New Ways in which the team will “Share and Spread” our message

The team are delighted to share the link to our NECS webpage – dedicated to evidence resources.

The link below will take you to the page, which offers the facility to filter the many reports and papers related to health and social care research and evaluation projects in the North East and North Cumbria. https://www.necsu.nhs.uk/research-evidence/

It offers access to:

- **Research Library**: database of local and national research and evidence reports and links;
- **Current Projects**: details of on-going research and evaluation being undertaken in the region;
- **Bulletins**: our regular round-up of all things research and evidence;
- **Events**: Details of upcoming events and historic presentations;
- **Finding Evidence**: where to find robust, reliable evidence and how to use it most effectively;
- **Get Involved**: Ideas box, training offer and taking part in research and evaluation projects;
- **Contact Us**: an introduction to the team and how to get in touch – includes our twitter feed.

Michelle McGuigan, NECS’ Organisational Development and Corporate Services Director said:

“NECS are committed to supporting best practice Research and Evidence within the service. The NECS R&E team is a small but skilled and experienced team which works across NC&NE to promote and implement R&E. The team have also been involved in successful R&E activity and projects elsewhere in England. They are committed keeping everyone updated on current activities whilst sharing case studies and best practice in R&E. Thanks to the team for their continued hard work and thought leadership in this area.”

**Do you have an idea for research or evaluation that should be undertaken? Please use the link and let us know so that we can help you to develop your idea and support you in accessing research grants, etc.**

https://www.surveymonkey.co.uk/r/R7WWYZV

This is in addition to the existing team webpage: https://www.necsu.nhs.uk/services/system-wide-transformation/research-evidence/
Society for Academic Primary Care: North Conference 29–30 November 2019, Kendal

SAPC aim to provide a clear voice, and a strong presence, for Academic Primary Care in the complex and ever-changing environment. This regional conference had presentations reflecting the wide range of interests and development areas. Presenters varied from medical students to Professors, with ample networking opportunities throughout to discuss topics. Educational highlights included learning about new developments in the North East and North Cumbria, such as the new medical school opening at the University of Sunderland, which will welcome their first cohort of students in September 2019, and projects which examined the role of placements in general practice from the perspective of medical students and GP tutors. Research presented from the region included the work of Rob Barker, an Academic GP, who has lead on the use of the National Early Warning Score in care homes, highlighting the need for context-specific training due to a mismatch between perceived and the actual complexity of the procedures particularly considering the constraints of care home staff. Members of the team from Newcastle University presented findings from the Newcastle 85+ study, which has recently conducted qualitative interviews with people now aged 96-97, regarding their experiences of living and accessing services, finding more independence than perhaps one would envisage for this age group. Other topics included issues regarding dementia in ethnic minorities from the University of Leicester (interestingly in some cultures there is no word for dementia), University College London presented on continence options following stroke highlighting the low use of behavioural interventions, and work is being carried out at Sheffield University working with Hull and York Medical Schools looking at the use of Advanced Clinical Practitioners in the GP practice setting. Attending the conference enabled us to hear the findings of recent studies and also find out who is carrying out research in different areas - invaluable information for our team which acts as a point of contact for primary care staff who wish to work with academics to develop research ideas. Next year’s conference will be held at the University of Central Lancashire. This is an ideal environment for those enthusiastic to get involved in research, or for those already involved in research to present their work, and we would encourage all to attend. See https://sapc.ac.uk/ to keep up to date on the work of the Society and to find out about forthcoming events.

Research and Evaluation Training Offer

The Research and Evidence Team offers high quality (and where required, bespoke) training to improve your understanding of evaluation tools and techniques, which includes appraisal of published evaluation and research.

The training packages consist of ‘Behind the Headlines – finding the evidence’, ‘What is Evaluation? How do I get one done?’, ‘Critical Appraisal Qualitative’ and ‘Critical Appraisal Quantitative’. These can all be bespoke to fully meet your needs and time, for example; “bite sized” lunchtime learning session or half-day workshops or blend of subjects to focus learning. Details of training courses can be viewed in our brief presentation or, if you want more details of what evaluation is and how it relates to your business, our other brief presentation will offer high level information:

ATHENS allows non-cost access to a range of academic journals and hence evidence you may require. This is open to all NHS staff – NECS/CCGs. Use the link to get aboard! https://openathens.nice.org.uk/

We will share any future training sessions within the “events” section of the new webpage. All queries can be addressed by mailing: NECSU.RETeam@nhs.net Training presently planned includes:

Behind the Headlines – Finding and appraising the evidence

Wednesday 6th March, 12noon (Lunch & Learn - 1 hour), Hartlepool and Stockton-on-Tees CCG, Boardroom.

What is service evaluation? How do I do one?

Wednesday 3rd April, 12noon (Lunch & Learn - 1 ur), South Tees CCG, Hills Room, North Ormesby Health Village

What is service evaluation? How do I do one?

