Creating a healthier Hull

NHS Hull Clinical Commissioning Group

Research & Development

Status Report April -October 2018

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Introduction

The purpose of this Research and Development Status Report is to present information to the Committee on the half-year R&D activity for Hull CCG since April 2018. The report provides the evidence that Hull Clinical Commissioning Group (CCG) maintains and develops its statutory duty to 'promote research, innovation and the use of research evidence' (Health and Social Care Act, 2012).

The report presents information on the following:

- Locally-funded research
- Excess Treatment Costs
- R&D strategic work in 2018
- Planned Future Work

Background

The UK government has stated its firm commitment to promote research throughout the NHS which it sees as essential to continually improve effectiveness of health services and patient outcomes. Indeed, there is an expectation that the UK will be the first research-led health service in the world.

A number of current policy documents have placed a strong emphasis on research activity in the NHS:

- The NHS Constitution 2015 (DoH, 2015)
  One of these principles includes a commitment to
  "(T)he promotion and conduct of research to improve the current and future health and care of the population".

- The NHS White Paper, Equity and Excellence: Liberating the NHS states
  "The government is committed to the promotion and conduct of research as a core NHS role. Research is vital in providing the new knowledge needed to improve health outcomes and reduce inequalities." (DoH, 2010, p.24)

- The government response to the NHS Future Forum report made the following commitments with respect to CCGs and research:
  "*CCG's legal duties should reflect their key role in making sure that, at a local level, the need for good research, innovation and a strong evidence for clinical decisions is paramount*." (DoH, 2011, p.26)

This mandate is recognised within NHS Planning Guidance 2016/17-2020/21 (NHS, 2015, p.20) which raises the issue of how commissioners can support research, innovation and growth in order to drive transformation to close the care and quality gap.

1. Promotion of Research and use of Research Evidence

1.1 Studies Funded by Hull CCG

Hull CCG has funded locally-grown research since 2013 as part of its commitment to promote research and the utilise evidence to inform its commissioning priorities. The reports below provide the progress updates on the status of studies allocated monies from the Hull CCG R&D budget since 2015.

1.1.1 Budget year 2015-16: Research Capability Funding Allocation
Hull CCG was allocated Research Capability Funding (RCF) for 2015-16 of £20,000.00; this was awarded by the Department of Health (DoH) for recruiting at least 500 individuals to non-commercial studies, conducted through the National Institute for Health Research Clinical Research Network (NIHR CRN), during the previous reporting period.

Based on DoH guidance, a local bidding process was developed for primary care professionals to apply for funded, protected time to work up NIHR research grant and fellowship applications. The study progress reports for these successful applicants are shown below.

Applicant Name and Research title	Funding Amount	Progress Update from the Study Team
Ann Hutchinson: RfPB Grant for breathlessness study	£9,138.00	The study team have been received notification that the study will be funded and are now in the process of signing the contract and the start-up work has commenced.
Catriona Jones: RfPB grant for larger perinatal mental health study	£5,682.00	The study team have developed the outline and submitted a stage 1 application to the Mental Health themed call for Research for Patient Benefit in July 2018.
Jane Wray: RfPB Grant for Involving Carer's in Risk Assessment in Acute Mental Health Settings	£2,781.00	The application to Research for Patient Benefit is in the process of being submitted.

1.1.2 Budget year 2016-17

Lesley Glover: Working with Older People to design sustainable healthy lifestyle interventions	
Purpose	In partnership with older people in Hull the research team will explore what it means to maintain health and well-being in older age and the barriers and facilitators to this.

Funding	£29964.00
Status	Closed. The summary final report can be found in **Appendix 1.**
Impact	The findings will be fed back to colleagues at Hull CCG during late 2018 via the Humber R&D Service. The potential impact of these findings at a local level will be outlined in the annual report due in April 2019.

