

Research and Evidence Strategy 2016 / 2021

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1. Purpose and Aim

A research strategy has been developed by the Research and Evidence team. The purpose of the strategy is to support the CCG deliver their statutory duties in respect of research.

The implementation of the strategy will also aid organisational understanding and raise awareness of the importance of embedding the use of good quality research and evidence in CCG commissioning functions.

The strategy will be monitored and reviewed by an internal CCG Research and Evidence group led by the CCG Medical Director. The CCG executive will review progress on an annual basis.

2. Why research is important

Research and Evidence (R&E) is part of the innovation process that acquires and converts knowledge and ideas into a better way of doing things, such as new or improved products or services that are valued by the health community and the patients. Within the context of the NHS, the objective of R&E is to answer service relevant questions and disseminate new knowledge to tackle the challenges of all aspects of health, social care, and well-being.

Recent Department of Health (DH) policy, communications, and the DH funded National Institute of Health Research (NIHR) have brought the profile of R&E more to the fore.

The NHS Constitution (2012) commits the NHS to aspiring to the highest standards of excellence and professionalism – in the provision of high quality care that is safe; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. The constitution also pledges to “offer patients the opportunity to be involved in research where applicable”.

The NHS Operating Framework states that the NHS must play its full part in supporting research and in 2012/13 states that further action is needed to embed a culture that encourages and values research throughout the NHS and that every patient should be given the opportunity to be involved in health research.

This is enabled by the NIHR with a vision to “improve the health and wealth of the nation through research”. The aim is to create a health research system in which the NHS supports outstanding individuals, working in world-class facilities, conducting leading-edge research which is focused on the needs of patients and the public. The aim is for “faster, easier research to be undertaken in the UK “.The NIHR Clinical Research Network (CRN) North East and North Cumbria (NENC) 2020 Vision Local Strategy aims to make the North East the best place to take part in research.



Embedding Research and Evidence as an *everyday expectation*

3. Commissioning research

3.1 What research is and how this relates to commissioning research?

Research is the attempt to derive generalisable new knowledge including studies that aim to generate hypotheses as well as studies that aim to test them (Health Research Authority, 2009).

NHS England have an ambition that by 2020/21 NHS Commissioners routinely consult evidence and design-in evaluation into their commissioning decisions and service reviews (NHS England, 2014b).

It has been shown that patients taking part in research have better outcomes. Research has shown that trusts active in research have been shown to have lower overall mortality rates (Bennett *et al.*, 2012).

3.2 What is going on in primary care research

Less than half of all of GPs in England are currently involved in recruiting participants into research studies (NIHR CRN High Level Objectives Year End Performance Report - 2016/17). The evidence is not always available and commissioners need support to identify the gaps in their knowledge, fill these gaps and use knowledge effectively to support commissioning decisions.

Pursuing the use of evidence and evaluation will improve how commissioners measure the impact of our work, meaning commissioners can learn from what works well, and what doesn't.

Improving how new knowledge is applied to NHS services will ultimately lead to better quality care and improved use of resources and also contribute to quality agendas such as the Quality, Innovation, Productivity and Prevention (QIPP) programme.

The NHS constitution pledges to give every patient the opportunity to take part in research studies (2012).

3.3 What is going on in secondary care research and how does this influence primary care?

Research is a core part of the National Health Service (NHS) in the United Kingdom, 600,000 patients took part in research studies in 2016, the majority of these studies took place in hospitals (NIHR, 2017).

In the North East and Cumbria, a total of 34,269 participants were recruited to research in 2016/17. 4% were recruited in mental health trusts, 13% in primary care and 83% within secondary care hospital trusts (NIHR Open Data Platform, 2017). If the aims of the NHS Department of Health Five Year Forward View (2014a) are to be achieved it is important that the level of research and evaluation taking place in primary care increases and that secondary care researchers look towards primary care for new and innovative care solutions that breakdown the barriers between secondary and primary care.

The Five Year Forward View (2014a) proposes networks of care that are integrated around the patient. Maintaining the historical divide between primary care and secondary care research will continue to create a barrier to the personalised and coordinated health services patients need.