Thursday 23rd May, 11am-12.30 (1.5 hour), Boardroom (2nd floor) Riverside House, Newburn

* Please Note: depending on SLA in place, there may be a charge for some services for some organisations
Identifying the active ingredients for success: Reducing emergency admissions from Care Homes

While new investment in community healthcare teams is welcome, Adam Steventon, Director of Data Analytics at The Health Foundation, encourages the NHS to build on past evaluations (December 2018) below is a summation of that.

The government recently announced a national initiative to reduce avoidable admissions to hospital by providing enhanced community healthcare, including rapid response teams, to support people in their own homes. Significantly, this support is also going to be available to people living in care homes. The initiative builds on work of the enhanced health in care homes vanguards, which have been widely evaluated, meaning that there is a rich evidence base available for those implementing the new initiative.

**Improving healthcare in care homes** The importance of providing good support for people living in care homes is a key theme emerging through the work of the Improvement Analytics Unit (IAU), a partnership between NHS England and The Health Foundation, which evaluates complex change in the NHS. The IAU has evaluated two vanguard initiatives related to care homes (Principia in Rushcliffe and Sutton Homes of Care) and two more evaluations are due to be published in spring 2019.

The IAU focused on how often people are “emergency admissions” to hospital from care homes, and found that around 40% were potentially avoidable. Although emergency hospital admissions are often essential for delivering care, they can expose a patient to stress, loss of independence and risk of infection, reducing their health and wellbeing after leaving hospital. Residents of care homes might be particularly affected by admission to hospital as they can be more susceptible to other complication. Emergency care is a costly element of the healthcare system, with three-quarters of acute hospital beds being occupied by emergency patients. Reducing avoidable emergency admissions for care home residents could have a significant impact on acute care. The critical question is – how can care for care home residents be improved to promote their wellbeing as well as reduce admissions? Examples from the IAU show that identifying the active ingredients is not straightforward.

**The findings** Principia’s enhanced support initiative included aligning care homes with general practices, regular visits from a named GP, improved support from community nurses, independent advocacy and support from the third sector. It also involved a programme of work to engage and support care home managers. Analysis found that care home residents who received this enhanced support attended A&E less frequently than similar care home residents and were admitted to hospital as an emergency 23% less often. The Sutton Homes of Care vanguard has worked to improve the quality of care offered to care home residents through a range of initiatives, including: measures to improve integrated care, such as the hospital transfer pathway (the ‘red bag’ scheme) and weekly health and wellbeing reviews for residents. The vanguard has also supported ongoing education and development for care home staff and promoting quality assurance and safety. Overall, though, the IAU found no strong evidence that people moving to a Sutton Care Home between January 2016 and April 2017 used hospitals more or less frequently than a matched control group.

**Evaluating results** More work is needed to understand why different results came from the two studies. Complex initiatives are not always effective immediately and need time to be embedded and adapted. According to the IAU’s evaluation, a key success criterion might be the extent to which a genuine partnership, based on shared objectives and approaches, is fostered between health and social care providers. The Principia vanguard had a long-standing programme of work to build relationships across organisational boundaries, engaging care home teams as well as the NHS. Did this lead to greater mutual understanding of the and, therefore, more effective interventions? The government is pursuing an initiative that includes healthcare professionals being assigned to care homes, where they can get to know residents’ needs and provide tailored treatment and support. It is therefore more important than ever to consider what contributed to the success at Principia and learn from it. Shifting care from hospitals into primary and community health services has long been a goal of policy. But turning that ambition into a reality on the front line has been elusive. A recurring lesson from our experience of improvement is that there is no one-size-fits-all solution. Those implementing the new initiative to improve care in care homes should learn from what has happened before, rigorously evaluate change and be prepared to tailor their approach to local context.

Follow Adam @ASteventonTHF and The Health Foundation @healthfdn on Twitter
The Newcastle Gateshead Enhanced Health in Care Homes vanguard was launched in March 2015. Its purpose was to increase collaborative working and establish partnerships between health and care providers to improve the health and wellbeing of residents, thereby reduce pressure on primary, secondary and social care services. In Newcastle, there was a limited and piecemeal rollout of the vanguard. Therefore, this evaluation focuses only on the effect of the vanguard in care homes in Gateshead. The vanguard was implemented only in Nursing and Residential care homes. Currently in Gateshead there are 34 care homes with 1694 care home beds in total. However, this evaluation only utilises data from 30 care homes consisting of 1503 beds as homes with populations including learning disabilities and younger residents were excluded. The vanguard consists of three key features:

- Link GP Practices;
- Older Person Specialist Nurses (OPSN); and
- Multi-Disciplinary Teams (MDTs).

Count data was obtained from the North of England Commissioning Support Unit (NECS) from April 2013 to December 2017 considering the following outcomes (this included data for 23 months prior to the introduction of the vanguard in March 2015, and 34 months post introduction):

- A&E admissions
- Bed days
- Non elective admissions (excluding ambulatory care)
- Outpatient Appointments (new and review)

RESULTS
Using data from thirty care homes in Gateshead, results were reached regarding the impact of the vanguard on the above outcome themes, and further broken down to consider all Care Homes and Nursing and Mixed Care Homes.

