NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE field team annual report

The report describes the field team's operations and findings in 2013-14.

The board is asked to note report.

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Deputy Chief Executive

September 2014

The National Institute for Health and Care Excellence

The NICE field team of implementation consultants

Annual report 2013/14

Contents

Contents 3
Executive summary 4
Working in a fast changing environment 4
Feedback to NICE 5
Planning for the future 5
Conclusion 6
Introduction 6
The NICE field team of implementation consultants 6
Engagement activities 2013/14 9
NICE in Northern Ireland 9
Engaging with CCGs 11
NHS England area teams and primary care commissioning 13
Engaging with social care 17
Supporting improvement in public health 22
Helping NHS providers put NICE guidance into practice 26
Working across NICE 35
Providing feedback to NICE 35
Working in NICE 36
Future work programme 38
External engagement success criteria – annual progress report 41

Executive summary

1. This report describes the work of the field team of NICE implementation consultants and our contribution to supporting NICE guidance, advice and quality standards during 2013/14.

Working in a fast changing environment

2. The implementation of the Health and Social Care Act in April 2013 led to the biggest structural change in the NHS since it was formed. NICE's role expanded to develop guidance and quality standards for social care in England.

3. The field team spent a large part of the year rebuilding networks with NHS commissioning organisations, developing relationships with NHS England and Public Health England, ensuring that links were maintained with public health teams who had moved to local authorities, and establishing links with social care commissioners and providers.

4. The team worked hard with NHS provider trusts to ensure that they were making the best use of NICE guidance, advice and standards to provide high-quality care for patients.

5. This work also took place in an NHS that was coming to terms with the findings of the Francis enquiry and was developing its response to the enquiry's recommendations. The social care sector was in a similar position following the Winterbourne View review of December 2012.

6. Despite the degree of organisational change taking place in the system, where the team could engage effectively with organisations, the offer of support from NICE was enthusiastically received. Also, the benefits to be gained from using NICE guidance, advice and

standards to improve services for patients and service users was appreciated.

7. The year 2013/14 was also the field team's first full year of working with the Northern Ireland health and social care system. This role was enthusiastically welcomed and extensive networks are being developed with the health and social services system in the province.

Feedback to NICE

8. We continue to refine the ways in which we deliver feedback to NICE so that our reports remain focused on what NICE needs to do to ensure that our future guidance and support resources meet the needs of users.

9. We have provided intelligence to the NICE Board, centres and directorates about the impact in the field of the changes arising from the Health and Social Care Act, and explained how the changes offer opportunities for NICE.

Planning for the future

10. This is the first year that the team was working towards the newly developed NICE success criteria for external engagement. The annual progress report in appendix 1 details the team's performance against the criteria. The criteria were developed before some of the new organisations in the system were created, and the team's experience from working with these organisations has helped to develop the criteria for 2014/15.

11. In July 2013, the NICE Board received a report from an independent researcher that evaluated the team's impact and effectiveness with both internal and external audiences. The report was positive and made some recommendations to improve the team's effectiveness, which have been taken forward.

Conclusion

12. At a time of such significant organisational change the ability of NICE to provide a personal link with organisations and to understand how NICE can effectively support them is even more important.

Introduction

13. This is the 8th annual report produced by the NICE field team of 7 implementation consultants and the implementation facilitator for Northern Ireland. It presents a summary of the activities and findings of the team during 2013/14. Detailed reports and recommendations for action are provided to NICE's Senior Management Team and the centres and directorates every quarter. This report has been produced for the NICE Board and will be presented at the July Board meeting.

The NICE field team of implementation consultants

14. The field team provides support to organisations in England and Northern Ireland that are implementing NICE guidance, advice and standards, and plays an important role in promoting and disseminating the entire range of NICE products. It:

- provides strategic advice and context to help senior management teams in NHS, public health and social care organisations work with NICE guidance
- helps to solve problems by sharing examples of how organisations have worked together to implement guidance and use NICE quality standards
- offers advice on how to use the NICE implementation support resources, pathways and NICE Evidence Services
- collects feedback for NICE from professionals and practitioners on new NICE products and suggestions for improvement
- gives NICE regular feedback on the results of its fieldwork.

15. In addition the implementation consultant for the West provides informal support for NICE implementation in Wales. This is a growing area of activity and one that it is hoped could become formalised in the future.

Our engagement strategy

16. The team has a dual role: giving organisations information about NICE, its guidance, advice, standards and supporting products; and gathering feedback from those organisations to help NICE centres and directorates develop guidance and support. The team approaches its audiences in a number of ways.

