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

An in depth study of the implementation of NICE guidance (technology appraisals, NICE guidelines and quality standards) July 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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[1] The behaviour change wheel; A new method for characterising and designing behaviour change interventions: Susan Michie et al; Implement SCI.2011; 6:42. Published online 2011 April 23.doi: 10.1186/1748-5908-6-42

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 (by which we mean technology appraisals, NICE guidelines and quality standards) in the region covered by the North East and North Cumbria Academic Health Science Network (NENC AHSN).

The studies were conducted by an independent consultancy in the period December 2013 – April 2014 and comprised a telephone survey of the implementation of the NICE guidance in general and an in depth study of some specific NICE guidance. This report is about the in depth (or 'deep dive') study (technology appraisals, NICE guidelines and quality standards).

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

The deep dive survey, which followed the telephone survey, explored implementation issues relating to the following NICE guidance:

- New oral anticoagulants – Dabigatran TA249 published March 2012 NICE Technology Appraisal TA249
- Autism in children and young people - CG 170 published August 2013 NICE Clinical Guideline 170 and QS 51 published January 2014 NICE Quality Standard 51
- New treatments for Type 2 Diabetes - CG 87 published May 2009 NICE clinical guideline 87 Type 2 diabetes - newer agents and TA 203 NICE Technology Appraisal TA203

These topics were selected because the telephone survey had revealed them to be current concerns in CCGs or Trusts and they reflected the diversity of NICE guidance topics and types of NICE guidance, i.e.

- specific drug treatments
- the needs of specific populations
- new treatments for common long term conditions
- technology appraisals (two), clinical guidelines (two) and quality standards (one)

Organisations were approached on the basis of their comments during the earlier telephone survey and their reported enthusiasm for being involved in the detailed study into the selected topics.

The survey team achieved an overall 70% response rate for the deep dive survey. Rich insights were garnered into the factors that were perceived as explaining variable uptake of the guidance and also the potential value of the Collaborating for Better Care Partnership in supporting the implementation of NICE guidelines.

1. Background

The North East Quality Observatory System (NEQOS) is working on behalf of the North East and North Cumbria Academic Health Sciences Network (NENC AHSN) to develop a collaborative approach to raising standards of patient care. The collaborative, named the 'Collaborating for Better Care Partnership' aims to maximise the uptake of NICE and other best practice guidance.

NEQOS commissioned a suite of work to support the launch and development of the Partnership and this included studies to explore current approaches to implementing NICE guidance in provider Trusts and CCGs throughout the NENC AHSN region.

2. Introduction

This study followed an earlier telephone survey which had provided an overview of organisational approaches (please see separate report 'A telephone survey of provider and commissioner organisations', April 2014). It set out to establish a more detailed understanding of the approaches described in the telephone survey.

The study was conducted for NEQOS by Clarity & Partnership Ltd, an independent consultancy in the NENC region.

3. Aims and objectives of the study

- To provide a detailed description of the implementation of NICE guidance (technology appraisals, NICE guidelines and quality standards) in different settings.
- Specifically, to describe and compare different organisations' experiences of implementing NICE guidance in relation to three different health topics.

4. Methods

4.1 Health issues & related NICE guidance selected for study

- New oral anticoagulants – Dabigatran TA249 published March 2012 NICE Technology Appraisal TA249
- Autism in children and young people - CG 170 published August 2013 NICE Clinical Guideline 170 and QS 51 published January 2014 NICE Quality Standard 51
- New treatments for Type 2 Diabetes - CG 87 published May 2009 NICE clinical guideline 87 Type 2 diabetes - newer agents and TA 203 NICE Technology Appraisal TA203

These topics were selected because:

a) they reflected current concerns in CCGs or Trusts - identified in the earlier telephone survey *and*

b) b) they reflected the diversity of NICE guidance topics and types of guidance, i.e.

- specific drug treatments
- the needs of specific populations
- developments in the management of common long-term conditions

c) they represented a range of types of guidance, i.e.
- 2 x technology appraisals
- 2 x NICE guidelines
- 1 x quality standard

4.2 Settings for Study

Organisations were initially approached on the basis of their comments during the earlier telephone survey and their reported enthusiasm for being involved in the detailed study into the selected topics. After initial contact with those interviewed in the telephone survey, the survey team were referred to the most relevant clinicians or managers. However, these individuals were often too time constrained to participate such that a smaller proportion of organisations eventually participated in the study.
The details of the organisations which were approached, and those which participated are summarised in Appendix 1, Table 3.