This joined up approach is also the focus of NHS England's 2017 document Next steps on the NHS Five Year Forward View, commissioners and providers across the NHS and local government need to work closely together to improve the health and wellbeing of their local population (2017b). This approach is being developed through Sustainability and Transformation Partnerships and Accountable Care Systems.

4. How can CCGs influence commissioning research?



Leadership

Leadership via CCG Internal Research Lead will increase visibility and the promotion of research. It is also important to identify a CCG clinical lead to promote the use of R&E at practice level.

Stakeholder partnership and communication

Support grassroots projects within the CCG with input from the R&E team. Understand the wider picture in neighbouring CCGs and promote projects across borders that would benefit the wider population. Forging academic links with local universities is essential to promote collaboration.

Training and Development

Identify training gaps with commissioning staff, but also clinical staff in the CCG and identify how the CCG uses evidence.

Evaluation, evidence and service development

The CCG needs to identify the questions that need answering and their priorities as a CCG.

The process for accessing, assessing and evaluating evidence needs to be agreed. It is important that a consistent approach is taken when implementing or decommissioning a service and a clear pathway of how evidence had contributed to this approach and that decisions have been made on facts and the best available evidence.

5. What this means for Newcastle Gateshead CCG

Duty in respect of research for the National Commissioning Board and Clinical Commissioning groups:

Each clinical commissioning group must, in the exercise of its functions, promote;

- (1) research on matters relevant to the health service, and
- (2) the use in the health service of evidence obtained from research in commissioning, and
- (3) to ensure the treatment costs in research are resourced.

1. Support and promote research

CCGs need to consider the following in delivering their duties with research by embedding research in all aspects of CCGs roles;

- Commissioning services – in NHS standard contract –monitoring provider activity in research as a quality measure.
- Patient involvement - Patients want to be involved in research. A poll conducted by the Health Research Authority website in 2015 found that 74% of patients think every patient should be offered the opportunity to participate in research. Patients should be encouraged to ask about opportunities to take part in research and it should be clear how patients can find out about these opportunities themselves and choose if they would like to be involved. It is therefore essential that as a commissioner, NG CCG have a responsibility to ensure all patients are given the opportunity to take part in research at all the member practices across the CCG.
- Member Practices involvement – encourage, monitor. In a study conducted for the Association of Medical Charities in 2013, the majority of GPs believed it is very important for the NHS to support research into treatments for their patients. As 90% of NHS contact with patients is made in general practice, GPs can play a vital role in engaging patients in research, conducting innovative research themselves. Involvement in high quality research for member practices can lead to better care for patients, contribute to ongoing professional development for staff, supports better use of local resources and this in turn aids improved informed commissioning decisions.
- Develop research and evaluations with support from the R&E team.

The R&E team supports the CCGs in delivering their duties with research by;

- Provides expert advice, governance checks and assurance for all research undertaken in primary care and CCGs that is not on the NIHR portfolio.
- Working with key stakeholders regionally and nationally to grow research, particularly local Universities and School for Primary Care Research based in Newcastle.
- Working with Local Clinical Research Network (LCRN) North East and North Cumbria (NE&NC) to provide research activity reports for services NG CCG commission and NG member practices.

Newcastle Gateshead CCG (NG CCG) commits to support and promote R&E by:

- Increase the awareness of research in practices and with patients.
- Increase the number of patients offered the opportunity to take part in both site studies and Participant Identification Centre (PIC) studies.
- Increase the capacity and capability of member practices to undertake research.
- Use research as an indicator of quality and improvement for member practices.

R&E should be an everyday expectation and all patients in the CCG should be provided with the opportunity to take part in research studies where applicable. The NECS R&E team can support practices to do this and have links with the CCG Delivery Teams and the Primary Care Quality group to ensure this message is conveyed to practices across the CCG.

2. To use research evidence in commissioning

As a commissioner it is important that CCG's recognise the key role of R&E in commissioning decisions and that the CCG looks outward to ensure we are basing decisions on the best available evidence. The Health and Social Care Act 2012 creates a statutory duty for CCGs to "promote research and innovation and the use of research evidence". In a new addition consider generating new evidence for all new services design, medical education and commissioned work with internal intelligence as well as external academics in proportion to the evaluation needs. The R&E team recognises that it's a challenging task to commission services based not only on national guidance and governmental publications but also on local needs, priorities, evaluations and local evidence.

