

Show me the evidence!

Evidence and evaluation best practice case studies and resources



“In an environment of increasing demand for services but with reducing resources, it is more important than ever to make the best informed decisions.”

Dr Peter Brindle, Lead for Commissioning Evidence Informed Care, West of England AHSN

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 West of England
Academic Health
Science Network

Welcome!

I am delighted to welcome you to our GP Clinical Evidence Fellowship Showcase, the first of its kind in the West of England, and across the UK.

As you will hear today, the GP Clinical Evidence Fellowship is a ground-breaking programme, designed to bring evidence and commissioning together to strengthen the effectiveness of services.

Our current ten GP Fellows will enlighten you with highlights of their work and its impact, as well as their own personal learning from working in these innovative roles and experience navigating the Clinical Commissioning Group (CCG) environment.

I am also delighted to welcome three guest speakers who have come from near and far to enhance our agenda. They will offer us a commissioner's viewpoint, insights from an educational clinical evidence champion programme from the North West of England, and findings of an independent evaluation of the Fellowship programme.

I am sure the stories you will hear will remind you of the merits of taking an evidence-informed approach and help you think how you might enhance this way of thinking across your own organisation. This accompanying booklet provides further detail and reference material – please use it to guide your day-to-day practice in whichever way you see fit.



Take the opportunity to catch up with colleagues, and make new connections; there is plenty of time to network over refreshments.

Please do come and talk to me in the breaks – I would love to hear your thoughts on the Fellowship Programme, and how we can support evidence-informed care in your own organisation.

I do hope you enjoy the morning with us!

Dr Peter Brindle

Lead for Commissioning Evidence Informed Care
West of England Academic Health Science Network

Thanks to: West of England AHSN, Health Education England, and NIHR CLAHRC West

Commissioning and research: improving value in healthcare

The setting

NHS commissioning is responsible for spending two-thirds of the NHS budget – approximately £80bn for 2017-18. Commissioning of health and care services is highly complex and subject to influences from political, economic and social contexts AND currently, facing the most challenging financial period in the life of the NHS. There is no room for waste: emphasis is on value-based healthcare.

The need to strengthen and support the use of evidence has never been so urgent!

The issue

At this critical time, evidence can play an important role but studies show commissioners' use of evidence is variable and inconsistent. Research evidence for commissioning decisions often doesn't exist, or is difficult to interpret and apply.

Manifesto for evidence informed health and care commissioning

Ten principles at the heart of improving value in healthcare



Call to action

This ten-point manifesto has been developed by Sian Jones, West of England AHSN, in collaboration with Alison Turner, Midlands & Lancashire Commissioning Support Unit. It represents a call to action across local and national levels to address barriers and challenges to commissioners' use of evidence.

Help us to:

- Plan how to take this manifesto forward
- Consider its relevance to other disciplines
- Identify actions to ensure research has a role in value-based healthcare

Evidence and evaluation training workshops for CCGs: what difference have they made?

Abby Sabey, Senior Teaching Fellow, NIHR CLAHRC West
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Background

Two two-hour training workshops have been delivered successfully across seven CCGs since March 2016 – ‘Finding the Evidence’ and ‘Getting started with Service Evaluation’. To date, over 140 people have attended the workshops, giving CCG staff a chance to learn about the Evidence & Evaluation toolkits, as well as pick up tips for using evidence and getting started with an evaluation project.

What was the feedback at the end of the workshop?

Evidence workshop: 95% of attendees scored either ‘excellent’ or ‘good’.

Evaluation workshop: 91% of attendees scored either ‘excellent’ or ‘good’. 99% of attendees would recommend the workshop to colleagues.

After the evidence workshop attendees said they would: *“Explore the [online] toolkit”; “Obtain an Athens login”; “Coordinate a thorough search to support new projects”; “Use databases and other trusted evidence websites”; “Access library services”.*

After the evaluation workshop attendees said they would: *“Rethink my aims and objectives”; “Start an evaluation”; “Better integrate evaluation”; “Build into contracts and service specifications”; “Use the [online] toolkit”, “Roll out to colleagues”.*

What has been the longer-term impact?

Follow-up interviews with nine attendees together with email feedback from four others, indicated that the workshops have achieved longer-term impact, specifically:

Simple change – motivating people and triggering an interest in “wanting to do more” in relation to using evidence and evaluation; recommending local library services to colleagues; sharing online toolkits and resources; providing a structure and template for those new to evaluation.

Change in processes – changing the way evidence was accessed and used – moving from ad hoc Google searches to more reliable searching methods and use of the library updates; widening “the breadth of evidence” used across business processes; implementing an evaluation of a new intervention.

Cost savings – a senior commissioner reported that the evidence workshop had triggered a search for evidence for a particular surgical procedure. When this revealed a lack of evidence supporting the procedure, the subsequent change in commissioning policy led to projected annual savings of £400k. Another participant was inspired to evaluate a new pharmacist intervention for care homes. As well as achieving patient benefit, this has also identified the scope for reducing the prescribing budget, with potential annual savings of £198K.

“The [evidence] workshop made me go out and check some of these things and not take things at face value.”

Senior Commissioning Manager, Planned Care & Contracting

Online Evaluation and Evidence Toolkits

Supporting evidence-informed patient care

Evaluation Works

Helping you to...

- ✓ Improve services and outcomes
- ✓ Determine value and effectiveness
- ✓ Make informed decisions

Evaluation Works will allow you to build appropriate evaluation into the commissioning cycle, in turn improving the quality of care and outcomes for patients.



✓ www.nhsevaluationtoolkit.net

Evidence Works

Your complete guide to...

- ✓ Finding
- ✓ Appraising
- ✓ Applying evidence

Evidence Works will help you to successfully provide evidence-informed commissioning in your decision making for new and existing services.



✓ www.nhsevidencetoolkit.net

in association with



For toolkit training in your area contact:

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Evaluation in the West of England

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Introduction

The West of England Evaluation Strategy Group, hosted by CLAHRC West, has developed a number of invaluable resources for its members in the West of England, many of which have been accessed by other regions.

These resources are designed to seek to support service evaluation activity for a wide range of staff groups across the health and social care sector.

