ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA
KNOWLEDGE AND INFORMATION

Collaborating for Better Care Partnership

NORTH EAST QUALITY OBSERVATORY SYSTEM

NICE National Institute for Health and Care Excellence

Exploring NICE guidance (technology appraisals, NICE guidelines and quality standards) implementation in organisations across the North East & North Cumbria region

A telephone survey of provider and commissioner organisations

April 2014

Commissioned by

North East Quality Observatory System

on behalf of

North East and North Cumbria Academic Health Science Network

Undertaken by

Clarity and Partnership Ltd

NEQOS – operated under a joint agreement between Northumberland, Tyne and Wear and South Tees Hospitals NHS Foundation Trusts

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BetterKnowledgeBetterCare

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Executive Summary

The North East Quality Observatory System (NEQOS) commissioned two pieces of research to explore current arrangements, challenges and strengths with respect to the implementation of NICE guidance (technology appraisals, guidelines and quality standards) in the region covered by the North East and North Cumbria Academic Health Science Network.

The studies were conducted by an independent consultancy during the period December 2013 – April 2014 and comprised a telephone survey of NICE guidance (by NICE guidance we mean technology appraisals, guidelines and quality standards) in general and an in depth study relating to specific NICE guidance. This report documents the findings of the telephone survey.

The telephone survey sought the views of one representative from each of the 12 NHS Foundation Trusts (FTs) and each of the 11 CCGs in the North East and North Cumbria region. It achieved a 78% response rate – 10 FTs and 8 CCGs.

In order to generate a comprehensive picture, supplementary interviews were also conducted with representatives from:

- North East Commissioning Support Unit
- NHS England Area Team
- Regional Drug and Therapeutics Centre
- Representatives of pharmaceutical companies

The results identified the organisational structure and processes for receipt, dissemination, implementation and monitoring of guidance, and how these varied. Factors affecting the ease with which guidance has been implemented were also identified. In addition interviewees also outlined how they thought the Collaborating for Better Care Partnership could be most valuable in supporting the implementation of NICE guidance.

1 Background

NEQOS is working with the National Institute for Health and Care Excellence (NICE) and on behalf of the North East and North Cumbria Academic Health Sciences Network (NENC AHSN), to develop a Best Practice Partnership aiming to improve patient outcomes by increasing and accelerating the implementation of best practice guidance.

In order to inform the 'Collaborating for Better Care Partnership' work programme, NEQOS commissioned a survey of NHS providers and commissioner organisations in the NENC AHSN region, exploring, with respect to all types of NICE guidance (Technology Appraisals - Clinical Guidelines; and Quality Standards):

- existing structures and processes for implementation
- local arrangements for measuring and monitoring compliance
- arrangements for partnership working for cross-boundary guidance

2 Methods

The survey team conducted a standardised telephone survey of a nominated representative from each of the 12 NHS Foundation Trusts (FTs) and each of the 11 Clinical Commissioning Groups (CCGs) in the NENC AHSN region using a semi structured questionnaire (Appendix 1).

The representatives were nominated through discussions with contacts in each organisation. These contacts were either existing NICE leads known to either Stephen Stericker (SS), the Regional NICE Implementation Consultant, CCG Chief Officers or CCG Quality Leads.

The semi structured questionnaire included open and closed questions exploring key issues generated by preliminary discussions with local health service managers, clinicians, NEQOS epidemiologists and NICE. It also sought views on appropriate topics for more detailed research, and names of individuals interested in participating directly in the proposed partnership.

The questionnaire was refined following a pilot study and advice from Dr Justin Presseau (JP), who is an implementation researcher at the Institute of Health and Society at Newcastle University. The pilot study led to some questions being omitted so that the telephone interviews could be a more acceptable length i.e. 30 minutes rather than 50 minutes pre-pilot.