Proactive programmes of activity

17. In January 2013, the field team assessed the priorities for engagement for the year starting 1 April 2013. At its planning meetings, the team considered how the success criteria could be delivered, and it reviewed the forthcoming changes in the health and care system as well as considering forthcoming NICE guidance and standards. It also received input from other teams in NICE. The strategy developed was widely circulated within NICE to allow centres and directorates to request that specific areas are covered during visits and to enable members of other teams to accompany the implementation consultants on their visits.

Regular work with NICE managers

18. NICE managers perform an essential role as the lead for NICE implementation in NHS trusts and clinical commissioning groups (CCGs). In recognition of their importance to NICE, we have developed a series of regular regional meetings that provide NICE managers with an opportunity to hear about the latest developments in NICE's work and an informal network for them to share experience and learn from each other.

Tailored interventions in response to requests

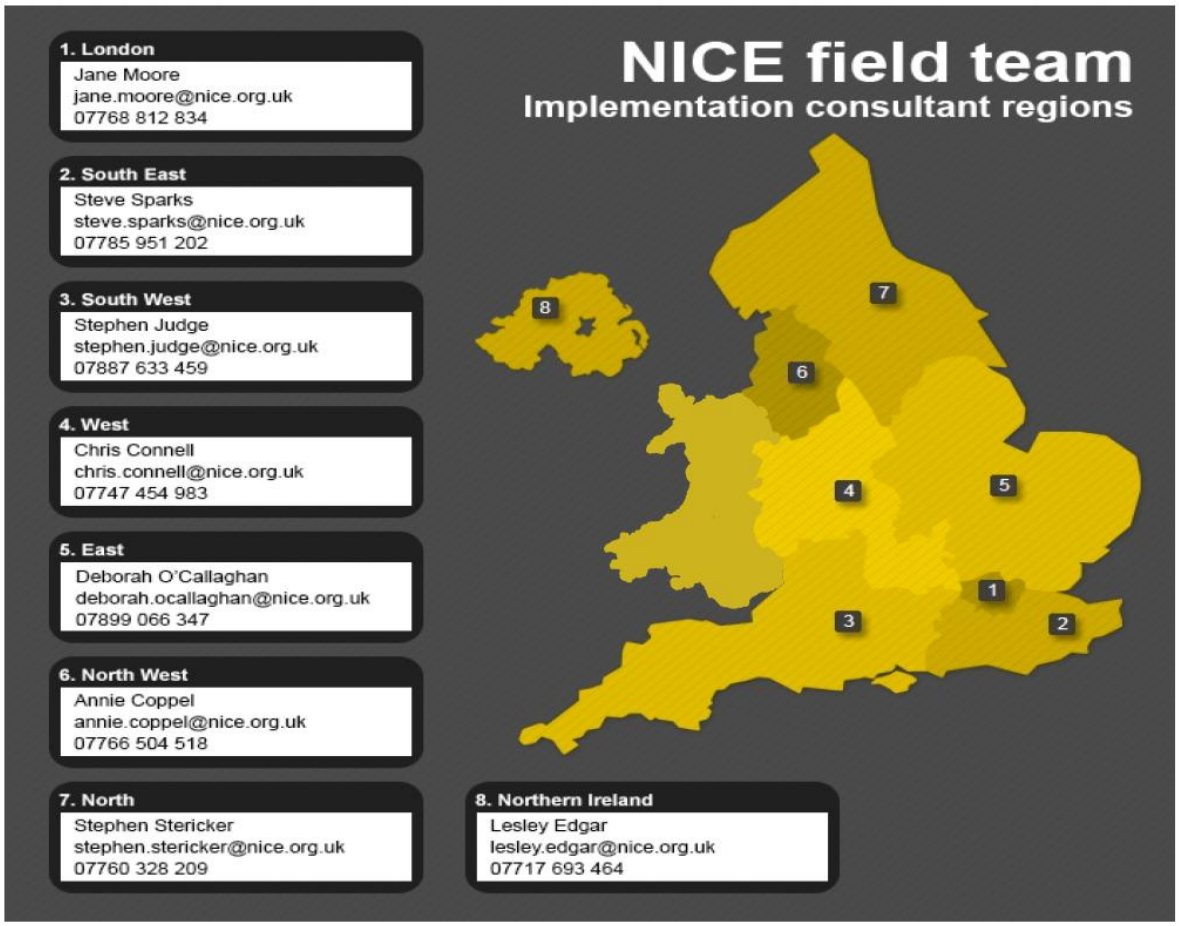
19. In our 8 years of operation, we have developed extensive networks across the health, public health and social care sectors and are often asked by organisations and individuals to help devise solutions to problems or deliver tailored sessions for their teams. These are an excellent opportunity for the field team to embed knowledge of NICE guidance and support products into routine practice and to explain how new developments at NICE can help improve services for patients and service users.