Resource	Purpose	Access
Case studies	Share learning and demonstrate impact and value	www.clahrc-west.nihr.ac.uk/evaluation/
Evaluation Online Network	Virtual support and information on evaluation	Contact Jo Bangoura to join j.bangoura@nhs.net
Online Toolkits: Evidence Works & Evaluation Works	Easily accessible five-step guide to planning and implementing an evaluation or finding and appraising evidence	www.nhsevidencetoolkit.net/ www.nhsevaluationtoolkit.net/
Guidelines for patient and public involvement in service evaluation	Guidance for health and social care staff on how to engage and involve patients in your evaluation	Printed leaflet. Currently in final draft form but will also be available online. Contact Jo Bangoura for further information j.bangoura@nhs.net
Guidelines for ethics and governance in service evaluation	This leaflet takes good practice from research to provide guidance for those completing service evaluations	

Knowing what works, for better commissioning decisions – the virtual team

Sian Jones, Primary Care Programme Lead, West of England AHSN

Commissioners understand the benefits of using evidence and evaluation findings in decision-making. However, across England there is great variation in the type of support available to them to do so. As a result, some commissioners report finding it a challenge to access evidence in a timely fashion, to understand the quality of the available evidence and apply it as part of their routine business. Without opportunities for training, they are not able to develop the required skills to do any of this themselves.

Support in the West of England

The West of England reflects the national picture, with varied types of support available for using evidence or carrying out evaluation. However, efforts have been made to address this. Currently, each of the seven Clinical Commissioning Groups have received training via the 'Finding the Evidence' and 'Getting Started with Service Evaluation' workshops. These reference the online NHS Evidence and Evaluation Toolkits which describe a five-step process and signpost to additional local capacity for accessing and appraising evidence. This includes the Local Authority Public Health teams, the NHS Library and Knowledge Service (Health Education England - HEE), GP Clinical Evidence Fellows and Graduate Evidence or Evaluation Assistants. Combined, these roles make up a virtual team, which contributes to strengthening the culture for evidence-informed commissioning, through their close work in CCGs, even whilst models for sustainable funding are explored for the GP Clinical Evidence Fellow and Graduate Assistant roles.

Who are the virtual team?

Trying to influence culture and behaviours across seven CCGs is a significant task! So, to make the most of the limited 'people' resource, the idea of a virtual team has evolved. This is simply about the joining up of different roles and staff whose remit is about enabling better access and use of evidence.

There is a difference in the make-up of the 'teams' across the seven CCGs. The GP Clinical Evidence Fellows are pivotal in facilitating the development of the virtual team by strengthening links and the process of evidence-informed commissioning through clinical leadership. The other constants are Public Health and the Library service. Public Health provide expertise in accessing evidence, especially as they are responsible for the development of a key source of evidence: the Joint Strategic Needs Assessment (JSNA). HEE are promoting the benefits of the NHS Library and Knowledge Service through their twitter initiative #AMillionDecisions.

So, in Bath and North East Somerset, Swindon, Wiltshire and Gloucestershire CCGs, the virtual team has representation from GP Fellows, Public Health and Library services. In Bristol, North Somerset and South Gloucestershire, the virtual team is enhanced by the additional input of the Graduate Evidence and Evaluation Assistants - temporary roles which provide extra capacity for evidence reviews, and in planning and carrying out service evaluation. This informal virtual team model is developing at different rates in CCGs across the West of England. Where they are better established the 'members' support each other, understand local resources and signpost CCG staff to provide an effective way to share requests for evidence. The complement of skills, knowledge and experience they bring can be shared to provide a coordinated, timely and consistent approach to supporting evidence and evaluation needs.



Knowledge Mobilisation: how the APCRC are bridging the gap

Dr Jo Hartland, Research and Development Programme Manager, APCRC

What is APCRC?

The Avon Primary Care Research Collaborative (APCRC) supports primary care and community based research across the Bristol, North Somerset and South Gloucestershire STP.

It aims to bridge the gap between the academic community and the practice community and embed evidence-informed commissioning under the umbrella of knowledge mobilisation.

APCRC's aim is practice-based research and research-based practice.

The APCRC approach to research and development support is very successful:

1. Investment in researchers and NHS staff in primary care and community health areas to develop strong NHS-focussed, co-produced research grant applications;
2. APCRC then 'host' successful NIHR-funded grants;
3. Significant Research Capability Funding (RCF) is subsequently generated each year on the basis of this research success;
4. RCF is then re- invested in a wide-range of research and innovative posts, which support commissioners to use the best evidence to underpin their decision-making.

This cycle of success leads to more good ideas... and more Research Capability Funding.

Innovative APCRC-funded posts include:

- GP Clinical Evidence Fellows; Researchers in Residence; NHS Management Fellows;
- Graduate Evaluation Assistants, Evidence Assistants and Health Economists;
- Collaboration with Public Health teams;
- A Professor of Knowledge Mobilisation to spearhead its knowledge mobilisation work.

What impact has this had?

- Raised awareness of the importance of evidence for good decision-making
- Embedding evidence-informed commissioning as normal practice
- Enabling NHS staff to influence research ideas
- Ensuring academics understand the NHS world better and that research is relevant with scope to impact.