4.3 Method of eliciting information

Interviews were conducted with the individuals named in Table 2 – either face to face or by telephone - using the semi structured questionnaire appended to this report (Appendix 2). This questionnaire built on the questions in the telephone survey and incorporated concepts from implementation science [2] which emphasises the importance of interventions to address the key organisational and individual factors which influence clinical behaviour. These factors are summarised in Figure 1 (page 14).

5. Results

The survey team achieved an overall 70% organisational response rate for this deep dive survey with a further breakdown as follows:

- Newer anticoagulants: interviews with 4 out of 6 organisations approached (67%)
- Autism: interviews with 2 of the 4 organisations approached (50%)
- Newer treatments for Diabetes – 6 out of the 7 organisations approached (85%)

For all the guidance, the organisational arrangements for implementation were as described in the earlier telephone survey (see separate report 'A telephone survey of provider and commissioner organisations' April 2014).

The interviews provided rich insights into the factors which were perceived as explaining variable uptake of the guidance. These findings are summarised in Table 1.

Table 2 also summarises interviewees' comments on the potential value of the 'Collaborating for Better Care Partnership'.

A key issue for the autism guidance was that it had implications for pathway re-design and/or service development.

[2] The behaviour change wheel; A new method for characterising and designing behaviour change interventions: Susan Michie et al; Implement SCI.2011; 6:42. Published online 2011 April 23.doi: 10.1186/1748-5908-6-42

Table 1: Summary and comparison of the 'deep dive' findings relating to each of the three examples of NICE guidance selected for study

Factors which interviewees identified could explain variable uptake of the relevant guidance

Dabigatran TA249 published March 2012	Autism in children and young people – CG170 and QS 51	New treatments for Diabetes
• Clinicians differ in their perceptions of the usefulness and safety of the drug. Some clinicians believe the drug to be safer than warfarin but others have safety concerns - the anticoagulant effects are not reversible if there is a bleed. These safety concerns are thought to explain the slower uptake of the drug in some services. • Dabigatran denatures quickly once the packaging is opened and it is therefore unsuitable for use in dosette boxes. • Patient choice and shared decision making plays a role – some patients and their doctors like the reassurance that regular INR testing gives them although others find that	• The vast scope of this guidance is across health & social care sectors and organisational boundaries with implications for effective partnership working and resources to implement the service improvements inherent in the guidance and quality standards. • Lack of resources or differences in commissioning budgets - with reports that commissioners in some regions have found it difficult to resource implementation of the autism guidance and providers working with different commissioners experience problems in achieving geographical equity due to variable commissioner resources. • Shortages of specialist staff - the loss of a single-handed consultant can have significant repercussions on the level of service provision which can be provided. • Competing commissioning priorities – autism has to compete with numerous other, potentially more pressing, Commissioner priorities.	• Intra-regional differences in the way Liraglutide has been approved in local formularies. North Tees Drugs and Therapeutics Committee approved the drug in 2010 as an amber drug (i.e. initiated and stabilised in secondary care, and can then be prescribed by GPs) and provided a shared care document. By contrast, the equivalent committee in neighbouring South Tees approved the drug as green (can be initiated and prescribed in any sector). • The loss of a local diabetes network or forum in the Tees area and the need for a regional network. • Inadequate clinical audit - no suitable database across primary and secondary care, lack of real time data in the national diabetes audit and the resource implications of undertaking audits across primary care. • Costs – although many areas were early adopters and high users of the new insulins, the cost implications led to commissioners encouraging a more conservative approach and analogue insulins are no longer prescribed as first line choices for patients requiring insulin. • CQUIN indicators could address quality issues but cannot be used to control drug usage. • Lack of regional procurement for related issues such as insulin pumps - requiring Trusts to risk developing costly services.