CONCLUSION
The results indicate that in the period following the introduction of the vanguard there has been an overall downward trend in A&E attendances, non-elective admissions and total monthly bed days. Similarly, outpatient appointments have experienced an overall upward trend possibly due to the earlier and prompt diagnosis of conditions from the MDTs.

As a consequence of the changes in these trends, substantial cost savings to the NHS have been estimated. The largest predicted cost-savings are as a consequence in reduced non-elected admissions. The limitations of this study are the reliability of the data in terms of identifying NHS resource use by care home resident by use of a postcode proxy, and despite GP costs being included in the running costs of the vanguard, the use of wider primary care resources has not been included in this evaluation. Despite these limitations, as highlighted by The Kings Fund (2013), this study has provided a clear attribution of the impact of the integration of health on social care in the form of the Enhanced Health in Care Homes Vanguard. The results of this evaluation are based on robust statistical method and contribute to the growing evidence base on New Models of Care and an Enhanced Health in Care Homes vanguard. Rather than short-term evaluations that are often utilised to measure the impact of service transformations within the Health and Social care system, this study shows the mid to long-term impact of the introduction of an integrated health and social care model.

This analysis was undertaken by colleagues at Northumbria University (Health and Life Sciences). The Full Report can be found at: https://www.necsu.nhs.uk/research-evidence/
NHS North of England Commissioning Support Unit (NECS), and National Institute for Health Research Clinical Research Network North East and North Cumbria (NIHR CRN NENC), together have produced a new strategy to help improve the quantity and breadth of primary care research in the region. Approved by the CRN NENC executive and all of the Clinical Commissioning groups (CCGs) across the region, the purpose of the paper is to “inspire the growth, delivery and adoption of primary care research”.

Its aims include to make research become core business, contribute to quality and skills of staff, improve patient outcomes and wealth, plus to support a vision of excellence of the local system and so aiding recruitment and retention of the primary care workforce.

The strategy outlines a number of areas and initiatives which will - as part of the NIHR CRN NENC’s aim - “make the North East & North Cumbria the best place to take part in research”. Aimed at professionals working within General Practices and Clinical Commissioning Groups (CCGs), and taking into consideration the priorities of the emerging Integrated Care System (ICS) and primary care, the strategy encourages a culture and method of developing research that comes from everyday practice and enhances the means by which decision makers can use the evidence emerging from research to improve patient care.

Given GP’s have access to every patient, opposed to those which only attend hospital, the potential for primary care research delivery is considerable and it is clear to see why it should be harnessed and focussed in the correct approach.

Shona Haining, Head of Research & Evidence at NECS, explains “the strategy, developed with consultation of all stakeholders, brings in all stakeholders whom can contribute to all aspects of primary care research. It’s crucial that we develop and deliver primary care research which is relevant and tailored to the North East and North Cumbria population. We’re trying to raise our game and build research capacity in association with Health Education England North East (HEE NE) and excellent academia, helping to address the priorities.”

The strategy will aim to increase awareness to the general public about primary and community care research. Concerted PPIE support will also be brought to primary care practices and Federations to create a culture where patients are confident to ask about research studies relevant to their condition.

Dr Justine Norman, NIHR GP Research Engagement Lead, states the strategy is an “integral element to help establish a committed and productive research culture in primary care across the region.” She adds: “With the launch of the strategy, we’re aiming to help more GPs and primary care staff to reach their potential. Research within primary care is a vital part to the success of the NIHR. Thanks to this strategy, we have an opportunity to change the face of primary care research in the region. Through working cohesively with all the key stakeholders, we can help increase primary care research capacity and influence achievements on a national basis. By helping to improve, harness and utilise the skills of specific staff and practices in our area, we can make a real step towards the NIHR’s aim of improving the health and wealth of the nation through research.”

The strategy is supported by the key stakeholders as members of the established Primary Care Strategy Implementation Group, to ensure the successful execution of the strategy.

Meeting quarterly and chaired by Dr Tim Butler, Assistant Medical Director NHS England (Cumbria and North East), the group will provide an oversight for assurance, challenges and opportunities to help deliver the strategy.
What is the research idea that you applied for RfPB funding to address?
My idea came from one of the James Lind Alliance Priority Setting Partnerships, looking at uncertainties in treating eczema. These Partnerships bring together clinicians, patients and carers to identify and prioritise uncertainties about the effects of treatments that could be answered by research. One of the agreed priorities for both patients and health professionals was to understand which emollients are the most effective and acceptable in treating eczema, so I decided to focus my efforts in this area.

What made you apply to the RfPB programme with your research idea?
There were uncertainties about how to design and conduct a definitive trial comparing different types of commonly used emollient, so we sought funding to conduct a feasibility trial. This fitted with the RfPB remit of patient benefit. The resulting study, Choice Of Moisturiser in Eczema Treatment (COMET), helped determine that an appropriate clinical trial a could be conducted.