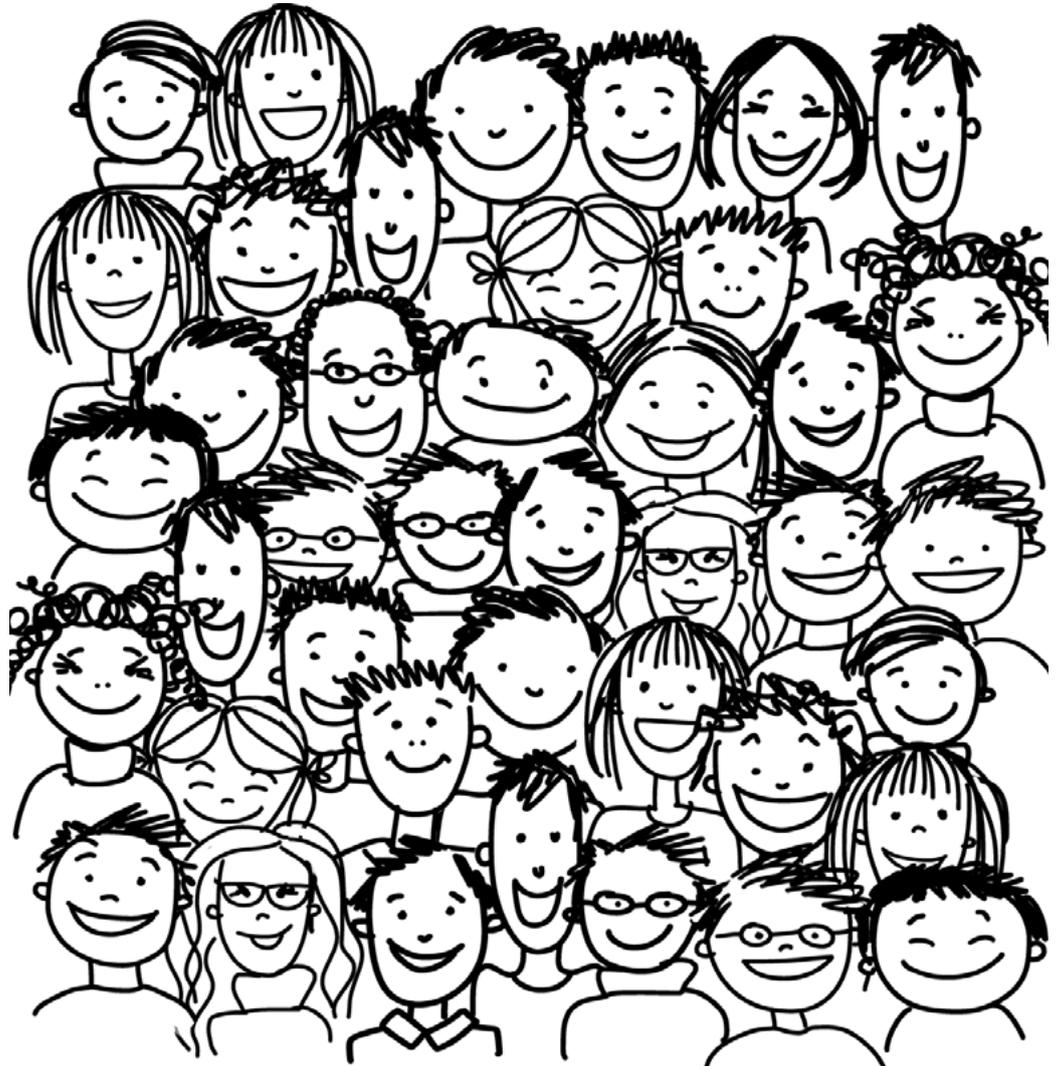
Knowledge Mobilisation

Bridging the gap between academia and practice, for robust health care decisions, and more impactful research.

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Clinical Evidence Fellow achievements

Some examples from the wide range of work and achievements of the current cohort of GP Clinical Evidence Fellows



Dr Bisola Ezobi, GP Clinical Evidence Fellow, Bath & North East Somerset CCG



Background – what’s the issue?

With an ever-increasing elderly population in the UK, it is imperative that there is suitable provision for the health and social needs of older adults.

In Bath and North East Somerset (BaNES) CCG, there is work underway to introduce a pathway to reduce the morbidity associated with frailty. I was tasked with collating evidence on effective interventions that may help to slow the decline of community-dwelling older adults with mild frailty.

What I did

I worked with my local librarian to conduct a literature search. Following a review, I was able to summarise some of the evidence to present to the A&E Clinical Subgroup, which is responsible for the development of the BaNES Frailty Pathway. A summary document was also sent to all the local GPs as a basis for discussions at a GP Forum meeting where their views were being sought about what a Frailty Pathway in the area would need to include.

In addition, I attended the Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Partnership (STP) Frailty Conference, which provided great insights into the successes and challenges of a neighbouring STP that had variable availability of interventions for frail older adults across its geographical area. It also provided insights into some gaps in the draft Frailty Pathway at that time.

What I found

Although there is a lot of research surrounding people with moderate-severe frailty, the evidence on interventions for community-dwelling older adults with mild frailty (Rockwood <5) is limited and often of poor quality.

Of the available evidence, the intervention that had the most supportive evidence for being effective is a Comprehensive Geriatric Assessment with subsequent individualised multi-factorial intervention. Although originally designed for use in hospital, there is good evidence to suggest that this is also effective in the community. There is also evidence to suggest that case management using a multidisciplinary approach may be effective.

What next?

Work on the Frailty Pathway in BaNES CCG is still ongoing. With the new NHS GP Contract highlighting ‘frailty’ as an area of focus for 2016/17, it has become even more topical and necessary.



Review of paediatric admissions

Dr Francis Campbell, GP Clinical Evidence Fellow, Swindon CCG

Background – what’s the issue?

Healthcare delivered in Emergency Departments is very expensive, relative to primary care. Wiltshire CCG wanted to find out if any children who were being seen by the paediatric emergency team in hospital (without being admitted) had potential to be managed within primary care.

Simultaneously, the paediatric hospital team communicated that they were keen to establish an advice telephone service for GPs.

Improved GP access to a paediatric doctor is one of the benefits identified in a report about consultant-led services by the Academy of Royal Medical Colleges. This is referenced by the Royal College of Paediatrics and Child Health in their 2015 paper, Facing the Future.



What I did

I obtained and reviewed a random sample of hospital notes for 0 day length of stay for 0-16 year olds over the 4 month winter period (November 2014 to February 2015) when A&E attendance for paediatric respiratory illness peaks. I reviewed the notes to assess, in my clinical judgement as a GP, which cases may have been managed appropriately in primary care, particularly if access to a paediatric specialist was available.

What I found

Of 35 reviewed cases, I assessed that a significant number of cases were likely to have been managed successfully in primary care if access to a paediatric specialist was available through an advice line. On this basis, A&E attendance could potentially be reduced.

There were also three cases identified that clearly did not need hospital-level review or intervention and would have been more efficiently seen in the community urgent care centre (SUCCESS) children’s clinics.

What difference has this made?

These audit findings increased Swindon GGG’s confidence in trialling a paediatric advice line for GPs to contact specialist paediatricians. The advice line is still operational. Its evaluation is pending, following a change in programme lead.



Evidence reviews for clinical policies

Dr Catherine Bennett, GP Clinical Evidence Fellow, Wiltshire CCG



Background – what’s the issue?

