailed developing detailed protocols in the form of flowcharts that outline the process for different scenarios, such as whether patients are registered with a GP or not and whether they live in or outside of the area. Information for new patients explains the process of referral and follow-up, and is given to each patient together with a verbal explanation.

In liaison with the local cancer collaborative and cancer network, a template has been devised to capture qualitative and quantitative data on all patients referred on the new pathways. This will constitute the testing phase of the project and run until spring 2008.

Quantitative data includes:
- Age, gender, ethnic origin, GP registration status, suspected tumour site, outcomes of conversations with the patient’s GP prior to referral, success or otherwise of the administrative processes, and the final outcome of the referral. Qualitative data includes information on the patient and GP’s perspective of the referral process.

‘We have learnt that it is possible to safely implement the NICE referral guidance for suspected cancers in a walk-in centre, but there must be detailed engagement with all stakeholders for this to be a success,’ says Ms Walsh.

She notes that: ‘It can be a time-consuming process but rewarding in that the patient experience is improved as a result of direct referral.’

There is a need to establish why some patients are not registered with a GP and whether systems that rely on this are appropriate for the new NHS, which offers patient choice at the front end of care.


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Box 1. Recommendations for primary care staff
- You should be able to identify typical presenting features of cancers and be alert to the possibility of cancer when confronted by unusual symptom patterns or patients failing to recover as expected;
- Systematically review the patient’s history and examination, and refer urgently if cancer is a possibility;
- Discuss with a specialist if there is uncertainty about the interpretation of symptoms and signs, and about whether a referral is needed;
- Recognise parents are usually the best observers of their children and listen carefully to their concerns. Be willing to reassess the initial diagnosis or to seek a second opinion from a colleague if a child fails to recover as expected;
- Investigations should not be allowed to delay referral and should be undertaken urgently to avoid delay. If investigations are not readily available locally, an urgent specialist referral should be made;
- When referring a patient with suspected cancer to a specialist service, assess the patient’s need for continuing support. Provide information to the patients, family and/or carers as appropriate;
- Keep up to date with the skills necessary for early diagnosis and referral and for communicating the possibility of cancer to the patient.

Box 2. Key points for implementing this guideline
- Make sure you form a project group that involves all stakeholders including the local medical council and local cancer collaborative;
- Do not rush the process. Have a thorough preparation period during which time all potential barriers can be addressed;
- Liaise early on with equivalent centres around the UK to uncover any existing solutions or ongoing projects;
- Make sure you follow up patients to examine whether the process is working or if new ways of working are required;
- Immediate referral for unregistered patients is vital to implementing this guidance successfully.
IMPROVING CONTINENCE MANAGEMENT FOR WOMEN

AUTHOR Caroline White, BA, is freelance medical journalist

Bradford & Airedale Teaching PCT used NICE guidance to develop a pathway to improve the management of women with continence problems. Caroline White reports.

An estimated five million women over the age of 20 in England and Wales have urinary incontinence. Stress incontinence, caused by physical exertion, such as sneezing or exercise, accounts for around four out of 10 cases, while urge incontinence, in which a sudden strong urge to urinate cannot be stopped, accounts for around one in five. A further one in three women will have both, known as ‘mixed’ incontinence.

The toll on an individual’s personal and professional life can be considerable, while the annual cost to the NHS is estimated to be around £1.8bn. But the true cost may be more as many women suffer in silence. NICE reports that it may take affected women up to 10 years to seek help, possibly due to embarrassment, or because they believe little can be done to help them.

To encourage more women to come forward and improve the clinical care offered, NICE published clinical guidelines (NICE, 2006) on the management of incontinence, including overactive bladder syndrome (the frequent need to urinate with or without urge incontinence before the bladder is full, including during the night).

The guidance places great emphasis on thorough initial assessment to determine incontinence type and rule out infections or other causes, and the use of behavioural interventions including pelvic floor exercises and weight loss, if appropriate, as standard treatment.

IDENTIFYING THE PROBLEM

The incidence of incontinence rises with age, and one in three women over 40 will be affected. A 2005 Royal College of Physicians’ national audit of incontinence care for older people, however, found that, at that time, only 53 of the 138 responding PCTs were providing an integrated care service.