Factors which interviewees identified could explain variable uptake of the relevant guidance

Dabigatran TA249 published March 2012	Autism in children and young people – CG170 and QS 51	New treatments for Diabetes
it is highly inconvenient. • Costs – the additional costs of dabigatran may be offset by the reduction in INR testing. • GPs would welcome clearer guidance as to when to prescribe dabigatran rather than warfarin. • NICE guidance does not appear to consider patient variation - dabigatran is perceived to be less appropriate for the frail elderly with multiple comorbidities. • Audit of TA 259 is difficult because it requires manual extraction of information confirming whether the drug was offered or not.	• The relatively new commissioning structures mean that arrangements linking commissioning with service developments are not yet fully developed. • Partnership working - involving front line staff to support the implementation of guidance might be preferable but is very difficult given the time constraints of hard pressed front line staff who often work in organisations other than those of the lead provider or commissioner. • IT systems – different sectors and organisations use different systems creating significant challenges for monitoring compliance across a pathway.	• Lack of educational support for GP's • Inadequate related support services, e.g. for self-care, especially tailored to at risk groups such as BME communities. • IT – lack of appropriate systems to automate and audit diabetes care in any sector and especially across primary and secondary care. • Poor integration of related services, e.g. retinal screening programme results are issued to primary care not secondary care - better IT systems could overcome this issue and provide real time access . • Lack of adequate integration across primary and secondary care in terms of leadership for coordinating implementation and assuring of standards of care in the community. • Lack of investment in lifestyle issues which could reduce the cost issues associated with drugs and remains the least well addressed dimension of the diabetes related guidelines.

Factors which interviewees identified as supporting uptake of the guidance

Dabigatran TA249 published March 2012	Autism in children and young people – CG170 and QS 51	New treatments for Diabetes
• The Regional Stroke Network which provides a forum to discuss new drugs. • The Regional Drug & Therapeutics Centre [3] - which provided an academic detailing aid as indicated in Figure 2. • The National Stroke Audit which explores anticoagulation. • One respondent described local audits assessing compliance with NICE guidance but explained that this is labour intensive with respect to filling in forms.	• Trust preparedness – the Trust interviewed already undertakes horizon scanning and was therefore prepared in advance of the guidance being issued with plans to complete a Rapid Pathway Development workshop once the guidance was issued. All service re-design reflects a gap analysis and is supported by outcome measures. • Trust systems and processes to promote implementation – a corporate database of NICE guidance; a traffic light system to monitor progress on implementation across all business units; monitoring arrangements accountable to a Quality Assurance Committee. • Trust funding arrangements to ring fence resources required for implementation. • Staff motivation to implement NICE guidance and improve services to meet the needs of patients.	• Successful local diabetes networks - North of Tyne, Tyne Valley, a steering group across three CCGs in Durham and Darlington working with an advisory group in the Foundation Trust. • In one area there is a successful stepped approach for new treatments with local prescribing guidelines based on cost effectiveness. • Another area ensures that specialist diabetes nurses guide prescribing in primary care based on secondary care practices. • A highly motivated clinical community of interest across the health economy.

[3] RDTC. New Drug Evaluation Number 111; Dabigatran in atrial fibrillation; October 2011. http://rdtc.nhs.uk/sites/default/files/publications/nde_111_dabigatran_a.pdf

Interviewees' feedback for the regional 'Collaborating for Better Care Partnership'

Dabigatran TA249 published March 2012	Autism in children and young people – CG170 and QS 51	New treatments for Diabetes
• There was little support for the 'Collaborating for Better Care Partnership' to address this specific guidance because relevant clinicians are already involved in the stroke network and the additional workload or other meetings would be too much for already time-pressed clinicians.	• The 'Collaborating for Better Care Partnership' was considered to offer a valuable role in supporting cross boundary implementation of NICE guidance. • Specifically, the partnership could provide a forum for relevant staff from a range of organisations to discuss NICE guidance which applies to a range of organisations and to explore the relevant and respective contributions of each organisation. Typical topics include smoking cessation, depression, dementia. • Such a forum could provide the means of communication and maintain the organisational memory which is lost through successive NHS reforms. An emphasis on practical realities rather than theoretical discussions would be most valuable.	• Views regarding the value of the 'Collaborating for Better Care Partnership' with respect to diabetes were mixed. Existing local networks are strong in some areas but lacking in others. There was a recognised need to strengthen integration across primary and secondary care, assure standards of care in the community, identify opportunities for regional procurement, and promote the implementation of guidance relating to lifestyle and self-management.