Across the Bath & North East Somerset, Wiltshire and Swindon STP, reviewing clinical policies is an ongoing process. Clinical policy or pathway review starts with the development of an agreed, prioritised list of topics.

There is a six-monthly meeting of a working group to enhance prioritisation decisions in a context of tight financial control. I was asked to look for evidence for policies currently under review to aid the decision-making process.

What I did

I carried out evidence searches relating to the following topics:

- Chalazia (eyelid cyst) and their management - discussion with Consultant Ophthalmic Surgeon
- Bunionectomy (bunion removal) - liaising with a senior Podiatrist
- Varicose veins
- Ganglions (cyst near a joint or tendon) – aspiration and excision versus conservative management.

What effect did this have?

These evidence reviews have been used to guide the formal policy review and redesign to ensure that evidence underlies the decision-making.

They have also been taken to discuss with secondary care colleagues regarding prioritising certain clinical procedures, such as stopping routine bunionectomy since evidence supporting surgery is limited.

There is an ongoing review process, so hopefully these evidence reviews will continue to provide guidance in the future.

What next?

I am starting to look at the evidence related to BMI, smoking and surgery, including health optimisation prior to surgery.



Minor procedures demand management

Dr Francis Campbell, GP Clinical Evidence Fellow, Swindon CCG

Background – what’s the issue?

Great Western Hospital has two main commissioners - Swindon and Wiltshire CCGs. The criteria for various minor surgical orthopaedic and surgical procedures such as trigger finger, tonsillectomy and carpal tunnel release can differ significantly for people living in these two areas, as does the spend.

I was asked to undertake a review of the appropriateness and effectiveness of Swindon’s protocol, and referencing work that Wiltshire CCG had recently undertaken to review their policies in line with evidence work completed by Dr Catherine Bennett, the GP Clinical Evidence Fellow.

What I did

I undertook an audit of patient notes, working with a CCG manager and using my clinical judgement to assess compliance to current policy for various minor procedures

I reviewed Wiltshire’s Criteria Based Access and Prior Approval processes against the evidence-based changes made in Swindon CCG.



What I found

I discovered that a variety of forms were being used in patients’ notes. It was sometimes difficult to be confident that the Criteria Based Access guidelines had been followed.

I shared my findings with the CCG and Great Western Hospital surgeons and clinical teams.

What happened as a result?

Swindon CCG have moved most procedures to the same evidence-based criteria as Wiltshire CCG, thus reducing inequality of access to these services to the local populations.

A project is under discussion to improve the quality and consistency of referral information for these minor surgical procedures. The project will incorporate CCG contract monitoring data to provide visibility of fluctuations in activity, and therefore cost, of the Criteria Based Access and Prior Approval processes.

Dr Caroline Ward, GP Clinical Evidence Fellow, Swindon CCG



Background – what’s the issue?

Antibiotic stewardship is vital to reduce antimicrobial resistance but, in clinical practice it can be difficult to achieve a balance between using antimicrobials when they are really needed and reducing use when perhaps they are not.

Within Swindon CCG, while there is a trend of year-on-year reducing antibiotic prescribing by GPs, prescribing has increased within the out-of-hours GP setting.

What I did

Presentations of respiratory tract infections are common in primary care and it can sometimes be difficult to distinguish patients with viral respiratory tract infections from those with bacterial infections.

I implemented a six-month pilot study of near-patient C-reactive protein testing (CRP) with the Urgent Care Unit in Swindon. This is a central unit where patients are seen when their own GP practice is closed. CRP is a marker of infection. A raised CRP indicates that the patient is more likely to have a bacterial infection and require antibiotics, while a lower result indicates a likely viral infection, which does not require antibiotics. The test involves a simple finger prick blood test in the clinic (point-of-care testing) with a result available in four minutes.

Clinicians used this test in line with recommendations from NICE guidance: Pneumonia in adults: diagnosis and management (December 2014).

What effect did this have?

Data analysis is still in progress. However, early results indicate that CRP testing is likely to have changed prescribing behaviour, and patients who underwent CRP testing were less likely to receive an unnecessary antibiotic.

There appears to be a shift towards delayed rather than immediate prescribing. Previous studies show that only around 30% of patients prescribed a delayed antibiotic will use them.

What next?

Now the pilot has finished, an evaluation report will be written and submitted to Swindon CCG.

This will inform a decision whether to fund continuing point-of-care (near-patient) testing.



Expert Patient Programme

Dr Vanessa Dane, GP Clinical Evidence Fellow, Gloucestershire CCG

Background – what’s the issue?

The Expert Patient Programme is a peer led self-management programme, launched by NHS England in 2001. It is a six-week course of two hourly sessions; usually generic but it may have a disease specific component.

The programme is based on Bandura’s self- efficacy theory that the key predictors of successful behaviour change are self-confidence (self-efficacy) in the ability to carry out an action and the expectation that the goal will be achieved (outcome expectancy).



What I did

I performed a review of the available evidence for peer led self-management programmes. In addition I specifically searched for the key features for a successful programme, such as generic versus disease specific; peer led versus professionally led; and patient and programme factors linked to success. I assessed the evidence for differences in uptake amongst different socio-economic and patient activation measure groups and whether the benefits persisted over time and resulted in a reduction in health care costs.

What I found

The evidence review showed that peer led self-management programmes increased the self-efficacy of participants. Whilst this did not translate into significantly improved health outcomes or a reduction in health use, an increase in self-efficacy was found to be highly valued by the participants in one qualitative study.

One UK study that assessed the cost-effectiveness of the programme found that it was cost-effective. However, this may not be reproducible as this study found reduced healthcare costs as a result of the programme whereas other studies did not have reduced healthcare costs. There was some evidence that programmes recruiting people with a lower self-efficacy rating or with more severe disease may have more significant improvement outcomes.

What difference has this made?

My evidence review was presented to the clinical programme teams who used the findings to inform development of the Expert Patient Programme by: incorporating disease specific session(s); considering how they can overcome reported challenges of recruiting participants; particularly from ethnic minorities and targeting those with the poorest health.



Reviewing the GOLD guidelines

Dr Farida Ahmad, GP Clinical Evidence Fellow, Bristol CCG



Background – what’s the issue?