‘There has been a tendency to believe that incontinence is a natural consequence of ageing,’ says nurse consultant Kath Wilkinson (pictured), who has had a key role in developing an incontinence care pathway at Bradford & Airedale Teaching PCT. The trust, which serves a population of over 511,000, was reconfigured from four PCTs. It includes 91 GP practices and two community hospitals, and covers some of the most deprived and wealthy areas in England. One in four people in the area is of South Asian origin.

‘When the NICE guidance was issued, I was asked to draw up an action plan as the continence lead. The guidance provided an ideal framework to support the case to build additional capacity in to the continence service,’ says Ms Wilkinson.

Many women with incontinence were being referred to urologists and gynaecologists when they could have been managed more appropriately in primary care by a specialist nurse or physiotherapist. This delayed treatment and added to costs. A local audit of nurse-led clinics in June 2006 showed that, of 80 patients seen in three months, symptoms either improved or were resolved in some three-quarters of them. Only one out of 10 patients needed to be referred to a consultant.

When the two continence services in Bradford and Airedale joined, it was clear that one pathway was needed in order to resolve the inequities that existed in service provision across the trust and address unmet needs.

‘Incontinence is not just a problem of older women. We see plenty of people under 65, who develop a problem after childbirth or around the menopause,’ Ms Wilkinson explains. ‘The PCT was interested [in a redesign], not only because it would improve services for patients, but also because it recognised it could save money on the numbers of continence pads prescribed and referrals.’

IMPLEMENTATION PROCESS

In July 2006 a working group was set up to develop a single pathway, built around NICE guidance and best practice, and informed by national policy for patient-led services and care closer to home. Drawn from primary and secondary care, this included consultant urologists and gynaecologists, GPs with a special interest, nurse specialists, physiotherapists, technicians, managers and commissioners.

The aim was to create a service that would reduce unnecessary referrals while boosting choice and access for women, and which would be easy for busy health professionals to use. The service also needed to be culturally sensitive. As Ms Wilkinson explains: ‘It can be embarrassing for Asian women to see a male doctor and have such intimate investigations, which are taboo.’

The group began with a mapping exercise to find out what was happening and what it would like to happen in the future, such as having more staff and training. An assessment protocol and referral form were developed, and practice guidance, policy and prescribing guidelines drawn up.

The referral form was designed to fast-track patients needing urgent referral to secondary care, such as those with bleeding or suspected tumours, while preventing others from having to have unnecessary hospital appointments and investigations.
GP referrals, except those with bleeding, persistent infections or suspected cancerous growths, to a central point. They are triaged every week by a continence physiotherapist or specialist nurse, and offered an appointment within four weeks of referral at a physiotherapist or nurse-led clinic near their home.

The hour-long appointment includes urinalysis, a bladder scan, a vaginal examination and a bladder diary review. The nurse and physiotherapist can order further investigations or make direct referrals to secondary care if the assessment results warrant it or conservative treatment has been unsuccessful.

**EVALUATION**

A full evaluation, including patient feedback on quality-of-life factors, is under way but 400 people were referred to the pathway in its first six months – around double the previous figures. In Ms Wilkinson’s words: ‘The GPs are referring patients to us thick and fast’.

‘The gynaecologists tell us that referrals to secondary care have also fallen, and that these are now more appropriate,’ she says. ‘Because [the women] have been thoroughly assessed and treated conservatively first, all the groundwork has been done.

‘We can take an holistic approach. Sometimes consultants can’t do this because there just isn’t time. Patients usually only get 10 minutes with them.’

She puts high acceptance of the service down to the respect continence services already had in the trust, the commissioner, who is a former nurse and effective teamwork: ‘We all worked together and respected each other’s roles and contributions,’ she says. ‘We didn’t encounter any real barriers, because we had good arguments for meeting the 18-week target, complying with NICE guidance and saving money.

‘It was more a case of reminding them of our existence. We ran a couple of evenings for GPs, to tell them about the service and gave a talk about the nurse’s role.’ But she admits that it wasn’t all plain sailing.

‘You have got to sell yourself. Continence is not perceived as sexy and glamorous. You need to gift wrap it and hook people in,’ she says. ‘We ran lots of training and link days.

‘If you can’t do a presentation or put forward a business case, find someone who can help you. There is always someone else somewhere who is doing the same as you.’

**LOOKING AHEAD**

The future looks bright. It is anticipated that the pathway will become part of practice-based commissioning next year, and the working group is looking at developing similar continence pathways for children and men as well as one for erectile dysfunction.