Targeted interventions at the request of NICE centres and directorates

20. The field team ensures that it has capacity to respond promptly to internal requests for information or feedback. This may involve incorporating specific questions into visits or road testing new products as part of routine engagement.

21. During 2013/14, the team delivered 1449 engagements. The implementation consultants exceeded their business plan objectives of meeting 80% of NHS organisations (86% actually visited) and 80% of local authorities (89% actually visited) in 2013/14. A detailed breakdown of activity is provided in tables 1 and 2 on page 43 of this report.

Figure 1 Areas covered by NICE implementation consultants



Engagement activities 2013/14

NICE in Northern Ireland

22. From 1 October 2012, NICE was able to secure funding, after negotiations with the Department of Health, Social Services and Public Safety (DHSSPS), for a permanent member of the field team to support and facilitate the implementation of NICE guidance in Northern Ireland.

23. In 2013/14, the main aim was to build relationships and raise awareness. Introductory meetings were held with all health and social care organisations in Northern Ireland to understand how they were implementing NICE guidance. This was in response to the DHSSPS Circular HSC (SQSD) 04/11 'NICE technology appraisals and clinical guidelines – new process for endorsement, implementation, monitoring and assurance in Northern Ireland', which requires that health and

social care organisations and family practitioners put in place the systems necessary for implementing NICE guidance as part of their clinical and social care governance arrangements. These processes were reviewed by the Regulation and Quality Improvement Authority (RQIA) with support from the implementation facilitator, and the review, National Institute for Health and Care Excellence (NICE) Guidance: Baseline review of the implementation process in health and social care (HSC) organisations, was published in July 2013. The recommendations from this review provided direction for the work plan for the remainder of 2013/14.

24. The main focus of the introductory meetings with the health and social care organisations was to provide an update on guidance, quality standards and support materials relevant to services in their responsibility, and discuss how NICE resources can best be used to provide high-quality care. The meetings were an opportunity for the health care professionals and managers to provide feedback on NICE guidance and discuss some of the challenges around working with NICE guidance, standards and advice. The visits also enabled the implementation facilitator to gain a better understanding of the extent to which NICE guidance is used by the organisations in Northern Ireland.

25. Following on from one of the recommendations in the RQIA review, the implementation facilitator established a network called the Northern Ireland NICE Managers' Forum, which includes NICE implementation leads from both commissioning and provider organisations, to discuss common issues and share good practice in implementing NICE guidance.

26. Over the course of the year, the implementation facilitator for Northern Ireland made 210 visits to 28 organisations. This included 69 visits to 6 health and social care trusts and 141 visits to 22 other organisations and networks in Northern Ireland.

27. The remaining sections of the report describe the team's work in England and Wales.

Engaging with CCGs

28. During 2013/14, the field team made 236 visits to 144 of the 211 (68%) CCGs – a considerable increase on the 49 visits made in 2012/13. The aim of the engagement programme was to re-establish links between NICE and commissioners, following the introduction of the new commissioning arrangements in the NHS, and demonstrate the value of NICE guidance, advice and quality standards to them.

29. More specifically, one of the team's goals was to identify a 'NICE lead' at a senior level within 80% of CCGs and obtain a minimum of 20 examples of quality standards being used to inform local commissioning arrangements. Both goals were achieved.

30. In contrast to 2012/13, access to CCGs in 2013/14 was relatively straightforward as people started to see the value of the 'NICE offer'. The team generally met with senior commissioners including accountable officers, medical directors and directors of quality.

What we found

31. There was remarkable variability between CCGs in terms of size, ways of working, awareness and use of NICE products. Some of the largest CCGs, with populations of up to 750,000 had sufficient 'in-house' resources to support most of their commissioning responsibilities. Smaller CCGs (a few with populations a little over 100,000) bought support for 'NICE implementation' and medicines management from their commissioning support unit or shared resources with neighbouring commissioners.

32. A common factor faced by all CCGs was significant financial pressure and this affected the approach that many of them took to using NICE guidance. A senior commissioner representing a group of 4 CCGs commented that affordability of NICE guidance was a key factor in

determining whether guidance recommendations were incorporated into commissioning intentions. Many CCGs cited managing the large volume of NICE guidance and uncertainty about how to use NICE quality standards as further challenges.