The final questionnaire is appended (Appendix 1) and covered the following issues:

- Policies and protocols for managing NICE guidance
- Internal structures and process for receipt, implementation and monitoring of NICE guidance
- Differences in arrangements for technology appraisals, NICE guidelines and quality standards
- Positive and challenging experiences of implementation
- Use of outcome indicators
- Aspirations for the proposed 'Collaborating for Better Care Partnership'
- Topics for further research

Two researchers conducted all of the interviews and jointly did so for the first four interviews to gain shared experience of using the tool and to promote a consistent approach.

In order to generate a comprehensive picture, supplementary interviews were also conducted with:

- The Head of Clinical Quality and the Head of Medicines Optimisation at the North East Commissioning Support Unit (NECS), and the Assistant Director of Clinical Strategy, NHS England Area Team Cumbria, Northumberland, Tyne and Wear
- The Director of Pharmacy and Head of Prescribing Support at the Regional Drug and Therapeutics Centre
- Representatives of GlaxoSmithKline UK and Boehringer-Ingelheim Ltd.

3 Results

Response rate

Details of the interviews completed are summarised in Appendix 2. It shows that interviews were conducted with 10 out of 12 Trusts (77% response rate) and 8 out of 11 CCGs (73% response rate).

Descriptions of the organisational policies and protocols for managing NICE guidance

All of the FTs interviewed described comprehensive policies and protocols for managing NICE guidance. Organisations did agree to send documentation regarding these policies and procedures, but despite follow up, too few were returned to allow meaningful analysis.

Descriptions of the organisational structures and processes for receipt and dissemination of NICE guidance

All FT respondents described organisations with a dedicated individual or team to manage receipt and dissemination of NICE guidelines to directorates and departments for baseline assessment and implementation.

By contrast, CCGs generally reported less direct involvement with receipt and management of NICE guidance.

Descriptions of the arrangements for implementation and monitoring of NICE guidance

All FT respondents reported formal arrangements comprising committee structures which support implementation on behalf of Trust Boards. These arrangements are integrated with clinical audit systems and include formal monitoring systems often with traffic light ratings. These mechanisms were essentially similar within organisations for all types of technology appraisals, NICE guidelines and quality standards.

Examples of the various arrangements are summarised in Box 1.

BOX 1: Examples of the organisational structures and processes for NICE guidance in NHS Foundation Trusts in the NENC AHSN region

Tees, Esk and Wear Valleys NHS FT

The Clinical Audit and Effectiveness Team monitors and receives alerts on new NICE guidance; they forward to Service Development Managers and Clinical Directors in the five specialities in the Trust, who conduct the baseline assessment, assess current practice and pull together a multi-disciplinary event to pull the gap analysis together and create an implementation plan. This event is facilitated by the Clinical Audit and Effectiveness Team, who challenge, seek assurances and apply traffic light ratings to the current position. Monitoring of implementation is undertaken by Quality Assurance Groups in each directorate and the Clinical Audit and Effectiveness Team maintain a corporate database of monitoring information. Reports are submitted to the Quality Assurance Committee, a sub-committee of the Trust board.

Northumbria Healthcare NHS FT

Implementation of NICE guidance is delegated to the Trust's four business units to assess for relevance to them using a grid or spreadsheet. Each unit has the resources to address most implementation issues, namely, clinical leadership, finance, management, and audit. The Clinical Policy Group, a monthly management meeting for all clinical leads, discusses action needed and progress achieved. If a decision is made not to implement guidance, this is signed off by the Medical Director and Trust Board. An example is NICE guidance on community insulin infusions, where the Trust had already invested in other pump methodology. Business units undertake forward planning; horizon scanning is in place and publication of NICE guidance is normally anticipated.

Cumbria Partnership NHS FT

A small team undertakes a daily check of the NICE website. Guidance is forwarded to the six NICE Leads for each area to check relevance and individuals are nominated to do a baseline assessment for their area and provide a NICE scoping report. This feeds into a newly established database which has an algorithm of steps in sequence i.e. publication date, decision about whether NICE guidance is relevant, and so on, through the process. Approval and acceptance of NICE guidance is through Clinical Effectiveness Committees in each area. Minutes of these meetings provide the necessary evidence of implementation. Any necessary actions are recorded for monitoring; all actions must be feasible and achievable and are monitored until complete.