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**Key points for success**

- Make sure there is a shared understanding of the needs of people with incontinence and a genuine desire to improve patient care;
- Identify key players in the trust to drum up support and get them together around a table;
- Base your plans on strong evidence and sound arguments;
- Use commercial sponsorship to run training;
- Take a multidisciplinary team approach;
- Hold regular meetings to update on progress and maintain momentum;
- Have an effective communications strategy, with practice visits and local media publicity so professionals and patients are aware of the service;
- Continue regular reviews after implementation to pick up teething problems;
- Audit progress and feed results back to all key stakeholders and attract further investment.
When a community mental health team decided to audit their practice against NICE guidelines, they sought new ways of working to improve patient care. Ingrid Torjesen explains.

In 2005, the Gillingham Community Mental Health Team began reviewing and auditing the NICE guideline for schizophrenia (NICE, 2002a) and its (2002b) technology appraisal for atypical antipsychotics.

Belinda Garnett (pictured), a senior nurse practitioner for the team, which is part of the Kent and Medway NHS Social Care and Partnership Trust, explains that the team had looked for a set of standards to assess its practice against.

The team chose the guidelines because they were the first from NICE on mental health and were applicable to a community mental health team working with people with severe and enduring mental illness.

The team determined which standards were applicable to a community mental health team of nurses, occupational therapists, social workers and doctors, then tried to incorporate elements of New Ways of Working for Everyone (Department of Health, 2007) and Essence of Care (DH, 2001). It then decided to assess antipsychotic medication, physical health review and nurse prescribing first and developed an audit tool. Ms Garnett had worked on an antipsychotic medication audit previously in East Kent, so was able to base the tool on that experience, which was a huge help.

THE AUDITS
Ms Garnett explains that: ‘The first audit we did was for the clozapine clinic, because we wanted to look at whether service users had access to services, choice of where they came to a clinic and choice in treatment.’

People on clozapine, an antipsychotic drug, attend the clinic either once, twice or four times a week. It was decided that four nurses who had been trained to prescribe would care coordinate those who needed medication management because it was more time and cost effective. Previously care of these patients might have been coordinated by a social worker, but they would still have to be seen at clinic by a nurse.

Ms Garnett says: ‘That has given nurses within the team a real focus on nursing skills because they are doing medication management and prescribing and, because we also do physical well-being, we take bloods within clinics.’

The audit showed 100% of service users preferred attending the clinic with other medical practices; in the future it would be more time and cost effective. Previously care of those prescribed antipsychotics were identified, and those with schizophrenia were filtered out for the audit.

A schizophrenia clinic was set up to ensure antipsychotic prescribing practice was in line with NICE guidance and service users’ physical health was assessed and monitored with appropriate interventions offered where necessary. Those prescribed antipsychotics were identified, and those with schizophrenia were filtered out for the audit.

The results showed prescribing practice and assessment of physical health improved but attention needed to be paid to data management. Also, no one person was identified as responsible for patients’ physical health reviews in the care plan.

Advice for implementing the guidance

- Identify standards most appropriate to the care your team provides and audit these;
- Think creatively and don’t be afraid to do things differently, if appropriate, in order to achieve desired outcomes;
- Pursue a wide range of options, such as charities and private companies, to secure funding and other support for projects;
- Re-audit to see progress and where more work needs to be done;
- Enable team members to develop their skills and focus on their interests where possible.
groups and another team member has been trained in smoking cessation. These and other activity groups are run to coincide with physical well-being checks and clozapine and depot administration clinics to make the service a one-stop shop. The clinic has a point-of-care haematology machine and another technician to dispense, which hopes to get a pharmacy haematology machine and a point-of-care technician to dispense, which.

‘People could come to get their clozapine bloods and monitoring done, have their physical well-being checked but then also go into a healthy lifestyle group, an exercise group or they might look at smoking cessation as well,’ Ms Garnett says.

The audit also included some of the standards for essence of care, such as self-care, record-keeping, personal and oral hygiene, and food and nutrition.

A support worker and two volunteer service users run a football team, which has proved very successful. A survey showed that all service users report feeling healthier and being 100% less troubled by voices and disturbing thoughts while playing football.

COGNITIVE BEHAVIOURAL THERAPY/ FAMILY THERAPY
One nurse who has undertaken the Thorn training for health professionals caring for people with severe mental illness has been facilitated to offer cognitive behavioural therapy (CBT) and family interventions alongside the clinics. The aim is for at least 10 CBT sessions over at least six months to be offered to anyone with schizophrenia and especially those with persistent psychotic problems.