Currently, Chronic Obstructive Pulmonary Disease (COPD) is the leading cause of morbidity and mortality worldwide and in the UK it is the only major cause of death on the increase. In Bristol, the admission rate for COPD is above the national average and the average cost per patient is £6,306.

What I did and found

I read and summarised the GOLD guidelines, as well as collated data from NHS RightCare and the local Joint Strategic Needs Assessment.

Global Initiative for Chronic Obstructive Lung Disease (GOLD) is an international initiative launched in 1997 in collaboration with the National Heart, Lung and Blood Institute, the World Health Organisation and various committees. Its guidelines for COPD care are shaped by these committees, made up of leading experts from around the world and using the best level of evidence available.

The evidence shows that pulmonary rehab is a much more effective way of managing COPD than the use of inhalers. Pulmonary rehab is a programme of exercise and education and the only intervention that can actually change lung function aside from stopping smoking. It is shown to be cost effective as well as clinically effective, with improvement in quality of life for patients lasting up to three years. Pulmonary rehab is preventative care and therefore reduces admissions. Hardwick CCG in Cambridgeshire has reduced admissions from COPD by 30% in seven months by following high impact interventions endorsed by GOLD.

What difference has this made?

A nurse has been employed by North Somerset CCG to go into individual practices and try to taper patients off inhalation corticosteroids. If evaluation shows this to be successful, there is a plan to roll this out to the rest of Bristol, North Somerset and South Gloucestershire (BNSSG).

I am now the Respiratory Lead for Horfield Health Centre and have joined a regional group of people with an interest in COPD. We are looking at prevention and education (of both staff and patients) in primary care and whether there is a possibility of piloting and evaluating an app 'My COPD' for patients to self-manage.

Most GPs and nurses were well informed with regards to inhalers but were not aware of the evidence that pulmonary rehab can make such a difference. Now that they are becoming more aware, we may see a reduction in admissions and therefore cost savings and improved COPD management for patients. Discussions and planning for an evaluation are in the early stages. There is also ongoing discussion around how to build on these changes and work collaboratively across the STP area.

Dr Ed Mann, GP Clinical Evidence Fellow, North Somerset CCG

Background – what’s the issue?

Depression is one of the most common reasons for people seeing their GP. There is a good evidence base for Cognitive Behavioural Therapy (CBT) in depression but demand for this cannot be met by existing face-to-face services. Computer-delivered CBT therefore offers an attractive alternative and is also recommended by NICE guidelines.



What I did

I looked at reviews and meta-analyses of the evidence around the use of digital media (apps/computer programmes) in treating depression.

There is conflicting evidence on computer CBT (iCBT) with depression and anxiety, although there is seemingly stronger evidence that it may work in the ‘pre-GP’ phase of a patient’s illness. In North Somerset however, patients already have direct access to CBT and other self-help via Positive Step without seeing a GP. Because of this, it is difficult to recommend the CCG invests in commercial CBT, for example ‘Beating the Blues’ which costs £50 per patient or £31,500 per year. A recent UK study found little difference between the two approaches and neither offered any advantage over usual GP care. MoodGYM is a free interactive self-help program. There is less evidence about this but while it may not be effective, it will not cause harm and may actually benefit some patients.

What difference did it make?

The CCG did not invest in iCBT as there was not strong evidence to recommend the value.

The CCG found the evidence review useful because “it looked at specific models (and the evidence behind them) currently available on the market. It also pulled in the current commissioning context and demonstrated a knowledge of the current pathway and therefore opportunities to transform. It then weighed up the pros/cons.”

Dr Nick Snelling, GP Clinical Evidence Fellow, Bristol CCG

Background – what’s the issue?

Treating back pain is hugely expensive to the NHS, and most of the costs seem to result from the small proportion of patients who go on to develop chronic problems. The main predictors of chronicity are psychosocial factors, such as catastrophising, fear avoidance and belief that movement is harmful. There is a lack of evidence on the best way for GPs and health professionals to identify these patients, in order to prevent chronicity.

What I did

I reviewed some of the literature on psychosocial factors and tools used to identify these patients. I found the STarT Back tool, developed and tested by Keele University, and assessed some of the research trials on its use in primary care.



What I found

I located some well-designed trials which suggested that implementation of stratified care in both general practice and by physiotherapy reduced both overall disability and time off work certification. Stratified care categorises patients by risk; low, medium and high – which in turn determines the pre-defined care pathway. This work was presented to the CCG, and also incorporated into a musculoskeletal training day for Bristol-wide GPs to attend.

What difference has this made?

This work has raised GP awareness of the importance of assessing psychosocial factors in low back pain. This was incorporated into the low back pain pathways in South Gloucestershire. These findings have been subsequently incorporated into the latest NICE guidelines on lower back pain. They are currently being incorporated into the musculoskeletal STP for Bristol, North Somerset & South Gloucestershire (BNSSG).

Dr Nick Snelling, GP Clinical Evidence Fellow, Bristol CCG

Background – what’s the issue?

Treating back pain is very costly. Bristol CCG wanted to look at the efficacy of injection therapy in light of the high cost. Other pathways are being considered in a wider related piece of work.

What I did

I identified and appraised the most up-to-date reviews in the Cochrane database and made use of the British Medical Association library search services across EMBASE, Medline and Cochrane.



What I found

For spinal stenosis and localised low back pain, the evidence (of low to moderate quality) suggests epidural injections are not clinically effective.

For facet joint injections, the evidence (of low to moderate quality) suggests insufficient clinical effectiveness.

What difference has this made?

The evidence review was submitted to the commissioning policy review group in Bristol CCG, which makes clinical recommendations on individual funding request policies. The group was aware that NICE was reviewing its lower back pain guidance but the update was not expected for several months. The locally produced evidence review provided confidence to the group in making policy change, at a time when the policy was under review. Engagement with clinical leads to implement this change took three to four months, the usual length of time for any new policy.

Facet joint injections can now only be requested by exception via the ‘interventions not normally funded’ process.

The anticipated savings are based on the majority of the £100,000 spend per annum for facet joint injections that will no longer routinely be administered, across the three CCGs - Bristol, North Somerset and South Gloucestershire.