33. Nevertheless, despite these concerns NICE was generally viewed positively. One accountable officer commented that:

"NICE guidance is usually the starting point for (the CCG's) redesign projects and new commissioning policies."

More specifically, a director for quality at another CCG said:

"COPD (chronic obstructive pulmonary disease) – a really useful piece of guidance that informed our commissioning of breathlessness (services). The recommendations on pulmonary rehabilitation were particularly helpful."

34. Awareness and approaches to using NICE guidance and standards differed considerably between CCGs, often in line with their commissioning capacity. A small number had already developed formal policies and discussed using a large number of pieces of guidance and quality standards with their providers. Others made relatively little use of them, with most CCGs somewhere in the middle – that is, in the process of developing a strategic commissioning policy while at the same time using guidance and standards to underpin commissioning particular services.

35. Although CCGs are not responsible for commissioning primary care, they have a responsibility for quality improvement in this sector. Almost all CCGs stated that ensuring the systematic use of NICE guidance and standards in primary care was a major challenge and there was considerable interest in discussing how NICE might help CCGs achieve this. CCGs suggested encouraging a strategic approach to incorporating NICE guidance recommendations into GP decision support systems, supported by raising awareness and education.

What we did

36. At a general level, the visits made by the field team were well received and increased commissioners' understanding of the value of NICE guidance and standards and how they can be used. The effort to go out and meet people was also appreciated. After a presentation made by a member of the field team, a commissioner said:

    "The whole presentation was fascinating. What I think made it particularly successful was how the empathy and inclusiveness of your delivery enabled you to engage directly with the audience and 'humanise' a complex and contentious subject."

37. More particularly, the field team supported the development of commissioning policies for NICE for individual CCGs, advised on specific projects such as falls prevention and chronic obstructive pulmonary disease services, and encouraged shared learning between CCGs, providers and Academic Health Science Networks. In one case, the team also supported a successful bid by a CCG and a university for funding to support and evaluate a new approach to implementing the clinical guideline on osteoarthritis in primary care.

NHS England area teams and primary care commissioning

38. NHS England was established as a statutory organisation in April 2013. It comprises 27 area teams that work to a single operating model.

39. The overarching role of area teams is to ensure that the NHS delivers better outcomes for patients within its available resources, and upholds and promotes the NHS Constitution. Area teams have 3 key functions:

    - Support and quality assurance of CCGs.
    - Commission primary care services.
    - Commissioning specialised services (10 area teams lead on this).

40. NHS England recognised that NICE guidance, quality standards and other products could support the work of the area teams. In November

2012, an outline of the NICE implementation policy for the area teams was drafted and sent to the shadow area team directors by Ian Dalton (Chief Operating Officer of the NHS commissioning board, at the time). The policy addressed the use of NICE guidance and quality standards for each of the 3 key functions of the area teams.

Area team engagements during 2013/14

41. The field team met with all the 27 area teams in 2013/14 and there were 65 engagements in total across the country. Named NICE leads were identified in all area teams and preferred means of communication were agreed with each area team.

42. Because the area teams were quite new to the process, early discussions were more exploratory than initially anticipated. Most of the area teams seemed unaware of the framework policy for NICE that had been developed and disseminated during November 2012. Concerns were also expressed about a lack of capacity to implement the policy, particularly in relation to primary care commissioning. As a result, early conversations focused instead on establishing relationships and providing a high-level briefing about NICE resources and how they could support the work of the area teams.

43. We found that most of our area team leads had low awareness of NICE quality standards despite being familiar with our guidance. Several area teams were keen to engage in discussion about how they could use quality standards, for example, to support quality improvement work in primary care, assurance of CCGs and scrutiny of service reconfiguration proposals put forward by clinical senates.

44. The field team also noted a wide variation in the area teams' approach to quality in primary care. In some areas, responsibility for quality in primary medical services seemed to rest with CCGs, and the implementation consultants found this to be a dominant topic for conversation with CCGs in those regions. Another area team maintained complete ownership of the primary care quality agenda and

expressed preference for the topic not to be raised with CCGs in their area. Most area teams, however, recognised the need for CCGs and area teams to work collaboratively to support quality assurance and improvement in primary medical services, and were keen to engage with their local implementation consultant to explore how NICE resources could support this.

45. As the year progressed, there was more recognition that a systematic approach for using NICE guidance and quality standards would be beneficial. The field team advised 10 area teams on such an approach and will continue to work with them to develop local policies for using NICE guidance and quality standards. We will also continue to support the other 17 area teams, with the intention of sharing good practice as it emerges.