How did you develop your research idea into a full proposal?
I worked with a mixture of methodologists and clinicians - and also the Bristol Randomised Trials Collaboration. Patient and public involvement work also helped to develop the proposal and I had help from a number of professional collaborators. The proposal was developed through the SAPC Skin research specialist interest group, which in turn is supported by the Centre for Evidence Based Dermatology and UK Dermatology Controlled Trials Network.

Did you know from the start that as an ‘early career’ researcher you could lead the proposal?
It was made clear to me by my collaborators that with senior experience within the research team, I could be supported to lead the application and delivery of the study. This was particularly relevant given that I was asking for a (relatively) modest amount of funding.

How did patient and public involvement help shape your research?
Three parents of children with eczema made detailed comments on the draft versions of the proposal. Specifically, they approved the proposed recruitment strategy, considered the feasibility of collecting weekly patient-reported outcome data for 3 months, prioritised the outcomes (symptoms first, appearance of the skin second, and acceptability of the emollient third), suggested means of disseminating the findings, and helped write the plain English summary and chose the study acronym.

What support did you receive from staff at the NIHR RfPB programme?
The feedback on my application was constructive and the programme team was helpful in supporting a (no-cost) 4 month extension to the study due to delays in set-up.

What did your research find?
We showed that it is feasible in primary care to randomise young children with eczema to different emollients and follow them up. We also noted that it was common for parents to use other emollients, which had implications for the follow-on trial. We have published in several journals.

What are your main pieces of advice for other early career researchers who are considering applying for research funding?
Make sure the research question is important to patients/clinicians, the NHS/funder and you – because if not, you risk wasting participant’s time, public money and your own life delivering it!

This is a summation of the full interview, which can be found at: https://www.nihr.ac.uk/research-and-impact/research/nihr-studies/new-researcher-matthew-ridd.htm

There are a range of funding options available for Primary Care and CCG staff wanting to undertake research. If you would like to get involved, please contact the team for further information necsu.reteam@nhs.net
Attitudes and perceptions of professionals to anticoagulation: warfarin versus novel/direct oral

Due to a patchy and slow uptake of Direct Oral Anticoagulants (DOACs) in the UK, this study aimed to elicit what were the perceived barriers to appropriate use of DOACs, with the hope of developing strategies to overcome these. However, what was found was that, whilst not yet universally preferred, we appear to be moving through a period of change with regards to use of oral anticoagulant agents, with a shift away from warfarin and towards DOACs becoming the first line drugs for some indications. There was variation in participants’ perceptions, which is most likely due to data collection being carried out during a period of change, thereby capturing a snapshot of attitudes and perceptions which are changing/have changed at different rates.

Results

Early in the data collection process, participants spoke of how they generally felt that their practice was changing and that they were comfortable using DOACs. Following completion of data analysis of the whole data set the overarching theme identified was one of change.

Changing practice and the end of warfarin  Change was discussed, or alluded to, throughout the interviews and is apparent throughout the other themes and sub-categories, however, there were points where participants spoke directly of how they perceived the changing landscape. The change in practice was described as a gradual process, involving increased familiarity and confidence.

Professional related factors affecting drug choice

There were four sub-categories which came under this theme: knowledge of DOACs, drug preferences, professional boundaries and thoughts on guidelines.

Barriers and facilitators to appropriate use of oral anticoagulants

Several sub-categories were identified under the theme of barriers and facilitators to the appropriate use of oral anticoagulants, both within the practice of the participants and their perceptions of others’ practice. Throughout this theme participants reflected upon how these had changed over time.

Some participants described various issues around what they perceived as inappropriate prescribing with DOACs. These were attributed to prescribers’ misunderstandings of the various different licensed indications and dosing regimens for the various different DOACs.

Shared decision making process

There was variation in the views held towards the shared decision making process, with all participants acknowledging that that was how the decision should be made, but the general feeling being that it was usually not carried out comprehensively.

Time constraints were perceived as a major barrier in effectively carrying out the shared decision making process. Alongside time constraints, the context in which the decision was being made was also highlighted as a barrier to shared decision making. Participants described how in the acute phase following a diagnosis, patients may feel overwhelmed with information and struggle to make an immediate decision on long term treatment. Patients’ prior knowledge of warfarin was often used by participants as part of the discussion around the different options. It was noted that patients will often have some knowledge regarding warfarin, which will inform their perceptions of it as a drug.

Participants described this experience as generally being either negative or positive, but not neutral. All participants described various ways in which they broke down the discussion around the need for anticoagulation and the various options for this.

This is a summation of the responses and views given by the participants in the study overall.

For any further information contact: Kimberley.stewart@sunderland.ac.uk

CURRENT PROJECTS LIST

Details of the current projects being undertaken regionally and supported by the R&E Team can be found at: https://www.necsu.nhs.uk/wp-content/uploads/2017/12/RE-Current-Projects-Lists-Q3-2018-19.pdf
Near Patient Testing and New Models of Care

The University of Sunderland has an active and ambitious research interest in near patient/point of care testing (NPT/POCT) and in particular its impact on patient care pathways. They are looking to establish links with those who have similar interests.