This change in policy has impacted patient satisfaction for some patients who were getting short-term relief with regular facet joint injections. Some will be managed by exception, others may be managed more comprehensively in the future.



Self-care in chronic disease and patient activation

Dr Phillip Simons, GP Clinical Evidence Fellow, South Gloucestershire CCG

Background – what's the issue?

I was asked by South Gloucestershire CCG to look into evidence for self-care in chronic disease and patient activation.



What I did and found

I completed an evidence review which demonstrated that self-care can improve health outcomes. The effects are generally small with strongest evidence in diabetes, mental illness and cardiovascular disease. Patient Activation Measure (PAM) is a reliable indicator of an individual's knowledge, skills and confidence in managing their own health. It can be used to tailor support and as an outcome measure.

There is a potential for costs savings through reduced use of health services.

Where did this lead?

- I presented the review at a Bristol, North Somerset & South Gloucestershire (BNSSG) STP event on Prevention, Early Intervention and Self-Care in May 2016. This influenced STP policy with self-care becoming a prominent part of strategy.
- I have successfully applied to NHS England for PAM licences on behalf of South Gloucestershire CCG.
- I am working with CCG managers to develop self-care/PAM services, and encouraging evaluation of outcomes.
- I am now a member of the BNSSG PAM Implementation Group and have been invited by South Gloucestershire Public Health to be member of STP Delivery & Assurance Board for Prevention, Early Intervention and Self-Care.
- I have developed links between the CCG, the University of the West of England and the West of England AHSN to enable a pilot of 'ESCAPE pain' – an evidence based 6-week exercise and education programme for those with knee/hip osteoarthritis run by exercise professionals in gyms. Outcome measures will be built into the planning process including PAM.



Suicide prevention in the LGBTQ community

Dr Phillip Simons, GP Clinical Evidence Fellow, South Gloucestershire CCG

Background – what’s the issue

As part of the national suicide prevention policy, the South Gloucestershire Suicide Prevention Strategy Partnership Group was formed by South Gloucestershire Council Public Health team and South Gloucestershire Clinical Commissioning Group. The Lesbian, Gay, Bisexual, Trans and Questioning (LGBTQ) population have been identified as a group at higher risk of suicide with a four times life risk for gay/bisexual men and two times for gay/bisexual women. The lifetime suicide attempt risk in trans individuals is 41% compared 4.6% for the overall population.

What I did

I did an evidence review on suicide prevention strategies, contacted experts on the subject (who informed me that there was no evidence on suicide prevention strategy!) and contacted local services such as the Child and Adolescent Mental Health Services (CAMHS) and the school nurse service. CAMHS and the Kingswood School Nurse Service advised that they had had no formal training on LGBTQ needs. The school nurse service was receptive to training and charitable resources from Stonewall.



What I found

I found a paucity of evidence to support specific strategies - more research was needed. What services existed had not been evaluated. As a result, I based my recommendations on increasing protective factors and reducing risk factors associated with LGBTQ suicide. These risk factors might include when individuals recognise and disclose their sexual orientation, mental illness, self-harm, drug and alcohol abuse, and stigma and prejudice. Protective factors included school safety, family ‘connectedness’, perceived caring from other adults, a sense of connectedness to an LGBTQ community, and positive sexual identity.

My recommendations included:

- Encourage a supportive school environment and family support
- Training in LGBTQ needs for adult/child mental health services, emergency departments & primary care
- Improved access to and use of culturally competent drug and alcohol services
- Educate LGBTQ population on relation of mood/anxiety to suicide, and encourage help seeking
- Consider online/telephone support; pump priming grants for support groups and use of social networks.

“Phil’s work has reinforced the LGBT community as one of our local priority groups for reducing inequalities... His review has helped shape what this might look like in practice, influenced strategy and specifically plans to provide more LGBTQ support in schools.” Public Health Programme Lead (Mental Health & Emotional Well Being) for South Gloucestershire Council



RightCare and a strategy for primary care

Dr Charlie Kenward, GP Clinical Evidence Fellow, North Somerset CCG



Background – what’s the issue?

RightCare is a programme for identifying unwarranted variation in health across CCGs, and is used to drive innovation and improvement. North Somerset CCG is leading the RightCare programme for the Bristol, North Somerset & South Gloucestershire (BNSSG) STP, as well as developing a Primary Care Programme for the local Weston area.

What I did

As one of the North Somerset CCG RightCare team, I produced reports on the musculoskeletal and cancer pathways, from the ‘commissioning for value’ data. As an experienced GP, I was able to add a clinical interpretation. The reports focus on clinical pathways and public health outcomes where the CCGs are outliers for spending or quality, compared with a group of similar CCGs. I also identified key areas for further analysis, and plan to produce in-depth reports on musculoskeletal, respiratory and cardiovascular. Separately, I compiled a report of evidence for primary care services co-located with emergency departments.

What I found

In the RightCare cancer care review I found high rates of day case admissions, which were a significant contributor to the £1.3m excess spend on planned cancer care for the STP. I also identified a pattern of low cancer screening rates, indicating an opportunity to improve the quality and cost-effectiveness of cancer care across the system. As a GP, I brought a clinical interpretation to my analysis. This report was shared with the planned care control centre.

The review on GPs in Emergency Departments revealed a lack of research evidence supporting this practice, but did reveal a wealth of learning about the planning and implementation of such services. These findings have been shared with the urgent care control centre.

What difference has this made?

It is too early to assess the impact of this work. However, the RightCare respiratory work output has been sent to the urgent and planned care control centres for discussion, and will inform logic models for service change. The review on GPs in Emergency Departments has been shared with the North Somerset Urgent Care team and the Weston Primary Care Transformation project board. As a result, the latter group will further discuss the need to develop an evidence-based plan for relieving pressure on A&E.