46. Some examples of successful engagement of the NICE field team with area teams are given below.

Greater Manchester area team

The implementation consultant has quarterly meetings with the area team to provide updates on joint working and share intelligence. With input from the implementation consultant and local CCGs, the area team is looking to include a metric on 'the systematic use of NICE to improve quality' on the primary care quality dashboard.

The area team is also exploring how it can influence secondary care quality through CCG commissioning by building the use of NICE into CCG commissioning assurance check points.

Briefing for medical directors across the Midlands and the East

Implementation consultants provided a briefing and contributed to a discussion about how NICE resources could support the work of area teams. Medical directors from all area teams across the Midlands and the East were present. The meeting was arranged by the regional medical director, and implementation consultants were asked to cover:

- brief update from NICE
- implementation consultants – who we are and what we do, examples of engagement with Academic Health Science Networks and health and wellbeing boards
- how we can support area teams:
  - direct commissioning functions
  - primary care (quality improvement/assurance)
  - CCGs (assurance and support).

Quality leads/nursing forums
Local implementation consultants attended 2 CCG nursing forums hosted by area teams to explain NICE support to commissioners, and to offer support to each CCG with developing approaches to using NICE resources to assure quality of both secondary and primary care services.

Primary care protected learning sessions
Implementation consultants gave presentations at 4 area team or CCG-led primary care education events. This equated to engagements with over 100 GP practices.

Engaging with social care

47. There are 152 local authorities responsible for social care, and over 25,000 different providers of social care services. Local authorities have a leading role in commissioning and developing a wide range of services. The implementation of personalisation, as described in Putting people first (HM Government, 2007), means that people are eligible to have a personal budget, with the option of holding the funding themselves so they can make direct payments for their own care.

48. Other significant changes impacting on the sector include the introduction of health and wellbeing boards, the drive towards integration of health and social care, and changes in legislation and guidance in children's social care, as a result of the 2011 Munro review of child protection.

49. To help NICE engage with the social care sector, we identified a programme of contacts with directors of adult and children's social care in local authorities (or their representatives). The objectives were to:

- continue to raise awareness of NICE guidance and quality standards, and encourage their implementation and use
- encourage active participation in developing NICE guidance
- inform the development of implementation resources
- seek feedback in relation to the relevance of referred topics.

50. During 2013/14, the field team established direct contact with social care teams in 125 (82%) of the 152 local authorities in England. Comments from local authority representatives recommended that the community, voluntary and independent sector care providers would benefit from increased awareness of NICE guidance and implementation resources. Therefore, we established contact with representatives from 14 organisations to establish initial feedback on the NICE social care programme.

Working across NICE teams

51. A joined-up approach to engagement has been adopted, with monthly meetings between the field team, social care programme, and the quality standards and indicators team. An implementation consultant links with the social care team to share intelligence and to coordinate engagement activities.

52. In December 2013, the field team held a meeting with the NICE Collaborating Centre for Social Care (NCCSC) to explore opportunities for coordinating our implementation support to the sector. Follow-up meetings are planned to align engagement and dissemination strategies.

What we found

53. There were generally low levels of awareness of the emerging role of NICE in social care, particularly from community, voluntary and

independent sector care providers. Few people were aware of the difference between guidance and quality standards and how to get involved with NICE. Challenges in releasing staff to participate in guidance development opportunities were stated. However, the sector was mostly positive about the reputation of NICE and was receptive to the need for evidence-based guidance in social care.

54. There was some concern that NICE does not have an adequate understanding of the social care sector, and that our products will not meet their needs.

55. The topics referred to NICE were reported to broadly match the priorities of the sector. Less emphasis was recommended on individual interventions and condition-specific guidance, with a preferred focus on prevention/population themes and multiple health and social care morbidities. Feedback from engagements can be themed into the following key issues.

The status of guidance and related quality standards

56. Stakeholders have requested that we develop a narrative setting out how we relate to, and work with, other standard setters. The status of guidance must be made clear in relation to existing Department for Education and Department of Health guidance, national minimum standards, Care Quality Commission and Ofsted (Office for Standards in Education, Children's Services and Skills) inspection frameworks.

Financial climate

57. The financial climate is challenging local authorities to meet basic, rather than aspirational, standards of care. Resources that review and advise on cost effectiveness and return on investment are a priority for local authorities.

National guidance and quality improvement programmes

58. Local authorities reported the potential for a 'crowded market place' of guidance and improvement initiatives. It was recommended that NICE

ensure that guidance and related quality standards are integrated into existing social care frameworks and quality improvement initiatives. Examples include the adult and children's sector-led improvement programmes, Think Local Act Personal (TLAP), Making Research Count and the Adult Social Care Outcomes Framework.