CCG respondents described how they are supported by NECS (within individual service offers), which provides horizon scanning and circulates a monthly document listing newly published guidance (not exclusively NICE guidance) with a commentary on what individual items mean for CCGs.

In addition, the CCG respondents explained that CCG commissioners also attend Clinical Quality Review Groups (QRGs) which have been established around providers. During the QRG meetings, summaries of NICE guidance and the current status of implementation and compliance are presented.

Descriptions of arrangements for gathering evidence of implementation and impact of NICE guidance

All responding FTs described NICE guidance arrangements integrated with clinical governance structures and activity, particularly through clinical audit of compliance with NICE guidance, and through formal reporting and evidence.

NECS is working with CCGs to develop a NICE guidance framework. The framework will inform CCG commissioners about guidance being published, provide an impact analysis, summarise retrospective guidance and signpost where CCGs can obtain assurance on implementation.

NECS is also working with CCGs on how to take NICE guidance forward in commissioning intentions. The 'Service Planning and Reform' section in NECS undertakes project work, pathway redesign and examination of best practice, which can also be taken forward to support implementation of NICE guidance.

There were no reports of formal structures for monitoring implementation of NICE guidance in primary care. CCGs do have the opportunity to contract with NECS for services from primary care support officers who provide data on variations in practice.

The NHS England Area Team flags up expectations about following NICE guidance in contract documentation in their role as specialist commissioners, but provides only light monitoring of implementation. They take the view that the principal mechanism for NHS Trusts and commissioners to work together on NICE guidance is the Quality Review Groups described above. In relation to primary care, the Area Team has resources in the Primary Care Surveillance Group, and is developing a framework setting out expected outcomes from primary care; this may be helpful in the wider sense.

Descriptions of the use of NICE implementation tools

FT interviewees explained that it was difficult to fully utilise the NICE audit templates to aid the baseline assessment of current practice, due to the lack of computerised medical records. In practice, any audits must be done manually by trawling notes, and manually inputting data into the templates.

The survey could not elicit whether commissioners used or valued any of the NICE commissioning tools.

Descriptions of the use of metrics or indicators to monitor impact

Responses to questions regarding the use of metrics were generally limited. One Trust referred to the use of NICE Outcome Indicators which are used to check against the Trust's internal monitoring systems and a small number of others mentioned their use of Quality Standards. None of the respondents said they used QOF indicators in the context of monitoring implementation of NICE guidance.

Descriptions of the factors which have affected the ease with which NICE guidance has been implemented

Interviewees identified 13 different factors which had affected implementation of NICE guidance and their responses are summarised in Table 1. There were more barriers (8 out of 13 i.e. 62%) than enablers (5 out of 13 i.e. 38%) Further information on these factors is summarised in Table 2.

Table 1

Factors which have acted as barriers to implementation	Factors which have enabled implementation
1. Changing thresholds	1. "Simple" guidance
2. Variable commissioning priorities	2. Leadership factors
3. Requirements for additional capacity	3. Trust preparedness
4. Requirements for new investment	4. Relevance to desired service improvements
5. Requirements for co-ordination across departments or organisations	5. Communication
6. Guidance which generates unanticipated clinical problems	
7. NICE guidance which is at odds with professional consensus	
8. The opportunity costs of monitoring or measuring impact	

For further information on these factors is summarised in Table 2.