**Learning disabilities, antimicrobial prescribing and paediatric UTIs**

Current activity includes research into the use of NPT in patients with learning disabilities with a view to improving their access to healthcare and treatment, commissioned by NHS England. This has resulted in a practical guide for anyone looking to implement using NPT, generated from the research findings and tested in pop-up clinics throughout Sunderland. This work has been conducted in collaboration with NTW NHS Foundation Trust, Sunderland CCG and City Hospitals Sunderland.


Research continues into the impact of a NPT C–reactive protein test (CRP) on antimicrobial prescribing in the GP setting, this work is in collaboration with Sunderland CCG. There is also ongoing collaborative work with NuTH NHS foundation trust on the use of NPT in the paediatric patient UTI pathway. These are just examples of the areas the University are currently involved with, further interests include the role of NPT in treatment and decision making in care homes.

**Resources to aid NPT research**

In addition to high specification laboratories and equipment, the University also has capacity to support NPT research in a real-world setting with a high-fidelity simulation suite, mock patient areas and a substantial patient, carer, public involvement group. Further information can be found here: [https://www.sunderland.ac.uk/more/news/story/pioneering-living-lab-set-to-revive-regional-patient-care-57](https://www.sunderland.ac.uk/more/news/story/pioneering-living-lab-set-to-revive-regional-patient-care-57)

The near patient testing team at the University has combined experience and skills in nursing, biomedical science and NHS workforce education. In addition, they sit on the BIVDA POC Working Group and the pathology based North East POCT Action Learning Set.

**Interested in NPT research?**

The University are keen to establish links and work with those with a similar interest and would very much like to develop a working group of parties interested in NPT research.

For more information, contact

**Karen Giles,**
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0191 515 3195

**Michelle Payne,**
Senior Lecturer, biomedical scientist and healthcare science programme lead.
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**Opportunity for GPs to get involved in Research**

A research project at the University of Sunderland is looking to explore the potential for pharmacists working in general practice to provide oral health promotion and/or targeted oral health interventions in this setting.

The research team are looking to perform 1-1 qualitative interviews with a range of primary care staff. They are looking to interview primary care pharmacists, GPs and practice managers. Participation is voluntary; however, the researchers can come to your place of work at a convenient time and date.

The research team at the University is led by Andrew Sturrock, a Principal Lecturer in Pharmacy Practice and Professor Scott Wilkes, Head of the School of Medicine, and Professor of Primary Care and General Practice.

If you are interested in taking part or would like further information please contact Andrew via email on andrew.sturrock@sunderland.ac.uk
One of the biggest challenges currently facing the NHS is how to slow increasing demand for acute hospital care. In New Zealand, the transformation of the Canterbury health system provides an example of how this has been done, and indicates that expanding hospital capacity is not inevitable if investment is made in alternative models of provision and community-based services.

Before examining Canterbury’s experience, it is worth noting some of the key differences between its health system and the NHS. In New Zealand, as in the UK, care is funded from general taxation. However, people make co-payments for GP appointments and these co-payments account for around half of general practice income. While GPs are usually independent contractors (as in the UK) there are strong local networks of practices: in Canterbury there is a primary care network, Pegasus Health, which involves 109 practices delivering care to more than 365,000 patients. Pegasus Health supports general practices and contracts with the Canterbury DHB to provide a range of primary and community services (acting as a primary health organisation). Unlike in the UK, most social care is paid for by district health boards, and provision of state-funded social care is relatively generous compared with UK standards, meaning that entitlements to health and social care are more closely aligned. The New Zealand health system has had no formal purchaser/provider split since 2001, has undergone no significant organisational restructures in recent years and has a far less complex regulatory environment than the NHS.

But while the context may be different, there are clear parallels between the pressures facing the Canterbury health system and pressures on the NHS – including financial deficits, rising demand and declining performance in emergency and elective care. The initiatives taken in response to these pressures – and the impact of those initiatives – offer useful learning for NHS leaders facing similar challenges. Understanding how Canterbury DHB implemented new ways of working is relevant to any system looking to work in a more integrated way, including those developing accountable care systems.

Three key approaches were central to delivering the transformation in Canterbury:

- the development of a clear, unifying vision behind the ‘one system, one budget’ message;
- sustained investment in giving staff skills to support them to innovate and giving them permission to do so; and
- developing new models of integrated working and new forms of contracting to support this.

The changes in Canterbury have been the result of collaborative working, relying on system leadership, and strong relationships and staff engagement across the health and care system. The overall transformation has not been the result of one ‘big bang’ change, but an aggregation of many simultaneous changes to the way in which care is organised and delivered. A number of new programmes and delivery models were developed as part of the transformation. Common themes running through these were integrating care across organisational and service boundaries; increasing investment in community-based services; and strengthening primary care. The networked organisation of general practice has been key to many of the developments.

As a result of the transformations, the health system is supporting more people in their homes and communities and has moderated demand for hospital care, particularly among older people. Compared with the rest of New Zealand, Canterbury has:

- lower acute medical admission rates;
- lower acute readmission rates;
- shorter average length of stay; and
- lower emergency department attendances;
- higher spending on community-based services; and
- lower spending on emergency hospital care.

