

Research into practice: a national perspective

Val Moore

Director of Implementation

National Institute for Health and Clinical Excellence

Areas to cover

- NICE guidance
- The NICE implementation strategy
- NHS Evidence

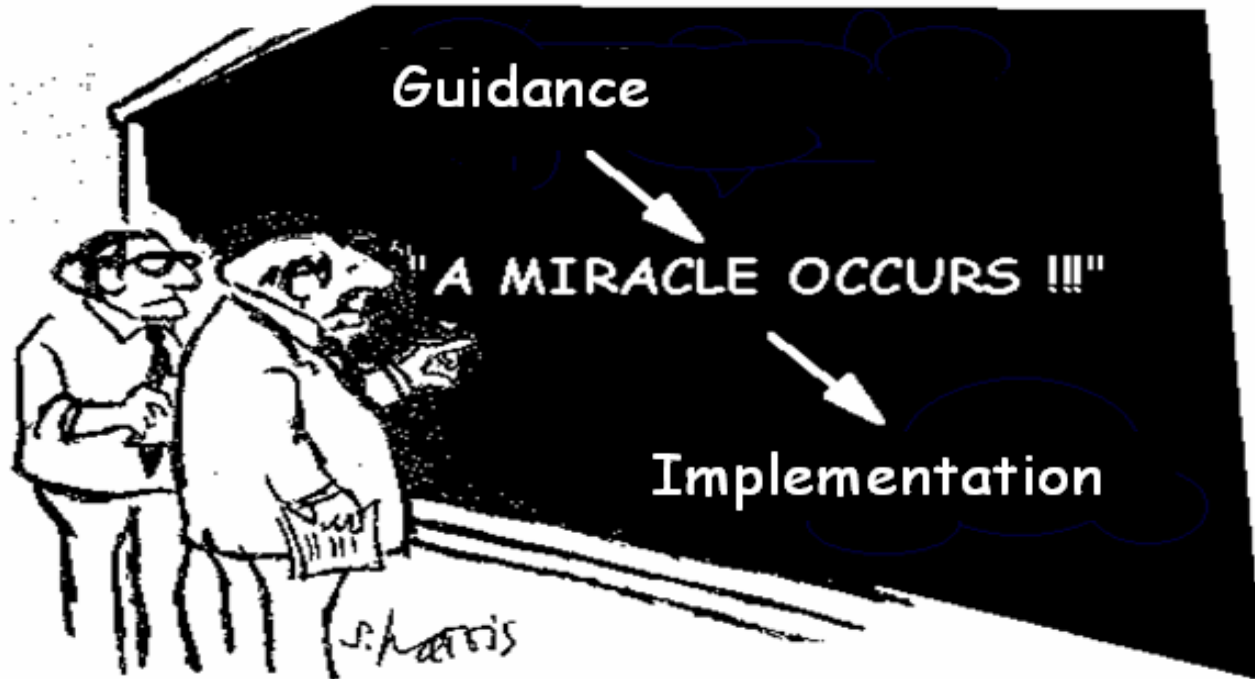


NICE – established 1999

The National Institute for Health and Clinical Excellence (NICE) is the **independent organisation** in the UK responsible for providing national guidance to the NHS and the wider public health community on the promotion of good health and the prevention and treatment of ill health.



.... But how to put this into practice?



I think you should be more explicit here in step two."

Key barriers to implementation

- Clinician distrust
- Lack of organisational support - structures and processes
- Resources (or lack of them)



Feedback from the NHS in 2003

Implementation strategy
launched 2004



- Effective dissemination
- Supportive environment
- Education initiatives
- Implementation tools
- Shared learning
- Evaluation

The NICE implementation programme

Four key aims - to:

- Ensure effective dissemination
- Motivate and inspire
- Provide practical support
- Evaluate impact and uptake



Local leadership is essential

Motivating – using ‘levers’

- Healthcare standards/indicators
- Inspection processes –
Healthcare Commission/CQC
- Commissioning
- Education – CPD and
undergraduate
- Financial arrangements – QoF,
tariff, funding direction



Inspection results - appraisals

Self assessment results – NHS Trusts

	2005/06	2006/07	2007/08
Compliant	84.6%	89.3%	95.1%
Insufficient assurance	11%	7.87%	TBC
Not met	4%	2.79%	TBC