Table 2: Interviewees' reports of their experience of factors affecting NICE guidance implementation

Factors which have acted act as barriers to implementation	Factors which have enabled implementation
1. **Changing thresholds -** The indication or threshold for use of some drugs may change such that many more patients are now eligible to be prescribed it and this might create funding issues with implications for variable pace of implementation across the region. An example is TA 274 Lucentis for treatment of macular oedema. 2. **Variable commissioning priorities -** Trusts have to work with multiple commissioners across geographies and over time. Different commissioners inevitably have different priorities and financial constraints. This creates real problems for Trusts faced with developing new services and implementing the associated NICE guidance e.g. autism. The result can be variability in the pace of implementation of guidance within one Trust but across its localities. **3. Requirements for additional Capacity -** For example, CG162 on stroke rehabilitation where additional capacity has been required to offer 45 minute physiotherapy sessions. **4. Requirements for New Investment -** Business cases may be needed to fund additional equipment , e.g. for the increased population requiring myocardial perfusion scans. **5. Requirements for co-ordination across departments or organisations -** Guidance which applies to all departments in a Trust may be more challenging to implement due to the complexities of co-ordinating implementation and monitoring across the whole organisation. Cited examples included**:** • Any public health guidance • Guidance on hypertension or adult	1. **"Simple" guidance -** Certain types of guidance were reported as easier to implement. These were guidance which has a narrow focus, tackles a single issue, where there is clear evidence of compliance, and where baseline assessment is straight-forward. Typical examples included guidance on hypophosphatemia in chronic kidney disease or hypertension in pregnancy. This latter guidance was straightforward to implement because, as well as being a single issue, the Trust had already achieved NHSLA level. 2. **Leadership factors -** Interviewees described how implementation had been straightforward because the clinicians in the relevant department were part of the NICE team which developed the guideline, or were closely involved in drafting it; examples given related to Quality Standards on antenatal care and on hypertension. One Trust had also led a successful multidisciplinary improvement event which identified gaps in compliance with guidelines on autism thus proving a strong baseline assessment. In another example, implementing the guideline on depression in a large acute Trust worked well because of senior clinical leadership and a mandate from the Trust Medical Director which produced effective engagement. Yet another example described how the haematology department had led to the implementation of guidance relating to prevention of venous thromboembolism

depression in acute Trusts.
- Guidance on prevention of venous thromboembolism, and falls prevention in mental health services.

6. **Guidance which generates unanticipated clinical problems** – One interviewee described occasions where implementation had led to clinical problems. For example anticoagulation therapy in orthopaedics, resulted in eight significant bleeds which were reported to the MRHA and a decision not to implement the relevant NICE guidance. According to the respondent, these incidents and other reports led to NICE altering their guidance.

7. **NICE guidance which is at odds with professional consensus -** Respondents cited regional guidelines for the management of urinary tract infections in children which are different to those issued by NICE.

8. **The opportunity costs of monitoring or measuring impact -** Interviewees reported that providing evidence can be time consuming. It can take considerable time to conduct baseline assessments for some large guidelines and whilst it might be relatively easy to collate soft evidence of implementation, it can be challenging to obtain more formal evidence. A good example is the patient experience guideline. Interviewees indicated that leadership is essential in terms of reconciling the opportunity costs and benefits of evidence gathering.

throughout other hospital departments.

3. **Trust preparedness -** One respondent described how publication of a guideline had coincided with its existing work on service improvement i.e. the guideline on managing violence in a mental health setting. For this issue, the Trust had already identified an existing lead and steering group; work on compliance was well underway and evidence on implementation was readily available.

4. **Relevance to desired service improvements** - In a number of reported examples Trusts were able to use a guideline to make a successful business case for an improved service, or to make a service more clinically and cost effective: Examples include business case for additional rheumatology nurses to meet a rheumatology guideline; and using a technology appraisal on hip replacement to audit and reduce the variety of prostheses in use to achieve better and cheaper outcomes. Other examples included linking implementation of NICE guidance with work on community pathways to reduce hospital stay. In one example, a whole pathway review incorporated all relevant NICE guidance.

5. **Communication -** Interviewees highlighted the importance of effective and wide communication and the value of a dedicated page on a Trust intranet.