National policy

59. Personalisation is an important practice and policy agenda for social care, and guidance must review the evidence and reflect the issues and challenges of person-centred coordinated care.

60. The integration of health and social care is also a policy priority and it was recommended that guidance and implementation resources address joint commissioning and the integration of care as a means to generate improved outcomes, system efficiencies and savings.

How NICE guidance and related quality standards are being used

61. We discovered that some local authorities are already reviewing guidance and quality standards and making good use of them. Examples of actions taken by local authorities include:

- A local authority has incorporated quality statements from Supporting people to live well with dementia (NICE quality standard 30) into their quality assessment framework for independent care providers. Care providers are financially incentivised through higher assessment scores that can be achieved by demonstrating use of quality statements to drive improvements in care.
- The adult social care services of a local authority have recently produced a draft policy statement for the systematic use of NICE guidance and quality standards. The policy recommends that the following text is used in all adult social care tenders, contracts and grants:

  'Adult Social Care is committed to adopting National Institute for Health and Care Excellence (NICE) guidelines and quality

standards throughout their contracted social care services. There is, therefore, an expectation that Providers will, wherever appropriate, incorporate these guidelines and standards into their processes and practices in order to demonstrate the delivery of quality services, and Providers will continue to do so as and when new guidelines and standards become available in relation to their service. Adherence to NICE guidelines and quality standards will be monitored by the Council.'

- A children's social care services team has reviewed the quality of their family contact services against the NICE quality standard for the health and wellbeing of looked-after children and young people.

Summary

62. Engagement with the social care sector has produced a rich collection of qualitative feedback that is contributing to the content of the NICE programme of work for social care. The field team aims to continue to build on the relationships that have been established in the regions by proactively using the feedback and intelligence gained to develop engagement priorities for 2014/15.

Engagement: next steps

63. The success criteria are often outside the direct control of the field team, but encouragement and influence can be applied when aiming to achieve the operational priorities for engagement for 2014/15. These priorities include the following:

- Follow up the outcomes of our recommendations to each local authority that they should register as stakeholders with NICE and contribute to the guidance development process.
- Encourage social care commissioners to routinely use guidance and quality standards to inform their commissioning activities. This will include targeting engagements in support of local authorities willing to develop case studies/shared learning examples of how local authorities might use guidance and quality standards.

- Prioritise engagement activities with the community, voluntary and independent sector care providers, encouraging a more systematic approach to incorporating guidance and quality standards into practice.
- Establish contact with regional leads for adult and children's sector-led improvement programmes and explore how NICE guidance and quality standards can be incorporated into regional quality improvement initiatives.
- Continue to coordinate activities with the NICE social care programme and other relevant NICE programmes, including the National Collaborating Centre for Social Care.

Supporting improvement in public health

64. April 2013 saw the formal transition of public health functions from the NHS to local government. Although most of the directors of public health in post before April 2013 had been based in the NHS (usually in primary care trusts), many already had joint appointments with local authorities. Alongside this Public Health England was established with a national, regional and local presence. The field team wanted to maintain its relationship with local public heath teams and at the same time forge effective links with Public Health England. Health and wellbeing boards provide a focus for local communities to ensure that service are being commissioned and provided in a way that meets the needs of the population. They are an important audience for NICE.

Working with directors of public health

65. During the transition, the public health teams in local government followed several different models. Some public health teams transferred almost unchanged and continued to function as discrete teams, whereas others adopted a distributed model in which public health professionals were located in existing local authority departments but with working arrangements agreed between the relevant department and the director of public health. Some directors of

public health reported directly to council chief executives, whereas others reported to other lead directors.

66. The field team visited 136 local authorities in 2013/14, including meetings with 35 directors of public health. Building on previous engagement with this audience, it set out to:

- Agree regular working arrangements with local public health teams in every local authority.
- Encourage the establishment of policies for NICE in at least 50% of all local authorities.

What we found

67. Local government briefings continued to prove popular. People continued to welcome their concise, factual and easy to read format.

68. There was significant interest in developing more return on investment tools after publishing the tobacco one. One county council had found the tool ‘straightforward, easy to use and made the case for smoking cessation services’. Several topics for potential development were suggested, such as the ‘frail elderly’. Interest in ‘return on investment’ mirrored requests for advice focused on disinvestment as local authorities are challenged to find significant savings. A public health version of the clinically oriented ‘Do not do’ database was suggested by one director of public health.