Table 2: A summary of the factors which could either explain variable uptake or improve uptake of NICE guidance - based on the survey findings

Factors which interviewees identified as factors which could explain variable uptake of NICE guidance	Factors which interviewees identified as supporting uptake of the guidance
Specialist guidance which crosses health & social care sectors and organisational boundaries has significant implications for effective partnership working and resources to implement the service improvements • Partnership working across boundaries is labour and time intensive • The frequently changing commissioner landscape is especially relevant to such guidance which may be slow to implement and which may require mature commissioning arrangements • Shortages in specialist staff • Competing priorities for commissioners • IT systems – different sectors and organisations use different systems creating significant challenges for monitoring compliance across a pathway **New drugs** • Local Trust formularies vary in their level of approval • Clinicians vary in their readiness to prescribe - according to personal perceptions of the drugs' usefulness and safety • Where alternatives exist, GPs may need help in how to choose • There may be practical implications for packaging and storage	• Clinical networks - local and/or regional • Regional support services, e.g. the Regional Drug & Therapeutics Centre • CQUIN indicators • Regional procurement to minimise Trust risks for costly service developments, e.g. insulin pumps • Educational support for GPs • System perspective – ensures relevant support services are developed to enable implementation to reduce needs for costly drugs, e.g. self-care, pulmonary rehabilitation • IT systems to automate audit within and across settings • Leadership across primary and secondary care to integrate and coordinate implementation • National or Local Clinical Audits • Trust preparedness - horizon scanning, gap analysis and service re-design processes; systems and processes to promote implementation; funding arrangements to ring fence implementation costs; formulary guidelines • Staff motivation • Specialist nurses to support and educate GPs

• Patients vary in their preferences and readiness to change and also their suitability for a drug depending on side effects • Costs - commissioners and Trusts may seek to contain costs • Audit of drugs with alternative options is difficult in Trusts because it requires manual extraction of information confirming whether the drug was offered or not • Audit of drugs across primary and secondary care is very difficult without real time intelligence	

6. Conclusions

The survey team achieved an organisational response rate of over 78% although this was dominated by responses from Foundation Trusts and NECS representatives with only one CCG participating directly in the study. The lack of CCG involvement was especially evident with respect to autism related guidance.

As the focus for the deep dive surveys were identified by respondents to the initial telephone survey no Public Health guidance was included, therefore issues relating to this important topic were not identified. This may be rectified if further research is undertaken.

As in the previous telephone survey, no information has been elicited from a patient/public perspective, again this could be rectified in any future study.

With respect to the guidance studies, the results indicate that:

- Uptake of Dabigatran is variable and that this clinical variation reflects clinical preferences rather than organisational arrangements for NICE guidance implementation. Clinical preferences appear to be driven by concerns over perceptions of the safety profile of the drug and its suitability for different patients.
- Implementation of NICE guidance for patients with autism is also variable because of the challenges of promoting uptake across sectors and developing services in the context of changing commissioning arrangements and competing priorities.
- Uptake of guidance for new Diabetes treatments also varies. Prescribing varies according to local arrangements and formulary guidelines alongside commissioning initiatives to contain drug costs. Lifestyle related guidance for diabetes appears to be least well implemented.

The study provided valuable insights into factors that are known to influence the implementation of NICE guidance in the region. Some of these factors are topic specific but others are more relevant to all of the guidance. Despite enquiring, the survey gave few insights into the person factors outlined in the Behaviour Wheel (Figure 1, page 14) but emphasised organisational or guidance related factors.

The common determinants of uptake of NICE guidance are summarised in Table 2 which also summarises the interventions which could improve uptake of NICE guidance.

The ‘Collaborating for Better Care Partnership’ provides an opportunity to support implementation by:

- Enabling clinical leadership and facilitating clinical engagement on topics for which there is no existing regional network
- Facilitating dialogue to clarify roles and responsibilities for topics which cross sectors or organisational boundaries
- Promoting a sustainable organisational memory in the context of perpetually changing NHS commissioning structures
- Offering a neutral space to debate care issues independent of the competing priorities of commissioners

7. Recommendations

7.1 To NEQOS in developing the 'Collaborating for Better Care Partnership'

- The Partnership should avoid duplicating the work of existing regional/local networks
- The Partnership should provide a forum to support clinical discussions relating to implementation and inspire front line staff to provide best practice
- The Partnership should provide a means of filling the leadership gaps outlined in the recommendations to the NHS, i.e. across primary and secondary care, across populations
- The Partnership should support regional clinical audit whilst minimising labour intensive approaches
- The Partnership should highlight to the regional NHS bodies key service gaps and development needs