1.2 Excess Treatment Costs

Excess Treatment Costs (ETCs) are the difference between the total treatment costs incurred as part of a research study and the cost of standard treatment. ETCs that occur in research in England funded by Government and Research Charity partner organisations should be met as part of the normal commissioning process (NHS England, 2015).

1.2.1 Funding for 2018

Hull CCG has demonstrated that it has committed to following this national policy guidance by approving the following ETCs since April 2018:

Study Title	Study details	ETC Amount Approved	Date Approved
CLASP	The study aims to evaluate an online intervention offering lifestyle and wellbeing support for cancer survivors	£878.40	11 June 2018
ASPECT	A randomised controlled trial comparing the clinical and cost-effectiveness of one session treatment with multi-session cognitive behavioural therapy in children with specific phobias	£6808.00	29 May 2018

1.2.2 Status Updates

The table below provides progress updates from studies that have previously been awarded ETC funding from Hull CCG.

Study Title	Study Details	Study End Date	ETC Amount Approved	Progress Update from the Study Team
BASIL III Balloon vs Stenting in Severe Ischaemia	To determine which of three methods (plain balloon, drug-coated balloon or	2019	£5025.00	• Hull is one of the top recruiters in the UK for this trial; 9 participants recruited to date.

of the Leg-3	drug releasing stent) keeps patients with severe limb ischaemia alive and with their leg intact, the longest.			• The trial has given patients the opportunity to participate in ground-breaking research and has the potential for preventing extra surgical procedures (amputations), saving the local NHS time and money; although the definitive savings are yet to be confirmed.
HERO	To determine the clinical and cost effectiveness of a home-based exercise intervention for older people with frailty as extended rehabilitation following acute illness or injury, including internal pilot and embedded process evaluation	2021	£13068.40	• Recruitment is going particularly well in Hull; 5 participants have been recruited to date, of these, 4 have been randomised to receive the trial intervention. • These 4 participants have received further therapy in their own home from physiotherapy teams trained to deliver the intervention. The original pilot suggested that those in receipt of such an intervention will improve/maintain their physical functioning compared to those who do not post-discharge.
ALL HEART	To investigate whether adding allopurinol to patients with ischaemic heart diseases' usual medications will reduce their risk of having a stroke, heart attack or dying due to cardiovascular disease.	2019	£877.50	• No recruits to date in Hull; the Humber R&D Service are liaising with the study team to ensure payments are only scheduled upon receipt of recruits.

1.2.3 National Changes to the Excess Treatment Cost Process

A national consultation on ETCs was undertaken in 2017 by NHS England, the Department of Health and Social Care (DHSC), the NIHR and the Health Research Authority (HRA). It proposed to streamline the ETC process across England. NHS England's response to the consultation was released in May 2018. It identifies next steps and changes to the current model. Three changes are to be implemented by the 1st October 2018 and are as follows:

1. Partnering with the 15 Local clinical research networks (LCRNs) to help manage the Excess Treatment Cost process on behalf of their local Clinical Commissioning groups (CCGs).

2. Establishing a more rapid, standardised process for ETCs associated with specialised commissioning, which are the responsibility of NHS England.

3. Setting a minimum threshold under which ETCs will need to be absorbed by providers participating in studies.

In contributing to a regional funding pot for payment, an allocation of 5.2 p per capita (per CCG patient) per CCG per annum to ETCs will be undertaken for a 6-month trial period from 1st October 2018 to 31st March 2019. This equates to an actual allocation of 2.6 p per capita for the 6 month trial period. Data on actual ETCs incurred during this period will inform a review of the allocation rate for 2019/20.

A position statement from NHS England was released in September 2018 outlining the implementation of the process and CCGs were to be notified of the confirmed definitive amount for the allocation of funds. The Humber R&D service is working closely with the local NIHR CRN and national stakeholders such as the R&D Forum to try and establish the operational detail of how the process will be implemented for Hull CCG. This is work that is still on-going.