69. There were continued calls for guidance to be written to reflect a population’s needs, rather than diagnoses or conditions. There were also demands for guidance to be given stronger direction to underpin it (for example, by greater promotion and support from other agencies such as the Department of Health, Ofsted and Public Health England).

What we did

70. The field team provided examples of implementation and assurance processes to help councils adopt approaches to disseminate and

implement guidance. However, few councils felt the need for a specific NICE policy because they feel that it is already integral to their work.

71. Working across departmental and sectoral divides was still cited as a barrier to using NICE guidance, and guidance from multiple sources can cause confusion. For example, there was a perception of overlap between publications from the Local Government Association and NICE guidance and briefings.

72. One director of public health provide a good summary of the profession's needs from NICE:

> "A jobbing director of public health like me . . . wants things that are simple and useful off the peg to make the case for protecting public health investment . . . what I would like most of all is some practical stuff that would help bring a public health focus to other council directorates, especially planning and transport . . . "

Working with Public Health England

73. The 4 regional offices of Public Health England reflect the 4 NHS regions, and 15 local Public Health England centres cover smaller geographical patches

74. In May 2013, a partnership agreement between NICE and Public Health England was signed, setting out the working relationship expected between the 2 organisations. The field team met with all but 1 of the local centres to develop a working relationship between NICE and Public Health England at a local level. Much of the work at this stage was about identifying where leadership and support should be delivered in the public health system and the relative roles of Public Health England, NICE and local authority public health teams in providing that.

75. A series of regional workshops are being developed for 2014/15 by the field team, which will enable Public Health England centres, local public

health teams and NICE to collaborate on tackling particular public health challenges for local communities.

Working with health and wellbeing boards

76. Health and wellbeing boards are strategic partnerships made up of the key players in a local health and care economy including CCGs, trusts, councillors, local government officers and Healthwatch. Tasked with setting strategic direction across health, public health and social care, their key responsibility lies in producing a Joint Strategic Needs Assessment for their area, followed by a health and wellbeing strategy to inform the commissioning and provision of care, to which CCGs must have regard.

77. The field team engaged with 49 health and wellbeing boards to:

- Start an ongoing relationship with NICE and their local implementation consultant.
- Identify how NICE guidance, standards and other products can support the work of health and wellbeing boards.
- Offer customised support as needed to help health and wellbeing boards embed NICE within their needs assessment and strategic planning activities.

78. We found that awareness and use of public health products from NICE was increasing, although from a low base when health and wellbeing boards were in shadow form in 2012/13. On at least 2 occasions, implementation consultants had helped map NICE publications to Joint Strategic Needs Assessment priorities to help raise the profile and use of NICE guidance and standards.

79. There was enthusiasm for the shorter, concise publications such as local government briefings. The Healthy Cities Network lists NICE local government briefings as resources in their documentation. A northwest borough council has made extensive use of the briefing on alcohol as part of their action plan to reduce alcohol abuse. In a major southwest

city, the briefings have replaced the council's own public health summaries and the briefing on cycling and walking is being tested to see if it can inform policy in a northwest council.

Summary

80. Overall, the profile of NICE's public health work has continued to rise over the past year, partly driven by introducing concise summaries and tools that aid good investment decisions.

81. As the changes in the public health sector settle down, there is a real opportunity for very effective links to be generated between NICE and public health teams at a national, regional and local level.

Helping NHS providers put NICE guidance into practice

Working with acute, community and mental health trust medical directors

82. The NICE field team has developed good relationships with medical directors of acute trusts and mental health trusts, visiting them regularly and often being invited back to attend high-level committees or to present at key events. Many of these organisations also now manage local community services. Medical directors often have a key role in ensuring a strategic approach to implementing NICE guidance across their organisations.

83. This year, the objectives for these visits were to:

- continue to maintain and develop effective working relationships with medical directors, building on existing long-term relationships with these key influencers of local healthcare
- promote and support the use of NICE quality standards as critical tools to underpin the delivery of the NHS outcomes domains; obtain examples of how they are being used at a local level; and ensure organisations are developing local policies for using quality standards
- reinforce the position and use of NICE guidance and evidence in local responses to high-level reports and government policy

- promote awareness of new topics, for example, new medical technologies guidance.

Findings from the trusts:

84. We visited 210 of 245 NHS trusts (86%) this year and found that NICE is well respected by NHS trusts, which generally try to implement our guidance swiftly, but some medical directors noted that the reduction in resources to support implementation, the volume of guidance being produced by NICE and the demand for information about 'compliance' from commissioners are becoming significant barriers to this.