Responses to questions relating to the planned NICE guidance implementation collaborative

The interviewees nominated individuals whom they considered would be willing to engage with the NICE Collaborative from their organisation. These names are listed in Appendix 3.

Interviewees also outlined how they thought the Collaborative could be most valuable and these responses are summarised in Box 2

BOX 2: Interviewees' views of the potential opportunities for a regional NICE guidance implementation collaborative (now called 'Collaborating for Better Care Partnership')

- *Network wide meetings* - Focusing on specific topics, such as large guidelines, or to gather support for major pathway changes.
- *Regional benchmarking and audit, and sharing good practice* - the opportunity to share practice with similar providers and learn from examples of innovative practice; identify methods of promoting NICE guidance without generating an additional burden of work. Specific support on managing the burden of baseline assessment and gathering monitoring data could also be useful alongside linking the implementation of NICE guidance to improved health outcomes.
- *Cross boundary working* - A regional forum to promote cross boundary working across primary, secondary and tertiary care, across acute and mental health services, between health and social care and with public health, would be welcomed. An example could be looking at a whole system approach focusing on primary care as the lead agency.
- *Clinical engagement* - a useful topic where Trust wide engagement and compliance has proved challenging; also, developing clinical champions and supporting leadership development.
- *Prioritisation and relevance* – help in identifying which guidance is particularly relevant to commissioners, which guidance needs no further attention currently; and help in prioritising guidance where a high volume is published over a short time period.

4 Conclusions

Whilst the survey described established arrangements for implementing NICE guidance across all the FTs, research repeatedly highlights that guidance is not always implemented consistently.

At a recent masterclass delivered by Professor Jeremy Grimshaw, the following information was presented: *Consistent evidence of failure to translate research findings into clinical practice*[1]

- 30-40% patients do not get treatments of proven effectiveness
- 20-25% patients get care that is not needed or potentially harmful

The NEQOS survey had a response rate for over 70% with respect to both FTs and CCGs. This level of response enables some conclusions to be drawn regarding the picture across the NENC AHSN region with respect to the implementation of NICE guidance. However, all of the information from the survey is based on the views of only one representative for each organisation so that the results could be biased or incomplete.

The survey failed to elicit any comments from a patient and/or public perspective on the implementation of any guidelines and this would need to be further explored in any additional research. Also noteworthy is the lack of comments referring to the evidence base supporting implementation.

Despite any limitations, it is possible to conclude that the NEQOS survey has shown that:

1. Across the NENC AHSN region there are wide discrepancies between primary care and FTs with respect to implementing NICE guidance. All FTs have established structures and processes but such arrangements are relatively poorly developed with respect to primary care.

2. FTs find it difficult to routinely use NICE or other audit tools as a means of promoting implementation. This is due to the lack of computerised medical records and the consequent resource implications of manual data extraction.

3. Measuring the impact of NICE guidance on patient processes and outcomes is not a routine practice throughout the region.

4. Numerous factors can promote or hamper progress with respect to NICE guidance implementation in the region. The factors which interviewees identified could be classified into three key areas:

    a) the nature of the guidance i.e. guidance is less likely to be implemented successfully if it:

        i. is complex and multifaceted covering multiple areas of practice
        i. requires coordination across departmental boundaries within or beyond organisations

[1] Schuster, McGlynn, Brook (1998) Millbank Memorial Quarterly
Grol R (2001). Med Care

ii. carries resource implications in terms of new service developments or additional staffing or time
iii. conflicts with local professional consensus
iv. generates unanticipated clinical problems

b) the intra-organisational context i.e. guidance is more likely to be implemented successfully if the relevant organisation
   i. can use it to strengthen a desired business case
   ii. is already working to develop that area of care
   iii. has an effective method of communicating with its staff, e.g. a successful intranet
   iv. has effective local leadership for the relevant issue

c) the external organisational context i.e. NHS changes - (commissioners, financial pressures, organisational boundaries). These make it especially challenging for providers seeking to implement guidance, problems which are magnified for providers such as mental health Trusts which have services across multiple commissioning populations.