1.3 Strategic Work

1.3.1 Improving the NIHR Portfolio Research Study Activity

As has been previously reported, there has been a continued regional reduction in the number of participants recruited into NIHR CRN studies and discrepancies had been discovered in GP recruitment data. Consequently, the Humber R&D Service has instigated formal partnership working arrangements with the Yorkshire and Humber CRN. The aim of this partnership is to form a collaborative approach to improving the quality and quantity of local primary care engagement in research.
So far, the following joint strategic objectives have been agreed:

1. Make CCG GP Data accurate by March 2019
2. Sign-up two practice nurses to the NIHR CRN Nurse Development Programme by September 2018

3. Promote Research at one promotional event for each CCG and obtain contact details of at least two clinicians whilst in attendance by March 2019
4. Establish links with allied community professionals within all four CCGs before March 2019

These objectives are reviewed on a quarterly basis; the next review is expected to take place in October 2018.

1.3.2 Maintaining the Focus of the Research and Development Steering Group

In recognition of the national agenda to offer a firm commitment to the promotion of research, innovation and best evidence-based practice, a Hull CCG R&D Steering Group is established and focuses on the following areas:

- Promoting opportunities for high-quality and relevant research to improve health outcomes and reduce inequalities
- Developing a strong evidence base for clinical decision making
- The promotion and conduct of research

Meetings have been held bi-monthly in 2018. There is proactive dialogue with partners within Public Health to further the level of engagement and potential collaboration on projects; this embodies an integrative partnership approach for R&D.

2. Planned Future Work

In addition to the above work, Hull CCG will be focusing on further projects in 2018/19.

2.1R&D Strategy

The establishment of an R&D strategy was formally agreed by the Board in 2014. This sets out the key objectives for Hull CCG and is reflective of the Hull 2020 vision. However in order to bring the strategy up to date for 2018 onwards, the R&D Steering Group are in the process of redrafting this document. It will set out the direction for research and development within Hull CCG and is expected to be completed in late 2018.

Summary

This report presents evidence that Hull CCG is continually striving to be at the forefront in making the promotion of research and the use of research evidence a part of its core work. The report demonstrates how it is supporting local and national studies and using the outcomes from research to inform commissioning decisions. This has been shown, for example by demonstrating the outputs from funding local projects and working with

partner organisations, including academia, public health and the progressive work of the Hull R&D Steering Group.

The developments in 2018/19 will aim to build on this commitment, including how R&D links particularly into the Hull Health and Care Place Plan 2018 - 2019. Further evidence will drive forward research, service evaluation and innovation when addressing the healthcare priorities of the population in Hull. This will ensure commissioning decisions are based on the best available evidence.

Glossary of Terms

CRN	Clinical Research Network
DoH	Department of Health
DHSC	Department of Health and Social Care
Hull CCG	Hull Clinical Commissioning Group
NHS	National Health Service
R&D	Research and Development
NIHR	National Institute for Health Research

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(Accessed 12 September 2018)

Appendix 1

Report from the DEarEST Project - Co-creating Healthy Ageing in Hull

Introduction

The population is ageing. With age comes an increased risk of poor health, social isolation and long term conditions. This is particularly evident in poorer populations including Hull. Evidence identifies five key elements that significantly contribute to health and wellbeing. These are often couched in complex health care language which can alienate people. In everyday language these are good hydration (**D**rink), healthy diet (**E**at), exercise (mov**E**ment), rest (**S**leep) and social interaction (**T**alk) (**DE**ar**EST**).

In October 2016 we received £29,964.00 from NHS Hull Clinical Commissioning Group (CCG) to undertake a co-creation study with older people to investigate what it means and how to support maintaining health and wellbeing in older age.

Background

In co-creative research future service users work with professionals on an equal basis to design, develop and produce the service or intervention; in this case to support healthy ageing. Older people are under-represented in research, which means they rarely get to shape the development and design of interventions or services. This is problematic as the lack of inclusion of older adults may result in interventions which do not account for their context or their barriers to participation. Services or interventions are then less effective due to this poor match.