More evidence and evaluation best practice

Further examples of how evidence and evaluation can be used to inform practice and service development



Real-life stories: using evidence & evaluation in practice

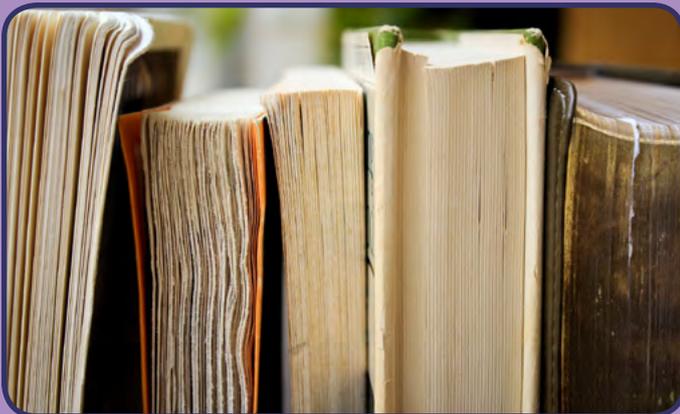
Jo Bangoura, Evaluation & Commissioning Liaison Manager, West of England AHSN & CLAHRC West

Introduction

It seems instinctive to most to check what evidence exists about the idea you have, and to evaluate whether it works, once implemented. Most will agree it is common sense. But, for a multitude of different reasons, evidence-informed commissioning, as we call it, is not routinely practiced.

Evidence-informed commissioning does require an investment in time, capacity and capability.

Through collecting and sharing real-life stories, we aim to demonstrate the difference this approach can make, and how this investment reaps dividends in terms of cost savings, improving patient safety, and influencing policy. It increases the certainty and the defensibility of commissioning decisions, reduces risk and thus reduces any potential patient harm and inefficiencies.



What we did

We have collected and recorded a number of short stories. They each describe their context, how the work was carried out, and critically, what difference it made. Some of the stories are recorded in this booklet, but more can be found on the CLAHRC West website at: www.clahrc-west.nihr.ac.uk/evaluation/

How will I benefit from reading these case studies?

Evaluation

- Understanding that service evaluation requires resource and planning, Is your service doing what it set out to do?
- Appreciating that an evaluation report can give you confidence in knowing your service is effective, or which aspects to improve.
- Learning that cost implications can be more accurately calculated with an evaluation report, than without one.

Evidence

- Discovering that a little time spent researching evidence CAN make significant cost savings, particularly through decommissioning clinically ineffective services.
- Appreciating that evidence comes from a wide range of sources – formal publications as well as unpublished reports from other CCGs, for example.

Dr Julian Treadwell, Salaried GP, Hindon Surgery, Wiltshire and NIHR In-Practice Fellow, Nuffield Department of Primary Care Health Sciences, Oxford



Background

It is well documented that older people with multiple chronic medical conditions are taking several different medications. However, only a small number of patients will benefit from the drugs they are treated with. The driver for this evidence review was to better communicate such information to GPs and provide them with clarity about the effectiveness of commonly prescribed drugs, to reduce unintended harm.

What I did and found

I drew on Cochrane reviews, related publications and clinical trials. I found national documents recommending a more rational approach to prescribing. GPs are expected to use their clinical judgement when applying evidence to individuals, even though most guidelines are based on evidence from trials on middle-aged patients with single conditions. Compiling 'at a glance' information about common treatments used in primary care could help GPs with their decision-making for patients with multiple chronic medical conditions by providing data on less effective treatment. The evidence was presented as a Rational Prescribing guide.

Outcome

The Rational Prescribing guide was shared with the Medicines Management team, CCG Clinical Governance committee and each senior group of the three geographical localities in Wiltshire CCG, the CCG Chair and a regional Chair. Two education workshops were also held to share the evidence with GPs and Pharmacists. My work put this topic 'on the map' and facilitated discussion. It has anecdotally led to reduced prescribing, although this has not been formally evaluated. The following factors were reported or observed at the workshops:

- GPs confidence in using 'numbers to treat' is not high. This is a measure of effectiveness of a medication treatment.
- GPs feel they should overprescribe as this is usually what guidelines recommend; there is a lack of guidelines for prescribing for individuals with multiple chronic medical conditions.
- Evidence-based information in the Rational Prescribing guide appeared to give GPs permission to make a confident clinical prescribing decision for a patient with multiple chronic medical conditions, which may go against the guidelines for single condition prescribing.
- The guide also presented efficacy of common treatments in an easily-accessible way, enabling GPs to discuss pros and cons of different treatments with their patients.

Information from this work has spread through informal GP networks. The Rational Prescribing guide was downloaded 213 times from the Wiltshire CCG website over 2 years. This work has introduced a new way of thinking about prescribing.

Patella resurfacing with total knee replacement

Belinda Alexander, Senior Commissioning Manager, Planned Care & Contracting,
Bath & North East Somerset CCG

Aim

To review the evidence for carrying out patella resurfacing with total knee replacements, to inform a commissioning policy review for this procedure.

What I did

After attending a 'Finding the Evidence' workshop, I requested a search from Royal United Hospitals library service. This included Google Scholar and healthcare databases such as Medline, EMBASE, CINAHL, PsychINFO, Health Business Elite and Cochrane. I also contacted The Royal College of Surgeons policy team for their views, as well as NICE, who were asked directly as the existing guidance wasn't very clear.



What I found

There are numerous papers assessing the evidence for the effectiveness of this procedure, but the available systematic reviews indicate that there is no significant benefit to routine resurfacing of the patella, either with patient satisfaction or functional status.

Most of the systematic reviews also report no difference between the groups in the incidence of post-operative anterior knee pain.

In April 2015, the American Academy of Orthopaedic Surgeons published an evidence-based clinical practice guideline on the 'Surgical management of osteoarthritis'. They concluded that "Strong evidence supports no difference in pain or function with or without patella resurfacing in total knee arthroplasty."

Outcome

BaNES CCG has changed patella resurfacing with total knee replacement to become a 'prior approval' procedure. Patella resurfacing leads to an increase in the cost of total knee replacement of approximately £3,000 per patient.

In 2015/16, 134 of these procedures took place, giving a potential full year saving of approximately £400,000.

**Potential saving of approximately
£400,000 per year**



Evaluation of a new care home pharmacist service

Helen Wilkinson, Deputy Head of Medicines Management,
South Gloucestershire CCG



Background

Following attendance at a 'Getting started with Service Evaluation' workshop, I undertook a clinical medication review of care home residents, working in partnership with GPs and community services in order to optimise individual patient medication; reduce prescribing costs; prevent hospital admissions related to medicines and lastly, provide support to care homes around medicines management.