Source: The Healthcare Commission, Annual Health Check

The Quality and Outcomes Framework

- A significant financial incentive mechanism for change in primary care
- NICE has been asked to:
 - Identify clinical and cost-effective new indicators
 - Assess their usefulness in practice alongside potential rates of incentivisation



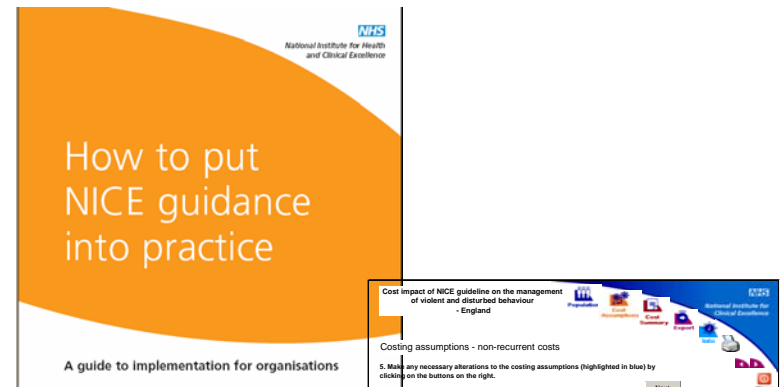
Practical support tools

Generic

- 'How to' guide
- Forward planner
- Shared learning database
- Field team

Guidance specific

- Costing tools
- Slides sets
- Audit criteria
- Commissioning guides



Cost impact of NICE guideline on the management of violent and disturbed behaviour - England

Costing assumptions - non-recurrent costs

5. Make any necessary alterations to the costing assumptions (highlighted in blue) by clicking on the buttons on the right.

Click NEXT to go to recurrent costing assumptions sheet.

	National Population Assumptions		Selected Population Assumptions	
	Standard	Local	Standard	Local
Total weighted population			182,545	182,545
Weighted population as percentage			0.36%	0.36%
Adult in-patient service staff headcount				
Clinical Staff	52,730	191	191	191
Non-clinical staff	9,500	34	34	34
Emergency department staff headcount				
Clinical Staff	18,950	65	65	65
Non-clinical staff	6,100	22	22	22
Management of violence training - in-patient psychiatric settings				
Cost per trainee day	£194	£194	£194	£194
Ratio of students to 1 trainer, headcount	12	12	12	12
Average attendance rate, %	80%	80%	80%	80%
Backfill costs	£95	£95	£95	£95
Current clinical staff training				
Percentage of currently trained staff	50%	50%	50%	50%
Percentage of backfill provided	100%	100%	100%	100%
Length of training course, days	3	3	3	3
Number of courses	2636.5	9.5	9.5	9.5
Course costs	£1,534,443	£5,529	£5,529	£5,529
Backfill costs	£7,614,025	£27,154	£27,154	£27,154
Current non-clinical staff training				
Percentage of currently trained staff	25%	25%	25%	25%
Percentage of backfill provided	50%	50%	50%	50%
Length of training course, days	1	1	1	1
Number of courses	237.5	0.9	0.9	0.9
Course costs	£46,075	£175	£175	£175
Backfill costs	£112,813	£408	£408	£408

Costing tools

Cost of optimum care
less cost of current care
 = **resource impact**

Resource impact can be either a cost (+) or saving (-)



1. National
 cost impact
 report

2. Spreadsheet
 template to help
 local users
 assess local
 impact

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Cardiac resynchronisation therapy for heart failure

costs and savings

	First year cost £ 000	Recurrent annual cost £ 000
Cost of implementation for England (49.9M)		
Cost of CRT-D procedures	1, 801.8	6,780.8
Cost of CRT-P procedures	8,334.0	16,668.0
Savings		
Reduced hospital admissions	(1,033.7)	(3,171.7)
Total net cost of implementation	9,102.1	20,277.1

Clinical audit tools

- Practical data collection tools
- Tools can be used as they are, abridged or incorporated into other, related standards
- Saves time and standardises data collection