Although the Canterbury system has moderated demand for acute care, it has not cut beds or taken resources from hospitals in absolute terms, and its finances remain challenging. This casts doubt over expectations that new models of care will enable disinvestment in acute hospitals in the NHS. A more realistic goal would be to bend the demand curve, slowing – but not reversing – growth.

The changes in Canterbury required investment – for example, in implementing new technologies, training staff and developing new models of provision – and took several years. These are also prerequisites for transformation in the NHS.

Anna Charles is senior policy advisor to Chris Ham (CEO) at the King’s Fund and has previously published work on financial pressures in the NHS, social care for older people, quality in community health services, demand and activity in general practice, mental health and new models of care. She published an appraisal of the Canterbury Model in August 2018. Below are some highlights from this report. More detail can be found in the full report at: https://www.kingsfund.org.uk/publications?search=canterbury
When it began in 2007, Canterbury’s programme of transformation focused on keeping people (particularly older people) well and healthy in their homes and communities. Three key approaches were central to delivering the transformation:

- developing a clear, unifying vision;
- ensuring sustained investment in giving staff the skills to innovate and supporting them to do so; and
- developing new forms of contracting to support more integrated ways of working.

Canterbury DHB developed a number of new programmes and ways of working as part of its system transformation. There are common themes running through these programmes:

- integrating across organisational boundaries;
- increasing investment in community-based services; and
- strengthening primary care.

In summation, what has been the impact of the transformation?

- More care is available in the community
- There are closer links between primary and secondary care
- Spending on diagnostic services has fallen
- Pressure on acute hospital services has reduced
- Hospitals have more capacity for elective work
- Demand for long-term residential care has fallen
- Financial performance has remained challenging

Canterbury faces other ongoing challenges, including workforce shortages, rising treatment costs and pressures due to the changing demographics of the population. There are also specific challenges resulting from the impact of earthquakes, including a significant increase in demand for mental health services over the past five years. The changes described above have not been a panacea, and improvements are being made on a continual basis.

Implementing online evidence-based care pathways: A mixed-methods study across primary and secondary care

**Study Aim:** To understand what contextual influences, mechanisms and outcomes affect the implementation and use of localised, online care pathways (HealthPathways) in primary and secondary care.

**Setting:** The first HealthPathways UK site, South Tyneside, England.

**Participants:** General practitioners, nurses, practice managers, hospital consultants and system leaders (managers, commissioners) (n=76).

**Results:** Use of the pathways significantly increased over time. Themes were developed showing how online care pathways were used—leadership, pre-existing networks and relationships; development of systems and processes for care pathways, the use of online care pathways to support decision-making and referral, and perceived availability of resources. Inter-related themes were arranged into configurations consisting of contextual influences, mechanisms and outcomes. Recommendations were made for future implementations, such as improved data collection processes to understand how and why there was variance in the use of pathways.

**Conclusions:** This study was early in the implementation process; however, emerging themes will facilitate the future implementation and use of online care pathways. Recommendations are made for further research to include other health and social care users and patients to inform future developments.

**Full Article:** [https://bmjopen.bmj.com/content/8/12/e022991.full](https://bmjopen.bmj.com/content/8/12/e022991.full)

This Study was undertaken by University of Sunderland University and Northumbria University

More information can be sought from Jonathan Ling at Sunderland University

jonathan.ling@sunderland.ac.uk
Developing New Care Models (NCM) through NHS vanguards

This is a summation of the National Audit Office report, the full details of which can be found at https://www.nao.org.uk/search/new+care+models/

The report focuses primarily on the two types of vanguards which were designed to test integrated models of health and social care for a local population: integrated primary and acute care systems (PACs) and multispecialty community providers (MCPs). These models were typically expected to involve an emphasis on prevention and admissions avoidance, sharing of patient records, a whole-population budget, and a single provider or network with responsibility across the patient pathway.

Key findings include:

Planning and implementation

- NHSE intended the vanguard programme to demonstrate how care could be redesigned to improve services while also achieving a financial return. NHSE stated that the success of this programme will not solely be determined by the performance of individual vanguards but also whether the programme has delivered replicable care models, interventions and learning for the rest of the NHS.
- The vanguard programme followed previous short-lived initiatives to build integrated services across health and social care. The NHS had several earlier initiatives to promote integration of services before the vanguard programme.
- The timeframe for the vanguard programme funding was three years, with the objective to develop proof of concept for fuller, longer-term transformation. Many stakeholders consider that such a transformation would likely take 10 years or more. Each new initiative requires effort and money to set up, and relies on the goodwill of local NHS organisations, but there is a pattern of initiatives being continually folded into a successor initiative, sometimes before their objectives are fully achieved. This history has not helped NHSE to communicate a constancy of purpose.
- NHSE coordinated the development of local vanguards but did not set clear national objectives or state how NCMs would be spread. This approach gave vanguards more freedom to design complex system change but makes it harder to assess overall performance of the programme.
- The original intention to expand the vanguard programme was not realised because funding was reallocated. Ultimately, the programme contained one wave of vanguards, rather than six waves as had been originally modelled. As a result, NHSE planned to save £360 million a year from 2020-21, rather than the £1.4 billion it had originally hoped for.

