

Putting NICE guidance into practice

A health community in the south west of England has developed a structured programme for tackling implementation of National Institute for Clinical Excellence guidance. The result is a consistent approach across primary care trusts and providers. **Harriet Adcock** finds out what is involved

The NHS in England and Wales is required to provide funding and resources for medicines and treatments recommended by the National Institute for Clinical Excellence through its technology appraisals. This is no mean feat considering the frequency at which such guidance is published.

One health community in the south west of England — comprising Bristol, North Somerset and South Gloucestershire — has responded to the challenge by developing a strategy that ensures NICE guidance is implemented effectively and consistently across the region. Specifically, it has set up what it calls a NICE College to bring together all parties involved in commissioning and delivery of services.

Alaster Rutherford, head of medicines management for Bristol North Primary Care Trust, explains that college members meet once a month and include chief pharmacists from all the acute and primary care trusts, as well as representatives from finance, commissioning and public health.

The college examines guidance from a local perspective and requires each health organisation expected to be affected by it to prepare an implementation plan. Each plan includes:

- Action needed to implement guidance
- Anticipated patient numbers
- Impact on waiting lists
- Changes in referral patterns
- Estimates of resources required over and above delivery of the existing service
- Savings in other areas

Using estimates given within each piece of NICE guidance, PCTs agree with their acute trust the expected level of activity for any given technology. Only technologies with a significant financial impact — over £3,000 per patient per year — are monitored on an individual patient level.

Other health communities within the NHS may decide to fund the implementation of NICE guidance on a cost per case basis. “The problem with this approach is that trusts have to bill and PCTs have to pay for individual interventions,” Mr Rutherford says. This, he adds, is unnecessary and overly bureaucratic.

Local initiatives

Mr Rutherford explains that Bristol North PCT has a number of local initiatives designed to improve implementation of guidance. These include an incentive scheme to encourage GPs to attend educational sessions timed to link in with the launch of NICE



recommendations. For example, the January meeting covered management of depression and followed a clinical guideline on this topic published in December 2004.

Practice pharmacists provide prescribing advice to each GP practice in the PCT. They are briefed about NICE recommendations and meet GPs to agree outcome targets for guidance implementation. “In the future, I see practice pharmacists as being change agents around NICE guidance. They are the catalyst within each practice,” says Mr Rutherford. Another intervention within general practice is the inclusion of “pop-up” boxes on GP prescribing systems, to remind GPs of relevant NICE advice.

Bristol North PCT has also developed an innovative scheme within community pharmacy to enhance awareness and implementation of NICE guidance. The PCT has made £20,000 available annually as a competitive funding pool to its 42 community pharmacies. To receive part of the funds, pharmacies sign up to one of three service levels, each level guaranteeing funding of £150. The remainder is divided up at each service level and distributed to participating pharmacies.

At the first level pharmacies must have copies of relevant NICE guidance or guidelines. Those aiming to provide the third level must conduct an audit around a piece of guidance. One area in which the PCT was keen for an audit to be completed was around use of cyclo-oxygenase-2 (COX-2) inhibitors. Community pharmacists reviewed NICE guidance relating to use of these drugs and identified patients presenting with prescriptions for COX-2 inhibitors plus aspirin and contacted patients’ GPs.

In addition to these initiatives, Mr Rutherford also ensures that awareness of NICE guidance is raised among pharmacists

through continuing education workshops. In his role as a tutor for the Centre for Pharmacy Postgraduate Education he links workshops with guidance. “We are trying subtly to get everyone up to speed on the most important clinical guidelines, including those for chronic obstructive pulmonary disease and heart failure.”

The effects of these initiatives, as a whole, can be significant. Mr Rutherford points out that local prescribing of COX-2 inhibitors has been half that of the national average. “The initiatives are about promoting an escalator of excellence,” he says.

Changes afoot

The introduction of “Payment by results” in April (when set tariffs for treatment will free PCTs from price negotiations) will change the focus of the NICE College, explains Mr Rutherford. “Up until now, the focus of the college has been driven by the allocation of resources.”

Payment by results will see an increase in the amount of money available to fund treatments covered by new NICE guidance. This means the college will be able to concentrate on quality and clinical governance — making sure patients are receiving the treatments they need — rather than on whether there is funding available.

In addition to this move, Mr Rutherford believes there needs to be a brutal analysis of how illnesses are managed. “We have newer treatments available for patients with worsened conditions. Do we necessarily still need the infrastructure that has been in place for dealing with that condition? Therapeutic advances may shift patient care away from hospital beds and into communities. Has the overall team approach changed to accommodate this,” he asks.

He also believes that implementation of NICE clinical guidelines presents a challenge. There is no statutory obligation to fund the guidelines but their implementation is included as a developmental standard within the Department of Health’s “Standards for better health” document published last year. “Health communities should be planning how they are going to tackle this,” says Mr Rutherford, warning: “The thing about developmental standards is that they tend to become obligatory.”

The initiatives introduced by this health community mean that stronger working relationships now exist between organisations and duplication of work across PCTs has been reduced. And there are now robust, long-term processes in place for implementing NICE guidance.