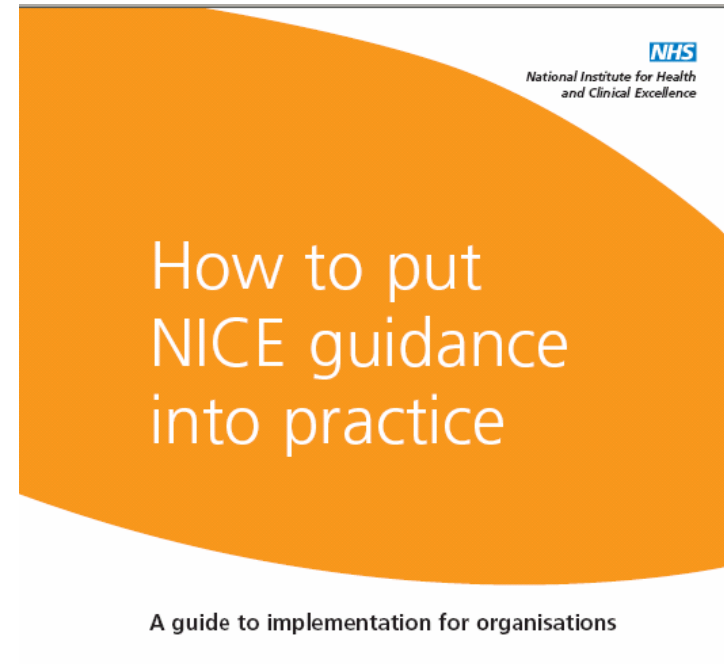
Complete one form for each patient. For definitions of the standards, please refer to the audit criteria and/or the NICE guidance.

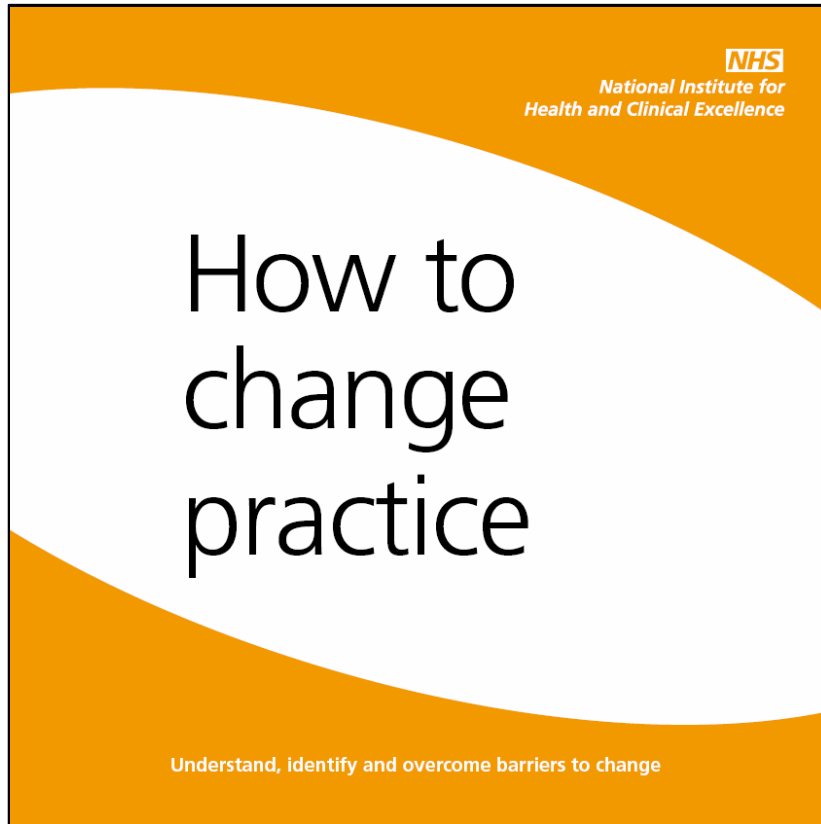
Patient identifier:		Sex: M / F	Age:	Ethnicity:		
Crit. No.	Data item no	Standard	Yes	No	NA/ Exceptions	NICE guidance ref.
Person-centred care						
1	1.1	Service user offered evidence-based written information about: • their condition – the treatment and care they should be offered • the service providing their treatment and care (Data source: patient records)	<input type="checkbox"/>	<input type="checkbox"/>	Person-centred care
	1.2		<input type="checkbox"/>	<input type="checkbox"/>	
	1.3		<input type="checkbox"/>	<input type="checkbox"/>	
2	2.1	Care(s) offered evidence-based written information about: • the service user's condition – the treatment and care the service user should be offered • the service providing the service user's treatment and care (Data source: patient records)	<input type="checkbox"/>	<input type="checkbox"/>	Person-centred care
	2.2		<input type="checkbox"/>	<input type="checkbox"/>	
	2.3		<input type="checkbox"/>	<input type="checkbox"/>	
Service user's status						
Vari-ous	S.1	Is the service user currently misusing substances? If 'Yes', go to section B (Data source: patient records)	<input type="checkbox"/>	<input type="checkbox"/>	