d) There is generalised support for a regional Collaborative to support the implementation of best practice guidance. Such a Collaborative will be most valuable if it provides for either:
   i. Network wide meetings to focus on complex guidelines affecting major pathways
   ii. Regional benchmarking and audit, and sharing good practice
   iii. Cross boundary working
   iv. Clinical engagement to develop clinical champions and leaders
   v. Support for commissioners in terms of prioritising the guidance in terms of relevance, impact or uptake

5 Recommendations

This small health service survey has identified some of the key issues experienced by providers and commissioners in the NENC region with implications for NEQOS, NENC AHSN and NICE.

Recommendations to NEQOS

1) In developing the 'Collaborating for Better Care Partnership', NEQOS should:
   a) draw on the pool of nominees identified in the survey (Appendix 2)
   b) draw on the aspirations identified in the survey (Box 2)
   c) refer to the various structures and processes existing in FTs and primary care
   d) focus on factors identified in this survey which could be modifiable by, or relevant to, a collaborative approach, i.e.
      I. Enabling intra-organisational leadership for NICE guidance implementation
      II. Enabling cross—boundary leadership for NICE guidance implementation
      III. Developing and embedding routine measurement of the impact of NICE guidance on patient processes and outcomes

IV. Prioritising cross-boundary guidance, especially:
   - Any public health guidance
   - Guidance on hypertension or adult depression in acute Trusts
   - Guidance on prevention of venous thromboembolism, and falls prevention in mental health services

2) In meeting regional needs for better care metrics, NEQOS should develop tools which enable providers to routinely measure and monitor their achievement of NICE guidance.
3) Ensure that the public and patient involvement thread is embedded in any further research undertaken.
4) Explore the role of evidence to support implementation.

Recommendations to NENC AHSN:

In addition to supporting the 'Collaborating for Better Care Partnership', the NENC AHSN Board should consider promoting the implementation of best practice guidance by championing:

- technologies to automate audit in hospital settings
- organisational development to support NICE guidance implementation in primary care

tools to measure the uptake of best practice guidance and its impact on patient processes and outcomes

Recommendations to NICE:

In addition to supporting the 'Collaborating for Better Care Partnership', NICE should consider how to adapt its own approaches to supporting implementation to reflect the challenges associated with:

i. Audit in acute hospitals with manual records
ii. Tools to measure patient processes and outcomes associated with NICE guidance uptake
iii. The guidance itself i.e.
   - Complex guidance
   - Guidance which crosses intra-organisational or inter-organisational boundaries
   - Guidance associated with potential patient safety concerns
   - Guidance at odds with professional consensus

Appendix 1

Semi Structured Script and Interview Questions

Interviewee Name

Q1 Contact details email

Telephone

Organisation

Organisation Type:

CCG / NHSE / NHST / NHSFT / NHSFT Mental Health / University / Local Authority / Other [specify_____]

Job Title

There is some deliberate overlap in these questions to ensure topics are covered

Cover NICE Guidance, Quality Standards and Tech Appraisals in each question, as relevant (hereafter referred to as NICE Guidance)

Initially pilot with 3 or 4 organisations and then amend as appropriate

Introduction

Thank you for talking to us, we will not take more than 30 minutes of your time.

I/we am/are ….. from Clarity and Partnership Ltd, we are working for the AHSN / NEQOS

The background to this interview is that it is part of the initial work to establish a programme of work under the auspices of the North East and North Cumbria Academic Health Science Network. The purpose of the work is to improve services for patients by optimising the use of NICE products.

The AHSN is funded to deliver this work for a five year period and this is one of the major themes. Through the AHSN, NHS, local authority and some partner organisations will have access to local and international expertise.