Evidence demonstrates that interventions are more effective when we consider determinants (barriers and facilitators) to the behaviour in question, we tailor interventions according to these, and we use psychological theory throughout the process. Interventions to promote health and wellbeing often address one aspect but fail to take a whole person perspective.

The Study

Aim

To undertake a co-creation study with older people to investigate what it means to maintain health and wellbeing in older age and how to support this.

Objectives

1. Form a project team of lay older people and researchers;
2. Develop a shared understanding of the meaning of healthy ageing from the perspective of older people and explore how these relate to the elements of **DE**ar**EST**;
3. Identify barriers and facilitators to adopting the **DE**ar**EST** healthy lifestyle behaviours;
4. Demonstrate the application of co-creation with the local community to inform future work;
5. Make recommendations for adapting existing services or developing new ones that are feasible, acceptable and sustainable.

Method

Design

A qualitative study underpinned by the gold standards of co-creation[1] and the Theoretical Domains Framework[2].

Project team

The project team consisted of ten lay and four university researchers. The lay researchers were aged between 70 and 79 years; seven were women and three men. All were white British with four married, three identified as having a disability; four had no formal education, one left school at 16, and five had engaged in higher education. The university

researchers were all female, and had expertise in psychology, nursing, behaviour change and working with older people.

Procedure

We recruited the lay project team through posters, attending community groups, and via social media and Radio Humberside. Lay team members were paid for their time and

[1] https://www.wearecocreate.com/
[2] Michie, S., Johnston, M., Abraham, C., Lawton, R., Parker, D. and Walker, A., 2005. Making psychological theory useful for implementing evidence based practice: a consensus approach. *BMJ Quality & Safety*, *14*(1), pp.26-33.

reimbursed travel expenses. Ethical approval was given by the School of Health and Social Work at the University of Hull (ref: 266). We held four, two-hour long project meetings between August and October 2017 at a local accessible venue.

Attendance at meetings was good and is illustrated in Table 1.

Table 1: Attendance at meetings

Project team member	*Meeting 1*	*Meeting 2*	*Meeting 3*	*Meeting 4*
Lay members	6	7	8	7
Researchers	3	3	3	4
Total	9	10	11	11

Each meeting had a focus but there was an open structure so that the direction of discussion could be set by the group. The meetings were facilitated by the university researchers. Between meetings the university researchers summarised content to feed back. Lay researchers collected agreed information (e.g. available local resources). Meetings were audio recorded and notes were taken by the researchers. After the final meeting a questionnaire was distributed to all team members to evaluate the process.

Data analysis

Data collection and analysis was iterative and has been synthesised and reported according to objectives 2 to 5 above.

Results

Outcomes are discussed below according to each of the specified objectives aside from the formation of a project team which is covered in the Method section.

Objective 2: Develop a shared understanding of the meaning of healthy ageing from the perspective of older people and explore how these relate to the elements of **DE**ar**EST**.

The group sought to define "older" and "elderly" and concluded state of mind and state of health were key. Feeling safe, comfortable and pain free were important. Being able to adapt to change, have choice and having a sense of personal freedom were important. Loneliness, being alone and a lack of connections were repeated themes in conversation and were thought to make people vulnerable. It was considered that having social interactions meant people were more likely to engage in the other **DE**ar**EST** elements as either a direct or indirect result of reduced loneliness.

"It was interesting how we had the different dearest elements, but it was loneliness/social isolation that people felt was the most important issue, both in terms of an issue in itself and as something that underpins everything else".

Objective 3: Identify barriers and facilitators to adopting the **DE**ar**EST** healthy lifestyle behaviours

Cognitive Barriers[3] were discussed; the reality of being older is that people often have fewer resources of all kinds, some people need more thinking time as they get older and need things to be slower. ***Knowledge*** about existing resources was problematic. Specifically, those without computer skills or access to the internet were less likely to know about the many existing groups and opportunities. ***Lack of confidence*** stops some people from going to new activities. ***Lack of transport*** and ***poverty*** can exacerbate isolation.