A) People at risk of misusing substances						
Definition of vulnerable and disadvantaged young person						
Vari-ous	V.1	Do any of the following characteristics apply to the service user? V.2 – has family members who misuse substances V.3 – has behavioural, mental health or social problems V.4 – is excluded from school, or a truant V.5 – is a young offender V.6 – is, or has been, a looked after child V.7 – is homeless V.8 – is involved in commercial sex work V.9 Other than by V.1 to V.8 above, do you consider that the service user is vulnerable and disadvantaged? If 'No' to V.1 and V.9, go to criterion 4 (Data source: patient records)	<input type="checkbox"/>	<input type="checkbox"/>	PH14
	V.2		<input type="checkbox"/>	<input type="checkbox"/>	
	V.3		<input type="checkbox"/>	<input type="checkbox"/>	
	V.4		<input type="checkbox"/>	<input type="checkbox"/>	
	V.5		<input type="checkbox"/>	<input type="checkbox"/>	
	V.6		<input type="checkbox"/>	<input type="checkbox"/>	
	V.7		<input type="checkbox"/>	<input type="checkbox"/>	
	V.8		<input type="checkbox"/>	<input type="checkbox"/>	
	V.9		<input type="checkbox"/>	<input type="checkbox"/>	
i) Assessment of risk of people misusing substances						
3	3.1	Is the service user aged under 25? If 'No', go to criterion 4 Has the service user had their risk of misusing substances assessed? If 'Yes', which type of screening or assessment tool was used? – the Common Assessment Framework – one from the National Treatment Agency – another – none (Data source: patient records)	<input type="checkbox"/>	<input type="checkbox"/>	PH14 Rec. 2
	3.2		<input type="checkbox"/>	<input type="checkbox"/>	
	3.3.1		<input type="checkbox"/>	<input type="checkbox"/>	
	3.3.2		<input type="checkbox"/>	<input type="checkbox"/>	
	3.3.3		<input type="checkbox"/>	<input type="checkbox"/>	
3.3.4	<input type="checkbox"/>	<input type="checkbox"/>			
ii) Treatment for people assessed as being at risk of misusing substances						
4	4.1	Do you have concerns that the service user is at risk of misusing drugs or other substances? If 'No', data collection completed Has the service user been offered brief interventions focused on motivation? If 'Yes': – how many sessions were offered? – how long did each session last? Did the sessions: – explore ambivalence about drug use and/or possible treatment? – provide non-judgemental feedback? (Data source: patient records)	<input type="checkbox"/>	<input type="checkbox"/>	CG61 Sect. 1.3.1.4
	4.2		<input type="checkbox"/>	<input type="checkbox"/>	
	4.3.1		<input type="checkbox"/>	<input type="checkbox"/>	
	4.3.2		<input type="checkbox"/>	<input type="checkbox"/>	
4.4.1	<input type="checkbox"/>	<input type="checkbox"/>			
4.4.2	<input type="checkbox"/>	<input type="checkbox"/>			

What are the local success factors?

- Clear leadership and motivated staff
- Systematic process
- Financial planning
- Audit and evaluation





“The role of patients in changing clinical practice is vital. If patients are satisfied with the care they have received and this is passed onto healthcare professionals, it can really change practice”.

*Dr Michael Smith,
NHS Greater Glasgow and Clyde*



“GPs are much more accepting of change when they have seen that GPs from other PCTs have implemented the change with a positive effect”.