We are undertaking this survey in order that this work can be based on a good understanding of the present situation in relation to the implementation of NICE guidance in the area. It will comprise two parts – the first part is the project that you are helping us with now, which will give an overview of the present situation. The second part will be to undertake a 'deep dive' into a number of specific topics or programmes so that we can get a detailed understanding of those particular areas.

Q2

a) Does your organisation have a policy and / or protocol on managing NICE GUIDANCE?

Y / N

b) If yes can we have a copy Y / N

c) How effective is it: excellent / good / satisfactory / not satisfactory

Q3

Now thinking about your organisation's internal structures / processes

In relation to NICE Guidance etc. what is your organisation's system for:

Topic	*Comment / Description*
a) Receipt	
b) Baseline assessment process	
c) Discussion/acceptance/approval	

d) Costing and funding	
e) Dissemination	
f) Implementation	
g) Monitoring	
h) Gathering evidence of implementation and impact	

j) Reporting back to the Board or a Board Sub-committee	
k) Engaging with partners on cross boundary guidance	

How do these structures and processes fit with:

	Please describe
l) Clinical governance structures and programmes	
m) Other quality improvement activity	

Q4

Does the way that you handle Technical Appraisals, Guidelines and Standards Differ?

If YES please explain the differing approaches to each form of guidance

Technical appraisals

Guidelines
Standards

Q5 Please can you talk through a couple of recent examples of implementation, ideally one that was straightforward and one that was not?

Straightforward

Not Straightforward

Q6 We would like to ask you about information feedback to your organisation TABLE PLEASE

a) Do you have access to NICE Outcome Indicators (CCG / Quality Standards / QOF information sets relevant to the organisation) Y / N

b) Do you use any of the following: c) How valuable are they in promoting the use of Nice Guidance

Indicators	Y	N	d/k	n/a		Not valuable	Quite valuable	Very valuable
CCG								
Quality Standards								
QOF								

Q7 Do you have any examples of good practice

Q8

a) Do you have any recommendations for 'deep dive' topics?

b) Why do you think that this (they) would be a good topic(s)?

c) Who should we talk to about this topic?

Q9 Another part of this project is to understand how NICE outputs influence prescribing

Who in your organisation is responsible for prescribing guidance? Contact details	
Who is responsible for prescribing information systems Contact details	
Who is responsible for monitoring expenditure Contact details	

Q10 What support would you find most useful from the Collaborative and more widely from the AHSN

Q11 We have been asked to identify who from your organisation should be invited to engage with the work of the Collaborative; this can be any number of people or roles

Name	Title	Contact details

Q12

Before we finish is there anything else that you would like to tell me/us?

Thank you very much for your help

Appendix 2: Details of the interviews completed
Trusts –interviews achieved for 10 of 12 Trusts

Organisation	Contact	Date of interview
City Hospitals Sunderland NHS FT	Gary Schuster Clinical Governance Manager Gary,Schuster@chs.northy.nhs.uk	27/12/13
County Durham and Darlington NHS FT	Helen Rutter* Clinical Effectiveness Lead Helen.Rutter@cddft.nhs.uk	31/12/13
Cumbria Partnership NHS FT	Robert Donlevy Robert.donlevy@cumbria.nhs.uk	15/1/14
Gateshead Health NHS FT	Sue Winn Head of Compliance and Assurance Sue.winn@ghnt.nhs.uk	9 /1/14
North Cumbria University Hospitals NHST	Dr Peter Weaving GP Clinical Director Peter.weaving@ncuh.nhs.uk	No response in the timeframe of this project
North Tees and Hartlepool NHS FT	Terry Holdcroft Quality and Clinical Effectiveness Manager Terry.holdcroft@nth.nhs.uk mailto:Terry.holdcroft@nth.nhs.uk	20/1/14
Northumberland Tyne and Wear NHS FT	Eryk Grant* Clinical Effectiveness Manager Eryk.grant@ntw.nhs.uk mailto:Eryk.grant@ntw.nhs.uk	13/12/13
Northumbria Healthcare NHS FT	Dave Evans Medical Director Dave.evans@northumbria-healthcare.nhs.uk	23/12/13
South Tees Hospitals NHS FT	Dr Nicholas Quinn Chair, NICE Action Group Nicholas.Quinn@stees.nhs.uk	No response in timeframe of this project
South Tyneside NHS FT	Jan Smith Quality Lead, Quality, Research and Clinical audit Jan.smith@stft.nhs.uk and Dr Jon Scott Clinical Lead for Clinical Governance Jon.scott@stft.nhs.uk	Jan Smith 30/12/13 Jon Scott 6/1/14
Tees, Esk and Wear Valleys NHS FT	Nick Land Medical Director Nick.land@nhs.net	30/12/13
The Newcastle upon Tyne Hospitals NHS FT	Steve Stoker Clinical Effectiveness Manager Steven.stoker@nuth.nhs.uk	10/1/14