What can limit everyday use of Evidence Based Practice?

The R&E team understand that there are potentially many limiting factors to why evidence based practice is not utilised; firstly limited and tight commissioner timeframes, secondly limited access to academic resources, thirdly lack of skills to appraise research and fourthly a lack of access to local 'best practice' sharing (Wye *et al.*, 2015).

Why is it important to use evidence in commissioning?

Clarke *et al.*, (2013) highlight how it is important for commissioners to utilise national guidance and governmental publications as well as local intelligence and needs, providing the commissioner with a wider reaching view in order to commission services.

Research can benefit healthcare provided to patients:

Evidence suggests that there is an association between engagement of individuals and healthcare organisations in research and improvements in healthcare performance (Boaz *et al.*, 2015).

3. To ensure the treatment costs in research are resourced

A process has been agreed by NG CCG executive to understand and consider excess treatment costs applications in relation to research. This is managed centrally by NECS R&E with the CCGs Medical Director being the CCG point of contact to ensure appropriate and timely decision making.

Accepting that there are occasional excess treatment costs necessary to deliver nationally funded research projects in services CCG commissions. With a pragmatic and sensible approach, considering with providers any savings from research and ensuring there is a process to collate and decide in line with the CCG financial plans.

6. Progress to date

- Research capability funding (RCF) of £20,000 has been awarded to NG CCG from the Department of Health for FY 2015-16 and 2016-17.
- NG CCG have commissioned service evaluations within member practices from RCF funding.
- R&E team members attended Primary Care Quality Group.
- R&E team members have attended and will continue to have regular representation at the NG CCG Delivery Groups.
- Internal NG R&E group comprising Medical Director, Lay Member and NECS R&E Manager meeting quarterly.
- NG CCG collaborating with Newcastle University on the 'Improving Self-Management Support and Planning in COPD' research project.
- NG CCG supported NECS R&E team in delivery of an evaluation training event.

7. Action plan for January 2017 onwards

- R&E team to continue to link in with Newcastle University COPD project team.
- NG CCG to identify clinical research lead in the CCG.
- R& E team to ensure timely reporting for research activity quarterly.
- R&E team to develop training offer for NG CCG in relation to accessing, assessing and evaluating research.
- Explore workforce development with regards to use of research evidence in commissioning with the CCG.
- R&E to support and provide advice to NG CCG regarding the evaluation of Mental Health Service - 'Proof of concept' Together in a Crisis project.
- R&E to support and advise the British Heart Foundation House of Care Programme in Gateshead.
- Aim to present at CCG Governing Body Development Programme meeting Q4 on commissioning research.
- Explore the possibility of incorporating participation in NHS research in provider contracts.

- As part of attracting quality GPs to NG a fellowship scheme is under discussion. A potential component would be to offer a research/academic placement. Links with Professor Louise Robinson and School for Primary care research have been made.
- Develop and progress current links with academic researchers from Newcastle University and Northumbria University. Work with stakeholders and local collaborators such as the Academic Health Science Network and the Professor Gill Rowlands, Professor of Primary Care at Newcastle University.
- Distribute a short survey to assess the current situation on research activity and what would help improve activity.
- Develop a process working with NECS to routinely access relevant evidence and inform the redesign of services and commissioning policy.
- Develop an agreed process in NG CCG for the use of research evidence in the commissioning decision making process.
- To ensure the treatment costs in research are resourced.
- Identify budget allocation for research leads.
- Plan allocation of RCF funding in next financial year.

8. Decisions required

- Continuation of research sub group to finalise strategy and deliver the action plan as well as to decide the research capability funding.
- NECS R&E service continues as described.

9. Monitoring

Internal NG R&E group comprising Medical Director, lay member and NECS R&E Manager meeting quarterly to review the implementation of the strategy. The CCG executive will review progress on an annual basis.

Review of the strategy will take place annually by the NG R&E group members.