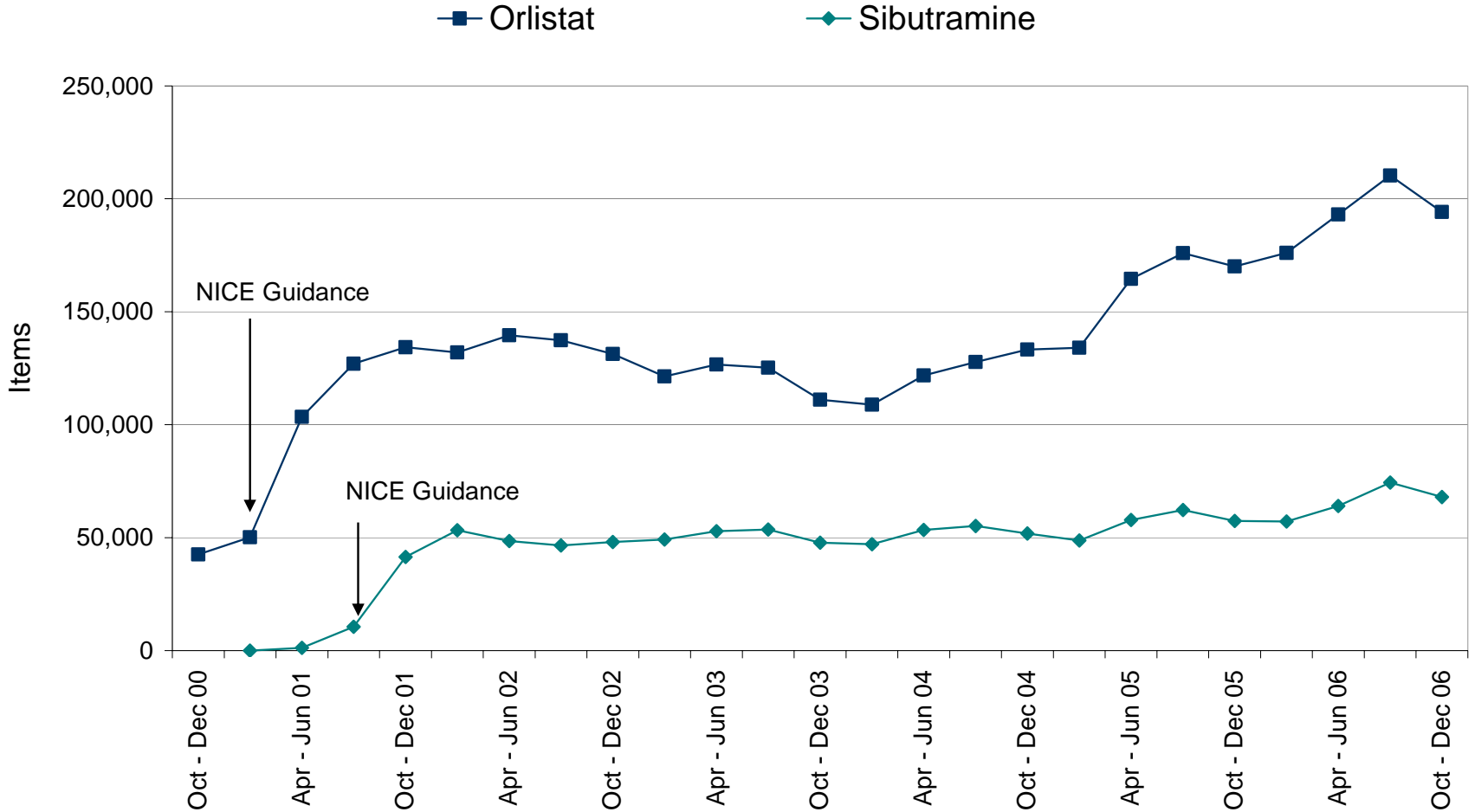
*Catherine Baldrige,
South Tyneside PCT*