Support and evaluation

- Almost 80% of the vanguards surveyed were satisfied overall with the support provided by NHSE and other national bodies especially support received for evaluation and care model design. They were least satisfied with support on workforce, technology, and governance and regulation. However, evaluating the impact of the vanguards is challenging, partly because of the difficulty of isolating the effect but also because of data quality issues. NHSE forecasts that vanguards will make net savings but given the evidence so far and the data burden that would arise from continuation, it does not intend to continue measuring the returns.
- NHSE is now developing plans to continue the spread of NCMs across the NHS. The Department of Health & Social Care has mandated that NHSE should spread NCMs, including those developed by vanguards, to 50% of the population by 2020-21. NHSE intends to spread NCMs through ICSs and networks of primary care providers as part of the NHS 10-year plan.
- Almost all vanguards plan to continue with their NCMs, but there remain some risks to continued progress. Barriers faced by vanguards are likely to be experienced by others aiming to replicate NCMs – especially STPs which did not have a vanguard within their area.
- NHSE also coordinated information sharing between vanguards, and many (24 of 28) told us they had changed their approach to implementing NCMs based on lessons from others’ experiences. NHSE has set up FutureNHS, an online platform, for sharing information between vanguards and parts of the wider NHS.

Continued on Page 11...
Conclusion on value for money

The vanguard programme is one in a series of attempts to transform the NHS to better meet patients’ needs and to respond to the financial pressures it faces. However, short-term financial pressures led to the diversion of much of the transformation funding, weakening the programme’s chances of success. Individual vanguards have made progress in implementing new models of care and there are early signs of a positive impact on emergency admissions. But the evaluation is not yet complete and, while NHSE expects to achieve savings, the long-term impact and sustainability of vanguards is still not proven.

An important objective of the programme was to design NCMs that could be replicated quickly across the NHS, and services have not yet been transformed to the depth and scale that was hoped for at the beginning of the programme. The Chief Executive of NHSE confirmed his commitment that NHSE will sustain and spread the vanguard NCMs through a long-term plan. Which will be necessary so that NHSE breaks out of previous cycles of missed opportunity and delivers full value for money.

Recommendations

* NHSE should strengthen its approach to transformation programmes by setting out what it has learned from the vanguard programme. It should set out clear expectations of when and how a national programme management methodology should be employed alongside the coordination of local projects within the programme. It should also ensure that appropriate connections are made between its transformation programmes.

* NHSE should work with the Department and other national bodies, to ensure that the momentum created by the vanguard programme is maintained. They should set out clear plans for transforming NHS services over the long term, including: setting out and publishing lessons learned from the vanguard programme;
  * allocating appropriate transformation funding;
  * setting out clear objectives for both the short- and long-term; and
  * assigning accountabilities to organisations for achieving these ambitions.

* NHSE should clarify how it will build further on its evaluation strategy to ensure that good practice can be identified and shared across the NHS to inform future initiatives to transform services. NHSE and its national partners should: encourage, and consider funding, further local evaluation of vanguards after 2018-19;
  * identify lessons on what works and what does not work and make these available to the wider NHS and other stakeholders in good time; and
  * use the lessons to refine its approaches to evaluating transformation programmes in future.

* The Department and NHSE should consider how they can incentivise NHS bodies to replicate or scale up good practice quickly. They should clarify how they will ensure that the progress made by vanguards will be sustained and scaled up, including through sustainability and transformation partnerships and integrated care systems, and how national bodies are going to monitor progress and hold them accountable for doing this. Informed by the evaluation work, this should include codifying into standardised approaches the most promising clinical and business models developed by vanguards.

* The Department, NHSE and NHS Improvement should ensure there is adequate support for local organisations to help them to transform services. Transforming health services is complex, and there is a risk that innovations introduced by the vanguards may not spread elsewhere without the financial and technical support provided by national bodies. It is important that appropriate national funding and support is therefore available. This should also focus particularly on supporting transformation in those areas that are in the early stages of implementing NCMs.

If NCM is of interest in your role – see also the NIHR paper - Understanding new models of integrated care in developed countries: a systematic review

https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr06290/#/abstract
Evaluating the impact of a community-based social prescribing intervention on people with type 2 diabetes in North East England

Summation of Full BMJ Article: https://bmjopen.bmj.com/content/9/1/bmjopen-2018-026826.full

Social prescribing enables healthcare professionals to use voluntary and community sector resources to improve support for people with long-term conditions. It is widely promoted in the UK as a way to

• address complex health, psychological and social issues presented in primary care,
• improve support for people with long-term conditions and making general practice more sustainable.
• an intervention with the potential to reduce health inequalities.