The audit identified insufficient capacity to give interventions to all those waiting, so the team wants to develop a social worker role to resolve this. Audit data has been used to make its case.

EMPLOYMENT
Mental health services aim to help users live as ordinary a life as possible, which includes supporting employment opportunities. The Gillingham team set up a ‘buddy scheme’ (www.thebuddyscheme.co.uk), which offers service users paid employment mentoring nursing students, occupational therapists and social workers. This won a Community Care Award in 2006 and a National Endowment for Science, Technology and the Arts grant to produce training manuals and a DVD, disseminate the scheme locally and nationally, and allow time for its evaluation and publication.

LEARNING FROM EXPERIENCE
Ms Garnett says the team used the results of the audits to make recommendations and set out an action plan. ‘We saw things that we were not doing and put them right. We hope to re-audit to show that we have ticked literally all the boxes.

‘It has made us think of doing things perhaps differently, finding out where there is a service shortfall and addressing it, really looking at improving practice.’

She recommends having a champion in the team to lead clinically, explaining that: ‘It is about engaging practitioners and looking at new ways of doing things, making people think they can do things and change their way of working.’

She adds it is also vital to think creatively about funding. A major hurdle was that the team could not do everything it wanted to in working hours, so Ms Garnett got extra funding from the pharmaceutical industry to pay for clinic time on Saturdays. Such funding goes into a central trust ‘pot’ and projects are approved and funded accordingly (Bristol Myers Squibb funded this project). Ms Garnett stressed such support does not affect prescribing practice. The team sought funding from the local rotary club for their football strip.

The team is now focusing in more depth on depot antipsychotics regarding patient choice of treatment and clinic location.

‘If you look at NICE guidelines as a way of providing care, we are meeting nearly all the standards for schizophrenia. We were way off on physical care before we started, we still need to audit on assertive outreach team and advance directives,’ Ms Garnett says. ‘A lot of teams are probably doing a lot of good work and meeting the standards but not everybody audits it to show that.’

UPDATING NICE GUIDELINES

AUTHOR Clare Lomas, BSc, BA, RGN, is news reporter, Nursing Times.

NICE guidance has to be updated in line with new research, technology and improved understanding of people's healthcare needs. Clare Lomas explains.

When NICE publishes final guidance on a topic, it does so with the expectation that it will be reviewed and updated.

According to NICE, a study of guidelines in the US suggested that the majority go out of date in some respect within three years of publication.

‘When a guideline is published, a review date is set accordingly, based on any knowledge we have about when new evidence, such as clinical trial data, will emerge,’ says Lucy Betterton, associate director for external communications at NICE.

Frequent changes to guidelines would make it difficult for health professionals to implement them, so review dates have to be flexible. For up to two years after publication, NICE will collate post-publication comments but will not actively seek new evidence.

‘Unless it was identified in the original guideline that important new evidence was likely to emerge in this time, the review date will usually be set at 2–4 years,’ says Ms Betterton.

There are two main reasons for which guidelines are updated:
- When any new evidence emerges;
- If errors are found in the original guideline.

Following the publication of new evidence on CT imaging, and research evidence on the management of paediatric head injuries, NICE updated its clinical guidance on head injury in September 2007, four years after its original publication date.

If a post-publication comment is made that highlights an error in a guideline, the director of NICE’s Centre for Clinical Practice and the guideline development group (GDG) will look at it. If the comment is found to undermine the conclusions on which the guidance is based, will result in harm to patients or compromises the institute’s quality-assurance procedures, it will be referred to NICE’s guidance executive. If it is then decided by the guidance executive that an error has been made, the guidelines will be amended and registered stakeholders may be notified in writing.

The responsibility for updating a guideline usually lies with the National Collaborating Centre (NCC) that developed it. As Ms Betterton explains: ‘One person takes responsibility for keeping up to date with the evidence, and they advise the collaborating centre of any significant changes’. However, she is quick to point out that ‘nurses can still be involved’.

If a nurse has new information and feels that a guideline needs to be updated, they can send their comments or feedback to nice@nice.org.uk, explaining why they consider the new information to be sufficient to require a guideline change.

But Ms Betterton emphasises that it is often best for a nurse to approach their stakeholder organisation first, as it may already be aware of the information. In such cases, a more coordinated response is much more helpful to NICE. A response from a stakeholder organisation, rather than an individual, can also add more weight to the comment.