Assessing impact

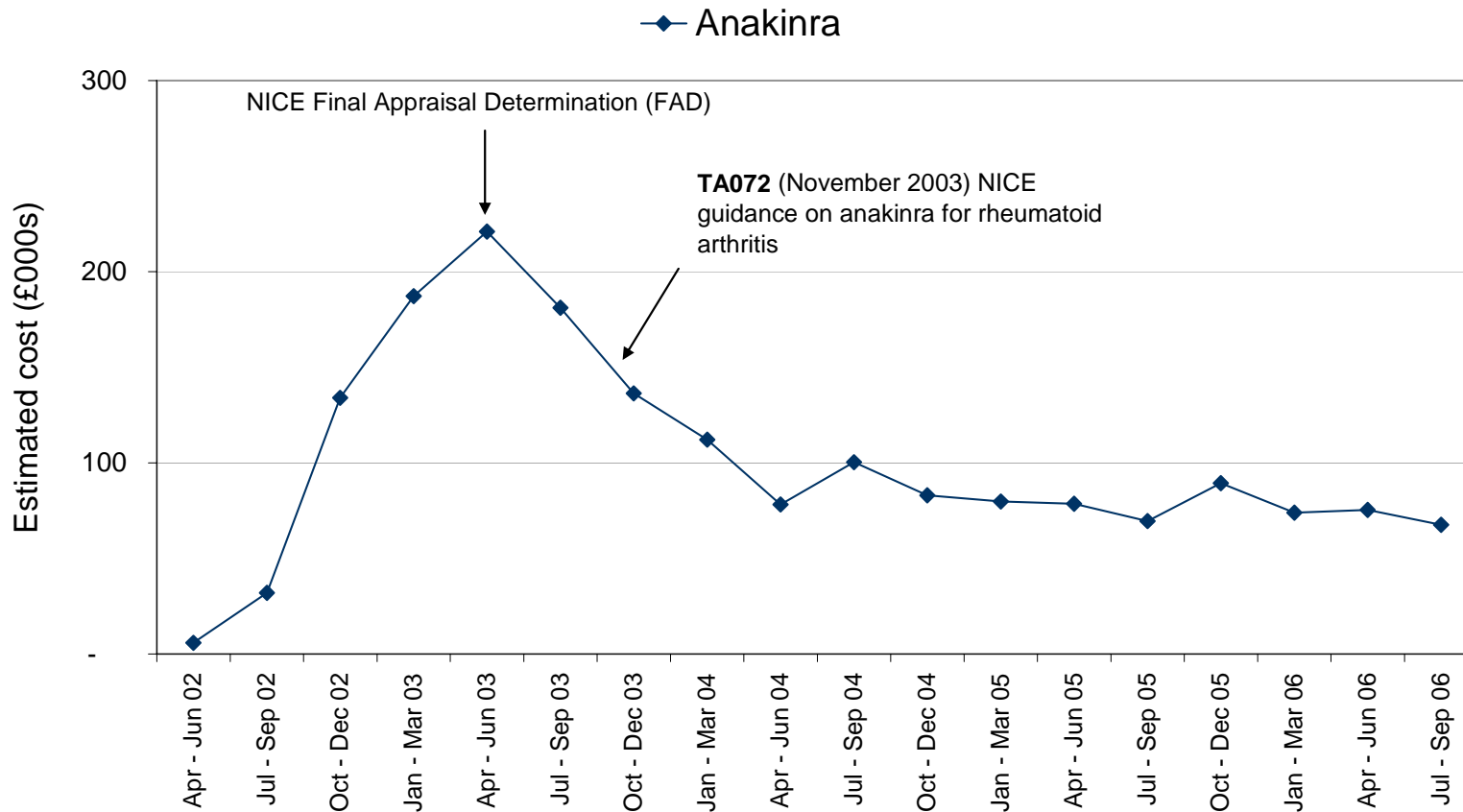
- Routinely collected national data
- Published research
- Healthcare Commission reports
- Patient surveys
- National audits
- Informal comments