Objective 4: Demonstrate the application of co-creation with the local community to inform future work

Through the process of co-creation we offer the following learnings to inform future co-creation projects in Hull. These are derived from team members' feedback and from minutes of meetings.

[3] Cognitive barriers are barriers relating to the way someone thinks or makes sense of things, they include memory, reasoning and understanding.

Be realistic about the scope of the project. There was a feeling that the project was ambitious and that we could not address everything at once, however there was some optimism that it would be possible to make a difference:

> *"Trying to solve all the problems at once is like eating an elephant, eat it all at once and it will kill you, a little at a time and it's doable. Perhaps targeting one aspect may be the way forward."*

Use diverse methods of recruitment. We were aware that our group, although diverse in some ways, was not representative of all older people in Hull, in particular in terms of ethnic diversity. Despite this, team members brought a great breadth of life experience. We tried to widen recruitment but often heard that people did not feel confident or clever enough to come to a university project. In some ways the team suggested we were:

> "*Preaching to the converted*."

Use skilled facilitators. Although an agenda was prepared for each meeting the whole team steered the discussion.

> *"At first I was worried that the conversation might go around in circles and get nowhere. But, every week I was surprised by how much progress we made. How, despite the diversity of the group we agreed isolation/ loneliness/ connectedness were so important to health."*

There was a value in the researchers collating and summarizing information from each meeting to feed back at the beginning of subsequent meetings.

> *"Often during the group I would not realise just how much richness there was in the discussion".*

Prepare well. Choose an accessible, familiar community location to make it easy for people to attend. Put in place simple payment systems. Offer sufficient information to all team members in preparation for the meetings.

> *Objective 5:* Make recommendations for adapting existing services or developing new ones that are feasible, acceptable and sustainable.

The team agreed that loneliness or connectedness was the keystone to achieving all other DEarEST components (**D**rink, **E**at, mov**E**ment, **S**leep and **T**alk). The team discovered a multitude of existing groups and interventions in the community which could support health and wellbeing in older age.

> *"The thing which stood out for us was the vast amount of material in hard copy and online available from local and national authorities and charities both large and small. The disappointment is that the majority of it does not reach its target audience. This became clear in our group by the amount of previously unknown information being tabled."*

The group concluded therefore, that more interventions would not be helpful. What is needed is a "bridge" between people in need and available activities and services. Such a "bridge" would i) help identify those in need in their immediate community, ii) find out what their preferred activities might be and iii) work with them to address the barriers to getting involved.

The team considered at length how to find people in need and decided General Practices would be a good starting point. Given the success of the volunteers in City of Culture, we discussed volunteers having a key role in acting as the bridge. The bridging role may involve overcoming barriers to **DE**ar**EST** behaviours (for example accompanying people to existing initiatives or signposting them to available resources). We are aware this approach has been successfully implemented in Frome, Somerset[4] and is in line with moves towards social prescribing.

Conclusion

The project team of lay older people and researchers developed an understanding of the meaning of healthy ageing and identified loneliness and isolation are the keystone to all other elements of **DE**ar**EST.** The most influential barriers to **DE**ar**EST** were cognitive, lack of knowledge, lack of confidence, no/poor transport and poverty. What has been key to the development of our co-design work is that the findings and recommendations are "owned" by the older people of Hull. The recommendations of the team are to create a "bridge" whereby individual need and existing resource are matched. The team are committed to building on this work through dissemination activities and further research.

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[4] https://www.kingsfund.org.uk/sites/default/files/2017-11/Catherine%20Millington%20Sanders.pdf

"I would like to see our team presenting to a CCG group."

"A really huge media storm.."

"Raising awareness in local communities could be a good place to start."

In the next few months the team will be working on journal papers, conference presentations and funding applications to progress this work.

Report compiled by Dr Lesley Glover, Dr Debbie Kinsey, Prof Fiona Cowdell, Dr Judith Dyson with input from the project lay team.

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