Once new information is received, it will be discussed by the Centre for Clinical Practice and the relevant NCC and, if they decide that an update is likely to be needed, an expert advisory group will be convened. The group will address whether an update is necessary, check if there is any other new evidence available that might affect the update and decide which recommendations in the original guideline need to be updated.

Using the advice from this group, the director of the Clinical Practice Centre and the NICE guidance executive will make a final decision on whether an update is needed and, if so, they will commission the relevant NCC to carry out the work. It is then the responsibility of NHS trusts to look at the updated guidance and review and change practice accordingly. NICE will update the tools to reflect the changes that have taken place, but the implementation process is the same as for the original guidance.

KEY POINTS
- Guidelines are reviewed every 2–4 years;
- Guidelines are updated in response to new evidence;
- Nurses can pass information to NICE if they feel a guideline needs to be updated;
- Nurses should ideally do this through a stakeholder such as a professional organisation or special interest group. This will add weight to the comment.
Finding the information you need from NICE’s vast resources – in both electronic and paper format – can appear to be daunting. It has produced well over 400 pieces of guidance across its four work programmes, many of which are available in more than one format, and its website comprises over 15,000 pages that contain a diverse range of information, guidance and support tools.

### Obtaining the Information

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<thead>
<tr>
<th>Guidance type</th>
<th>Description</th>
<th>Outputs – versions available</th>
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<tbody>
<tr>
<td>Technology appraisal</td>
<td>Recommendations on the use of new and existing medicines and treatments within the NHS.</td>
<td>NICE produces three versions of its technology appraisals:</td>
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<td>• Full guidance;</td>
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<td>• Information for the public.</td>
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<tr>
<td>Clinical guidelines</td>
<td>Recommendations on the appropriate treatment and care of people with specific diseases and conditions</td>
<td>NICE produces four versions of its clinical guidelines:</td>
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<td>within the NHS. They are developed by groups of clinical and patient experts.</td>
<td>• Full guidance;</td>
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<td>• NICE guidance;</td>
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<td>• Understanding NICE guidance.</td>
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<td>Public health guidance</td>
<td>There are two types of guidance on public health:</td>
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<tr>
<td></td>
<td>• Public health intervention guidance – makes recommendations on clear activities (interventions) to</td>
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<td></td>
<td>promote a healthy lifestyle or reduce the risk of developing a disease or condition;</td>
<td>• Quick reference guide.</td>
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<td>• Public health programme guidance – deals with broader activities for promoting good health and</td>
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<td>preventing ill health.</td>
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<td>Interventions</td>
<td>An interventional procedure is a procedure used for diagnosis or for treatment that involves:</td>
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<td>procedure</td>
<td>• Making a cut or a hole to gain access to the inside of a patient’s body;</td>
<td>• Quick reference guide;</td>
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<td>• Gaining access to a body cavity without cutting into the body (for example, endoscopies);</td>
<td>• Information for the public.</td>
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<td>• Using electromagnetic radiation (for example, X-rays, laser treatments).</td>
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<td>• The safety of the procedure;</td>
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<td>• Advice on whether it works well enough for routine use;</td>
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<td>• Advice on whether special arrangements are needed for patient consent.</td>
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### Descriptions of NICE documents

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<thead>
<tr>
<th>Document</th>
<th>Description</th>
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<tbody>
<tr>
<td>Full version</td>
<td>All the recommendations, an overview of the evidence and a discussion of the rationale behind the</td>
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<tr>
<td></td>
<td>decision-making.</td>
<td>It is possible to purchase full versions of clinical guidelines via the National Collaborating Centres.</td>
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<td>NICE version</td>
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<td>aimed at health professionals and NHS bodies.</td>
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<td>Quick reference guide</td>
<td>Presents recommendations in a suitable format for health professionals. This is available as a</td>
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<td>printed document. For public health guidance, the quick reference guide is also suitable for people</td>
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<td>without specialist medical knowledge.</td>
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<td>Information for the</td>
<td>Written using suitable language for people without specialist medical knowledge.</td>
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<td>public</td>
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What does the NICE website offer?

From the NICE homepage you can find information about guidance, implementation tools and how NICE works.

The ‘using guidance’ section of the site gives you access to implementation support tools.

‘Get involved’ tells you how you can contribute to the development of NICE guidance, for example by commenting on draft guidance or volunteering to join a guidance development group or committee.

You can also find links to all the latest guidance from NICE and see the most recent news.