Uptake of anti-obesity drugs



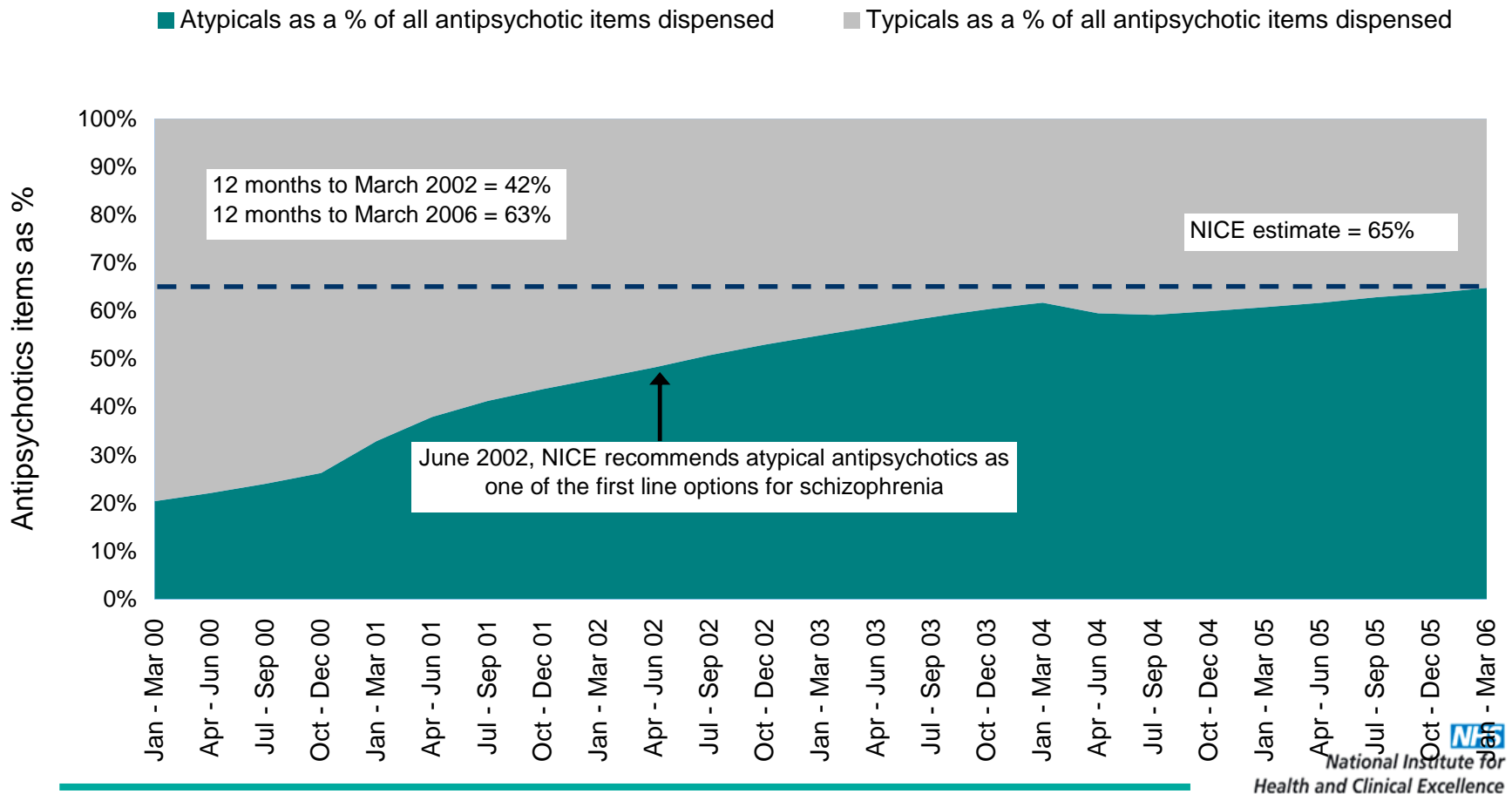
Anakinra for rheumatoid arthritis



Source © IMS HEALTH: Hospital Pharmacy Audit

Atypical antipsychotics for schizophrenia

source: PCA



Setting future strategy

The NICE implementation strategy group

A small group of leaders in the field of research reflecting a range of issues relevant to implementation to:

- Advise NICE on existing ongoing/ new research into change and implementation practices
- Provide suggestions on future strategic direction of the implementation support programme
- Comment on current Implementation Directorate programme performance
- Identify opportunities for further research and marketing