**Note: colleague no longer understood to be in post; at the time of writing the new contact at County Durham and Darlington NHSFT is Denise Kirkup (denise.kirkup@cddft.nhs.uk)*

CCGS -interviews achieved for 8 of 11 CCGs

Organisation	Contact	Date of interview
Darlington CCG	Elizabeth Graham* Chief Nurse and Head of Quality Elizabeth.Graham6@nhs.net	6/1/14
Durham Dales, Easington and Sedgefield CCG	Dr Dinah Roy* Director of Clinical Quality and Performance Dinah.roy@nhs.net	19/12/13
Hartlepool and Stockton on Tees CCG	Ali Wilson Chief Officer Awilson18@nhs.net	21/1/14
Newcastle East,West and Gateshead CCG Alliance	Dr Neil Morris Medical Director neilmorris@nhs.net	6/1/14
North Cumbria CCG	Via Dr Peter Weaving GP member Peter.weaving@ncuh.nhs.uk	No response in the timeframe of this project
North Durham CCG	Dr Ian Davidson Director of Quality and Safety Iandavidson2@nhs.net	4/2/14
North Tyneside CCG	Pauline Fox Head of Governance Pauline.fox@northtynesideccg. nhs.uk	16/12/13
Northumberland CCG	Viv Braithwaite Head of Quality and Patient Safety/Lead Nurse v.braithwaite@nhs.net	5/3/14
South Tees CCG	Amanda Hume Chief Officer Amanda.hume@nhs.net Clinical Lead Iain Marley Iain.Marley@nhs.net	No response in the timeframe of this project
South Tyneside CCG	David Hambleton Chief Executive David.hambleton@sotw.nhs.uk	No response in the timeframe of this project
Sunderland CCG	Dr Geoff Stephenson Medical Director g.stephenson1@nhs.net	3/2/14

**Note: colleague no longer understood to be in post;*

Other interviews

Organisation	Contact	Date of interview
NECS	Anne Greenley Head of Clinical Quality Anne.greenley@nhs.net	Interview complete 20/1/14
NECS	Janette Stephenson Head of Medicines Optimisation Janette.Stephenson1@nhs.net	Interview complete 21/02/14
NHS England Area Team Cumbria, Northumberland, Tyne and Wear	Tony Baldasera Assistant Director of Clinical Strategy Tony.baldasera@nhs.net	Response received 18/03/14
Regional Drugs and Therapeutics Centre	Sue Dickinson Director of Pharmacy Sue.dickinson@nuth.nhs.uk mailto:Sue.dickinson@nuth.nhs.uk Bhavanna Reddy Head of Prescribing Support Bhavanna.reddy@nuth.nhs.uk	Interview complete 18/12/13

Appendix 3 - Individuals willing to engage with the work of the BPP

Organisation	Name	Job title	Contact
City Hospital Sunderland NHS FT	Gary Schuster	Clinical Governance Manager	Gary.schuster@chs.northy.nhs.uk
	Richard Castling	Clinical Governance Facilitator	Richard.castling@chsft.nhs.uk
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