- *Dr Shona Haining*
- *Jeff Hurst*
- *Dr Neil Morris*
- *Jody Nichols*
- *Helen Riding*

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11. Equality Impact Assessment



An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

| | |
|----------------|---|
| Policy | A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue. |
| Service | A system or organisation that provides for a public need. |
| Process | Any of a group of related actions contributing to a larger action. |



STEP 1 - EVIDENCE GATHERING

| | |
|--|---|
| Name of person completing EIA: | Helen Riding |
| Title of service/policy/process: | Newcastle and Gateshead CCG Research Strategy FINAL v.1.0 2017 |
| Existing: <input type="checkbox"/> New/proposed: <input checked="" type="checkbox"/> Changed: <input type="checkbox"/> | |
| What are the intended outcomes of this policy/service/process? Include outline of objectives and aims | |
| A research strategy has been developed by the Research and Evidence team with input and consultation from Dr Neil Morris and Jeff Hurst. The purpose of the strategy is to support the CCG deliver their statutory duties in respect of research. The implementation of the strategy will also aid organisational understanding and raise awareness of the importance of embedding the use of good quality research and evidence in CCG commissioning functions. An implementation plan will follow with key deliverables over the next five years. | |
| Who will be affected by this policy/service /process? (please tick) | |
| <input checked="" type="checkbox"/> Staff members <input type="checkbox"/> Other | |
| If other please state: CCG statutory duties | |
| What is your source of feedback/existing evidence? (please tick) | |
| <input checked="" type="checkbox"/> National Reports <input type="checkbox"/> Staff Profiles <input type="checkbox"/> Staff Surveys <input type="checkbox"/> Complaints/Incidents <input type="checkbox"/> Focus Groups <input type="checkbox"/> Previous EIAs <input checked="" type="checkbox"/> Other | |
| If other please state: Legislative requirements, CCG statutory duties | |

| Evidence | What does it tell me? (about the existing policy/process? Is there anything suggest there may be challenges when designing something new?) |
|----------------------------------|--|
| National Reports | |
| Staff Profiles | |
| Staff Surveys | |
| Complaints and Incidents | |
| Staff focus groups | |
| Previous EIA's | |
| Other evidence (please describe) | |



STEP 2 - IMPACT ASSESSMENT

What impact will the new policy/system/process have on the following staff characteristics: (Please refer to the 'EIA Impact Questions to Ask' document for reference)

Age A person belonging to a particular age

No impact identified

Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities

No impact identified

Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.

No impact identified

Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters

No impact identified

Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.

No impact identified

Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.

No impact identified

Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

No impact identified

Sex/Gender A man or a woman.

No impact identified

Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes

No impact identified

Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person

No impact identified



STEP 3 - ENGAGEMENT AND INVOLVEMENT

How have you engaged with staff in testing the policy or process proposals including the impact on protected characteristics?

No impact on protected characteristics identified. Strategy will be discussed, reviewed and approved via the usual CCG channels.

Please state how staff engagement will take place:

Reviewed and approved by CCG Governing Body, Executive Committee, Delivery Group, Clinical Quality, Primary Care Intelligence Group



STEP 4 - METHODS OF COMMUNICATION

| |
|---|
| What methods of communication do you plan to use to inform staff of the policy? |
| <input checked="" type="checkbox"/> Verbal – through focus groups and/or meetings <input type="checkbox"/> Verbal - Telephone <input type="checkbox"/> Written – Letter <input checked="" type="checkbox"/> Written – Leaflets/guidance booklets Newsletter <input checked="" type="checkbox"/> Email <input checked="" type="checkbox"/> Internet <input type="checkbox"/> Other |
| If other please state: |
| |



STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

| Potential Challenge | What problems/issues may this cause? |
|-------------------------------------|--------------------------------------|
| No challenges have been identified. | |



STEP 6- ACTION PLAN

| Ref no. | Potential Challenge/ Negative Impact | Protected Group Impacted (Age, Race etc) | Action(s) required | Expected Outcome | Owner | Timescale/ Completion date |
|----------------|---|--|--------------------|------------------|-------|-------------------------------|
| Non-applicable | | | | | | |

| Ref no. | Who have you consulted with for a solution? (users, other services, etc) | Person/ People to inform | How will you monitor and review whether the action is effective? |
|----------------|--|-----------------------------|--|
| Non-applicable | | | |



SIGN OFF

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| Date: | 4 th October 2017 |
| Signed: | |
| Presented to: (appropriate committee) | |
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