The future – disseminating evidence



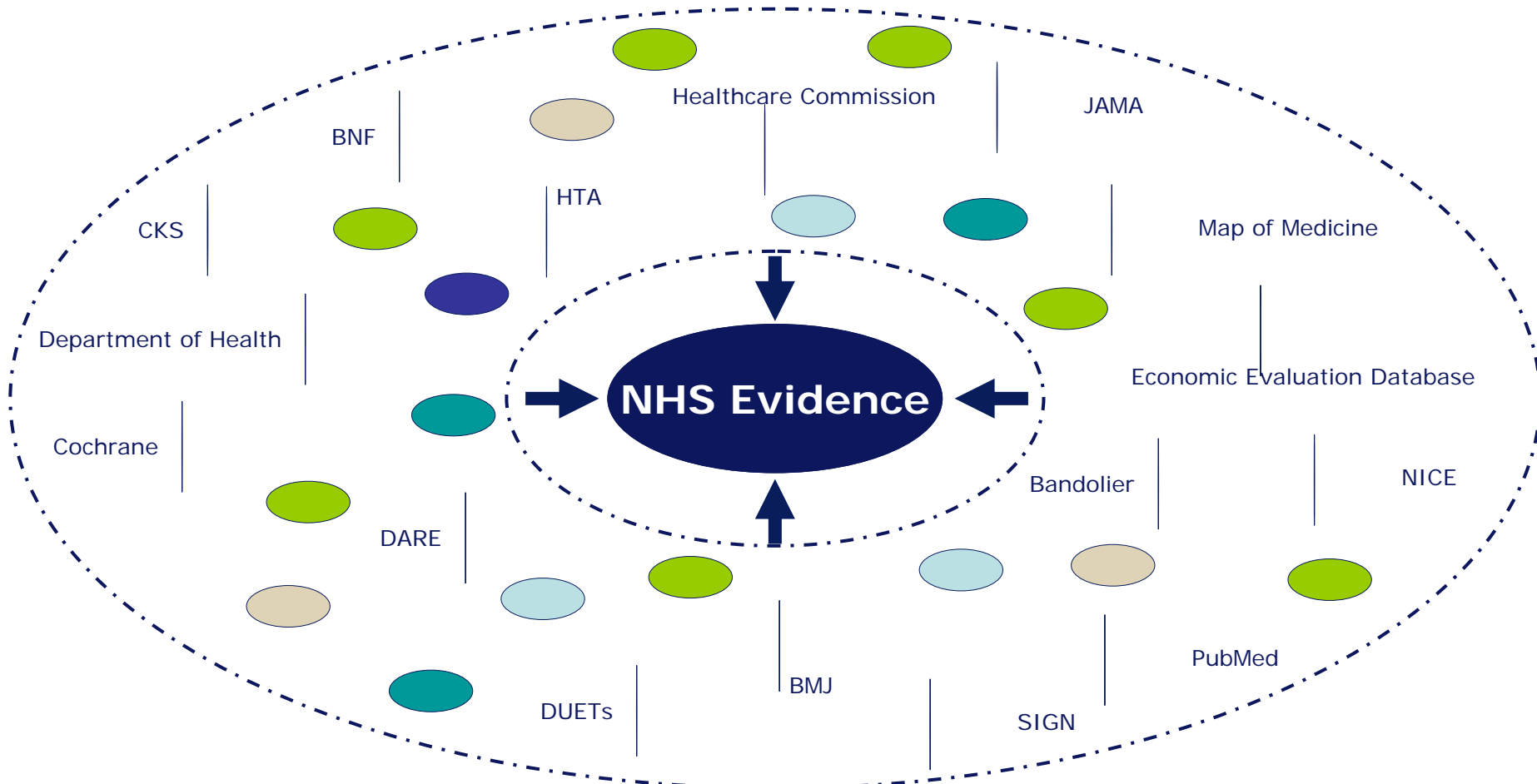
Darzi report: *NHS Evidence*

The report stated that:

‘NICE will manage the synthesis and spread of knowledge through NHS Evidence – a new single portal through which anyone will be able to access clinical and non-clinical evidence and best practice, both what high quality care looks like and how to deliver it. Greater clarity on standards, and where to find them, will support the commissioning and uptake of the most clinically and cost-effective diagnostics, treatments and procedures’.



The challenge of multiple sources of information



NHS Evidence will sort, sift and prioritise information according to user needs

Evidence in Health and Social Care



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Email: mark.roberts@nhs.co.uk
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Guidelines

- [Bell's Palsy: Highest incidence of Bell's Palsy between ages 15-45 years](#)
- [Bell's Palsy: Bell's Palsy is an acute, unilateral, idiopathic, facial nerve paralysis](#)
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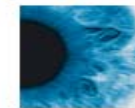
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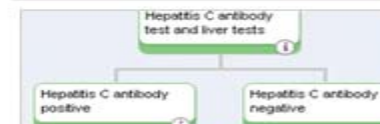
[Neuro Kinetics: Research Suggests I-Portal\(R\) NOTC Data Shows Mild Traumatic Brain Injuries That Other Technologies Miss](#)
 Medical News Today, 5 March 2009

[Case study of Bell's palsy applying complementary treatment within an occupational therapy model](#)
 Medworm 4 March 2009

[Prednisolone and valacyclovir in Bell's palsy: a randomized, double-blind, placebo-controlled, multicentre trial](#)
 Medworm, United Kingdom 19 February 2009

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Key conclusions

- An implementation programme needs to be responsive to users needs and to any strategic developments
- NHS Evidence will establish clear standards for guideline developers in England and help users identify best evidence