There is no agreed definition and no single model of social prescribing. However, typically social prescribing for people with long-term conditions harnesses voluntary and community sector assets to encourage self-care and facilitate health-creating communities. To encourage engagement, most social prescribing schemes involve a facilitator ‘link-worker’ who supports service users to identify and achieve personalised condition management and behaviour change goals.

This study aims to evaluate the impact and costs of a link-worker social prescribing intervention on the health and healthcare use of adults aged 40–74 with type 2 diabetes, living in a multi-ethnic area of high socioeconomic deprivation (study group).

This study aims to answer the following questions:
1. Does a link-worker social prescribing intervention, result in changes to glycated haemoglobin (HbA1c), body mass index (BMI), systolic blood pressure, cholesterol, smoking, EQ-5D-5L and healthcare use from baseline to 12 months?
2. Does the intervention demonstrate greater effectiveness in subgroups (gender, age, and ethnicity) of the eligible population?
3. Does the intervention lead to improved health-related quality of life (measured by EQ-5D-5L) at 12 months?
4. How cost-effective is a link-worker social prescribing intervention targeting adults aged 40–74 with T2D?
5. How does link-worker social prescribing lead to changes in the daily lives of individuals, their families and wider social networks?
6. To what extent does link-worker social prescribing reduce health inequalities?

There is considerable support at policy level in the UK for social prescribing and the UK’s Department of Health recently pledged £4.5 million towards social prescribing in primary care. However, a systematic review of the effectiveness of social prescribing interventions concluded that there is currently insufficient robust evidence of effectiveness or value for money. This review reinforces the conclusions of three non-systematic reviews advocating that evaluations of community-based social prescribing require control groups, larger sample sizes, longer-term follow-up and clinically meaningful outcome measures.

Summary This study is the first of its kind to take a mixed-methods approach that combines quantitative quasi-experimental methods, economic assessment and ethnography to assess the impact and value for money of a social prescribing intervention. The study is timely and relevant to the NHS and the voluntary and community sectors. Three elements make it distinctive: the use of quasi-experimental methods; the use of ethnography; and combining natural experimental methods and ethnography in a distinctive mixed-methods approach. There are challenges in generalising the findings to other settings and providing sufficiently detailed evidence for decision-makers to enact policy changes and implement appropriate services. Maximising the generalisability of the study findings requires both quantitative data about health improvement associated with the intervention and its associated costs, and in-depth qualitative data about the operationalisation of the intervention. Although social prescribing has become a more ‘mainstream’ intervention in the UK since 2012, commissioners and practitioners require robust evidence to guide the implementation of best practice social prescribing.

This study was undertaken by colleagues from; Institute of Health and Society, Newcastle University; Business School, Newcastle University; and Department of Anthropology, Durham University. The authors acknowledge; Professor Chris Drinkwater, Dr Guy Pilkington, Ways to Wellness, First Contact Clinical, Mental Health Concern and North of England Commissioning Service and the service users who took part in the qualitative study.

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Creative Healthcare stars honoured at the Bright Ideas in Health Awards

Around 400 healthcare professionals gathered at the prestigious ceremony to celebrate the cutting-edge work of individuals and teams within the NHS, academia and industry. This year’s Bright Ideas in Health Awards on Thursday 29th November 2018, shone a spotlight on people working to improve healthcare services through innovative problem-solving across the North East and North Cumbria.

The winners in each category were:

**Service Improvement**

ReCoCo (The Recovery College Collective) Northumberland, Tyne and Wear NHS Foundation Trust

**Development of an Innovative Device or Technology**

Blood Borne Virus (BBV) Test South Tees Hospitals NHS Foundation Trust

**Innovation Champion of the Year**

The Pop-up Hospital – Team from the Great North Children’s Hospital Newcastle upon Tyne Hospitals NHS Foundation Trust

**Demonstrating an Impact of Patient Safety**

Pressure Area Care – spreading the knowledge North Cumbria University Hospitals NHS Trust

**Research Impact: Improving patient care**

Leading Collaborations to Deliver Practice Changing Research South Tyneside NHS Foundation Trust

The Academic Health Science Network for the North East and North Cumbria (AHSN NENC), offer specialist expert support to all the winners, as well as a cash prize, to develop the ideas further.

* For more details on this year’s Bright Ideas in Health Awards, visit: [https://brightideasinhealth.org.uk/](https://brightideasinhealth.org.uk/)

New research identifies social factors influencing why people attend A&E

17 January 2019

A survey of 20 disadvantaged neighbourhoods across the North West has revealed the social influences on why people attend their local Accident & Emergency department. The research found that 18-26 year olds are three times more likely to attend A&E compared to those above 64 years of age. A lack of a job increased the likelihood of A&E attendance by 38%, poor housing conditions increased attendance by 34%.

Researchers from the University of Liverpool, supported by the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) North West Coast, conducted a survey, including over 3,500 face-to-face interviews, with households in communities across Lancashire, Cheshire and Merseyside. Participants were asked to complete general background about their physical health, mental health, lifestyle, social issues, housing, environment, finances and local health service usage. Households were approached at different times during the day to ensure a mix of sample participants.

If this is of interest, further details of the research are published in BMJ Open.