7.2 To the AHSN in innovating to raise standards of care

- The AHSN should support initiatives which support the development of real time automated intelligence across primary and secondary care

7.3 To NICE

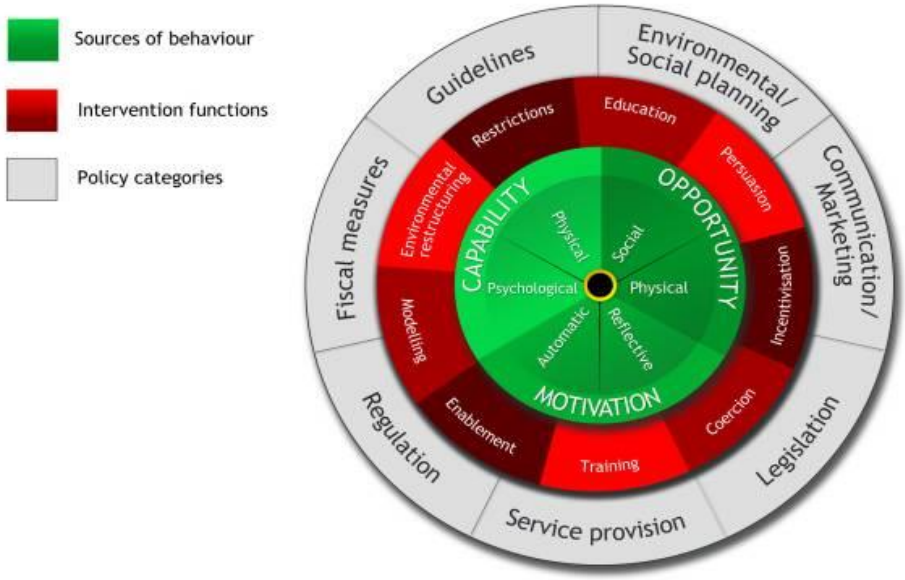
- NICE should differentiate between 'simple' and 'complex' guidance in terms of support for implementation
- NICE should avoid implementation tools based on electronic audits in hospitals or across primary and secondary care
- When issuing complex guidance, NICE should consider nominating accountable organisations to lead implementation of guidance

7.4 To the NHS

The NHS should recognise and act to address the following organisational factors which undermine implementation of NICE guidance (with subsequent implications for patients):

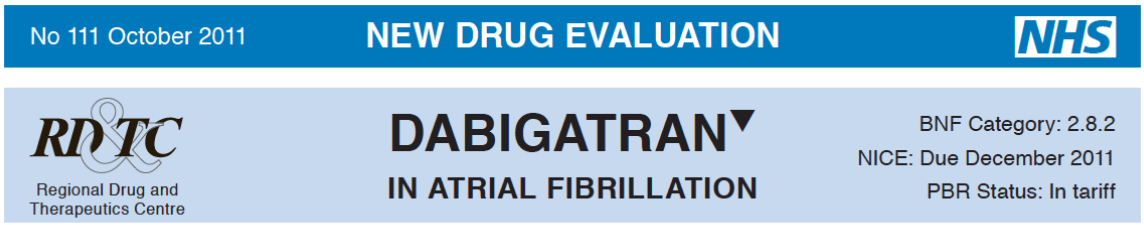
- Frequent changes in the commissioning landscape with implications for commissioning capability
- Lack of effective leadership / accountability across primary and secondary care
- Lack of effective leadership / accountability across sectors
- Inadequate real time automated intelligence to support clinical audit
- Lack of electronic records in Trusts
- Lack of population leadership to address 'system' gaps in services to enable effective implementation
- Lack of regional procurement.

Figure 1: The Behaviour Change Wheel [4]



[4] The behaviour change wheel; A new method for characterising and designing behaviour change interventions: Susan Michie et al; Implement SCI.2011; 6:42. Published online 2011 April 23.doi: 10.1186/1748-5908-6-42

Figure 2: Excerpt from RDTC bulletin



No 111 October 2011 NEW DRUG EVALUATION NHS

RDTC Regional Drug and Therapeutics Centre

DABIGATRAN▼
IN ATRIAL FIBRILLATION

BNF Category: 2.8.2
NICE: Due December 2011
PBR Status: In tariff

Dabigatran is a thrombin inhibitor indicated for the prevention of stroke and systemic embolism in patients with atrial fibrillation. Unlike warfarin, it does not require regular monitoring using blood tests. Dabigatran 110mg has been shown to be non-inferior to warfarin in the prevention of stroke and systemic embolism, while dabigatran 150mg has been shown to be superior. Both are associated with lower or comparable levels of bleeding. The adverse effect profile is similar to that of warfarin, but cost, lack of an antidote and relatively short-term safety data are disadvantages.