What we did

We reviewed data collected at care home pharmacist visits about what medications had changed (as result of the visit), as well as changes to dose, medications stopped, and identifying side effects. GPs and care homes were contacted for feedback and two patient case studies were produced.

What we found

The service employed 1.8 full time equivalent pharmacists who visited 30 care homes and reviewed 486 patients over a 12 month period. The evaluation identified 1,062 interventions with patients, an average of 2.18 per patient. 75% of patients had an intervention of some sort, with service activity reported as higher on de-prescribing than prescribing. The top three interventions by the pharmacists were:

- Stopping medication for clinical reasons or because they were not needed
- Reducing the quantity of medications (to reduce waste)
- Switching medications to more cost-effective options.

This highlighted the service was about de-prescribing more than prescribing.

What difference has this made?

Interventions were risk stratified and five patients were deemed to have been prevented from a hospital admission. A potential projected saving was calculated from this at £12,000 of admission costs. The in-year savings to the prescribing budget in 2016/17 was £98,000 with 12 month recurring savings of £198,000.

The care home pharmacist service is continuing and new mobile technology is being developed to support the role. Stronger links are being built with the care home liaison team (dementia).

The investment in the pharmacist role in care homes has been off-set by savings, and so the service will continue to benefit patients, reduce costs and improve professional standards of medicines management in care homes.

Evaluation of 'Don't Wait to Anticoagulate' project

Sarah White, Quality Improvement Lead, West of England AHSN
with Faculty for Health & Applied Sciences, University of the West of England



Don't Wait to Anticoagulate

Background

The Don't Wait to Anticoagulate (DWAC) project aimed to optimise anticoagulation treatment for patients with a diagnosis of Atrial Fibrillation in Gloucestershire CCG. Effective anticoagulation has been shown to reduce the risk of stroke for patients with Atrial Fibrillation.

What we did

We completed an evaluation of the DWAC project in order to measure the impact of the intervention, evaluate the role of the Quality Improvement Support Team and gain insight into the experience of undertaking a quality improvement project in primary care.

What we found

The project had a positive effect on rates of anticoagulation in Gloucestershire CCG in the 12 week period within which it was measured. During this time 2,228 patients with Atrial Fibrillation were reviewed in line with NICE guidance, and an additional 654 patients with Atrial Fibrillation were identified and added to the register. Of these, 265 were optimally anticoagulated as a result of the project.

Modelling shows that during the second 12-week programme DWAC potentially prevented 13 strokes.

What next?

Receiving national recognition, a number of AHSNs around the country now have plans to run the scheme across their regions.

Phase three of DWAC was rolled out in partnership with Bristol CCG to all primary care practices. Completed in March 2017, the full evaluation of this latest phase will be available in the autumn.

In addition, the Bristol, North Somerset and South Gloucestershire (BNSSG) STP is considering DWAC as part of their stroke prevention pathway, which we hope would form phase four of the local rollout.

Each new phase is tailored to meet the specific needs of the CCG or Academic Health Science Network that undertake it, using the learning from this evaluation.

**Potentially prevented 13 strokes
during 12-week programme**



For further information:
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Preventing cerebral palsy in preterm births (PreCePT)

Anna Burhouse, Director of Quality, West of England AHSN

Background

There is evidence to suggest that magnesium sulphate given before anticipated early preterm birth reduces the risk of cerebral palsy in surviving infants.

The PreCePT project aimed to increase the numbers of eligible women offered and receiving treatment of magnesium sulphate in preterm labour in the West of England. It did this by training core staff to understand the benefits of using magnesium sulphate for neuroprotection and supporting system change in the five NHS trusts to embed this practice as 'business as usual'.



What we did and found

We evaluated the PreCePT project to determine whether it had a favourable effect on the uptake of magnesium sulphate for eligible women in the five trusts involved and whether the approach used created sustainable change.

A total of 89 preterm deliveries happened over the lifespan of the project and 76 received the intervention, representing 85% uptake - the initial target was 60%.

Over the five sites undertaking the project, 664 core staff received training. This was found to be of high quality and effective.

Focus groups highlighted that different staff groups wanted different types of training - the medics required more of the evidence based information, while the midwives required information on the practical elements of the intervention. The focus groups also revealed that finding the time to do widespread training was difficult and many of the innovations developed by the midwives concentrated on how to deliver the training quickly and efficiently.

What difference has this made?

All the trusts/maternity units found that the changes were sustainable and now operate as 'business as usual'.

The longer-term impact of the project has since been evaluated and found that in addition to 76 eligible births treated during implementation of the project, it has been projected that approximately 276 additional eligible births may have been identified (12 per month) and received the intervention. This equates to seven instances of cerebral palsy being prevented across the West of England area since the start of the project.

The estimated lifetime cost per patient with cerebral palsy (including health care, productivity and social costs) is £720,000 for men and £670,000 for women. Therefore, the projected reduced financial impact of PreCePT may be in the region of £5.1 million to date.

**Potential saving of
approximately £5.1 million**

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Nurse Research, Royal Cornwall Hospitals



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For contact details for your local library please visit www.hlisd.org

"Essential assistance in literature searches... as a result... patients will have an improved care pathway."

Oncology Consultant, Taunton and Somerset NHS Trust

"I always get an excellent, friendly, speedy response from the library."

Nurse, Gloucestershire Hospitals NHS Foundation Trust

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Service Improvement Facilitator, Avon and Wiltshire Partnership



A MILLION DECISIONS

Every day more than a million decisions are made across the NHS and healthcare sector. Under the Health and Social Care Act 2012, there is a responsibility for health services to ensure use of evidence obtained from research.

#amilliondecisions is a new campaign from CILIP and Health Education England calling for decisions in the healthcare sector to be fully evidence based, highlighting improvements in quality of care, patient experience and cost effectiveness when healthcare providers and their teams work closely with health librarians and knowledge specialists.

Reduction in cost of treating long-term conditions within acute and primary healthcare

"We needed to present in-depth evidence around options that will reduce costs in both the acute sector and primary care, and to evaluate a range of innovative service models in psychological therapy for long-term conditions."

Having access to a dedicated library and knowledge service negated the need for us to spend time on this and ensures we can confidently and competently ensure that those with a long-term condition can benefit from a psychological intervention".

Damian Brennan, Head of Public Health and Wellbeing Services, Sussex Community NHS Foundation

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