Appendix 1 Table 3: A summary of the organisations which were approached and those which participated in the study.

	Oral anticoagulants	Autism	New treatments for Diabetes
Organisations Approached to participate in the study	FTs: Northumbria Healthcare, City Hospitals Sunderland, N Tees & Hartlepool CCGs: N Tyneside, Sunderland, Hartlepool & Stockton	FTs: Tees, Esk & Wear Valleys CCGs: N Durham, Darlington, Hartlepool & Stockton	FTs: Northumbria Healthcare, Co. Durham & Darlington, Newcastle upon Tyne Hospitals CCGs: N Tyneside, Durham, Darlington, Newcastle east, west & Gateshead alliance.
Details of individuals and their organisations which participated in the study	FTs: Dr Stuart Huntley, Consultant Physician & Head of Service – Stroke, Northumbria Healthcare Dr Janice O'Connell, Consultant Stroke medicine, City Hospitals Sunderland CCGs: Helen Seymour, Pharmacist, NECS on behalf of N Tyneside CCG Angela Dixon, Pharmacist, NECS on behalf of Hartlepool & Stockton on Tees CCG	FTs: Leanne McCrindle, Head of assurance and effectiveness, Tees, Esk & Wear Valleys CCGs: Dr Ian Davison, Dir Quality & Safety, N Durham CCG	FTs: Dr Stuart Bennett, Consultant Physician & Head of Service - endocrinology & diabetes, Northumbria Healthcare Dr Nicky Leech, Consultant in Diabetes & Metabolic Medicine , Newcastle upon Tyne Hospitals Dr Srikanth Mada, Consultant Endocrinologist Co Durham & Darlington Commissioning organisations: Helen Seymour, Pharmacist, NECS on behalf of N Tyneside CCG Angela Dixon, Pharmacist, NECS on behalf of Hartlepool & Stockton on Tees CCG Dr Ian Davison, Dir Quality & Safety, N Durham CCG

Appendix 2

NICE Best Practice Partnership Stage 1 Development

Clarity & Partnership Ltd

Deep Dive Interviews

Interviewee Name: _____

Q1 Contact details: email _____

Telephone _____

ORGANISATION

Job Title

Deep dive topic(s) covered in interview:

(1) New anticoagulants for stroke care/prevention TA 249 Dabigatran March 2012

Yes/No

(2) Autism CG 170 Aug 2013; QS 51 Jan 2014

Yes/No

(3) Diabetes CG87 newer agents for Type 2 Diabetes May 2009; TA 203 Liraglutide for Type 2 Diabetes October 2010

Yes/No

(4) Aliretinoin for treatment of eczema TA 177 August 2009

Yes/No

(5) Denosumab drug for osteoporotic fractures TA 204 October 2010

Yes/No

Q2 Review organisation's arrangements for receipt, baseline assessment, approval costing/funding, dissemination, implementation, monitoring, evidence gathering, reporting, working across boundaries as recorded in the initial interviews

Q3 In relation to the deep dive topic being discussed, was the process carried out as described in Q2? *If not, please describe below.*

Deep dive 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	

Q4 What was the interviewee's role in implementation?

Q5 Record the interviewee's narrative about implementation in their organisation:

In terms of capability, motivation and opportunity

What interventions (if any) were required, e.g. persuasion, incentivisation, coercion, training, enablement, modelling, environmental restructuring, restrictions, education.

Were any wider policy issues relevant to implementation e.g. guidelines, planning, communication/marketing, legislation, service provision, regulation or fiscal measures?

Q6 In the interviewee's opinion, what made implementation successful?

Q7 What were the barriers to successful implementation and how were these overcome?

Q8 Were any outcome indicators used to monitor successful implementation, and how useful were they?

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

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Have Lightfoot/HSCIC approved use of NDA in order to disclose small numbers?	N/A
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