85. Last year the field team spent time raising awareness of NICE quality standards with trust medical directors, and discussing how to use them to improve quality. This year we started to see some organisations considering how to use them more effectively to drive quality improvement, and understanding their potential value. The publication of NICEs Into practice guide has helped trusts to consider an organisational approach, and develop local policies for using them.

86. We identified 57 examples of trusts using quality standards, and encouraged them to submit their work to our shared learning database. Some medical directors mentioned they are using them to identify quality improvement priorities for the coming year, to inform their trust clinical audit programme, in local CQUINS (commissioning for quality and innovation payments) agreed with commissioners, to amend local treatment pathways, and in doctors' quality improvement projects for revalidation.

87. However, some of the people we spoke to were still unaware of the value of NICE quality standards, and where they were being used, this was generally being led internally and not by the commissioners of acute and mental health trusts, who have an equally low level of knowledge about how to use quality standards in a practical and useful way. There also remains concern about quality standards becoming mandatory measures.

88. We found that acute trust and particularly mental health trust medical directors were very interested in our programme of guidance and quality standards for social care. Mental health trusts were also particularly pleased to see us producing guidance for people with learning disabilities for the first time.

89. There was a lot of interest from providers in the way NICE guidance will be used in the Care Quality Commission's new inspection framework. As part of the team's work with NHS providers in 2014/15 we will describe the contribution that NICE guidance can make to providing assurance to regulators.

90. Trusts told us that the medicines practice guideline on Developing and updating local formularies and the NICE innovation scorecard have both helped to streamline the process and improve the time taken for drugs to get onto local formularies, helping them meet requirements around NICE technology appraisal guidance.

91. Later in the year, there was much interest in the work that NICE had started on developing safer staffing guidelines.

Working with ambulance trusts

92. We met with medical directors or other senior personnel in 9 of the 10 ambulance trusts in England, and also the ambulance trust in Northern Ireland.

93. Ambulance trust medical directors were pleased to see that NICE will be producing a suite of 'trauma' guidance, but would still like NICE to do more around pre-hospital care. They feel it is particularly helpful when NICE refers directly to ambulance services (for example, in our guidance on self-harm), stating that "there is nothing better than when NICE recognises our existence".

94. Ambulance trust medical directors would also like to contribute to a wider range of guidance, not just trauma guidance (for example, guidance relating to mental health and learning disabilities, because

they have significant engagement with these service users on a daily basis).

95. Ambulance trusts particularly like NICE pathways, and the NICE and British national formulary apps have been a ‘big hit with ambulance trust staff who are using it on their own phones’.

96. The main challenge for using NICE guidance in ambulance trusts is the lack of joined up working with other parts of the health economy on issues that need ‘joined up action’. Strategic clinical networks may provide the focus for those conversations in some areas.

Working with clinical senates

97. Clinical senates were established in April 2013 to be a source of independent, strategic advice to commissioners and other stakeholders, assisting them to make the best decisions about healthcare (redesign and reconfiguration) for the populations they represent. Each of the 12 clinical senates is hosted by a local support team based in an NHS England area team.

98. The overall objective for engagement is to support clinical senates to use NICE guidance, quality standards and advice to inform service reviews and recommendations. The field team identified the associate director or the appointed senate chair for all 12 clinical senates and engaged with 10 of them.

99. NICE can help the clinical senates with 2 main elements of their role by:

- mediating about the implementation of best practice, what is acceptable variation and the potential for improvement of practice in conjunction with Academic Health Science Networks
- supporting commissioners to identify areas of healthcare where there is potential to improve value and outcomes.

100. Each of the 12 hosting area teams appointed an associate director for the senate who is also responsible for the strategic clinical network. Part-time chairs were appointed but some not until several months into the financial year. Work to establish senate councils and their assembly, together with associated governance arrangements, followed mid-year onwards.

101. Early discussions with clinical senate leaders indicated that the clinical senates will provide the 'clinical conscience and guiding intelligence for strategic service change'. The councils would bring together a range of professionals to take an overview of health and healthcare for local populations and provide a source of strategic, independent credible clinical advice on how services should be designed to provide the best overall care and outcomes for patients. Although they will be informed by patients, carers and the public, they are not formal consultation forums.

102. Clinical senate leaders saw NICE as a relevant source of evidence-based information to guide their strategic, independent advice, leadership and support to statutory commissioning bodies. A couple of senate chairs noted interest in the service guidance that NICE is due to produce in the future

103. Towards the end of 2013/14, it was confirmed that clinical senates would take over the role of the now dissolved National Clinical Advisory Team. The impact of that is still unknown but may place a stronger emphasis on the assurance aspect of safe, effective and accessible service provision.

Working with strategic clinical networks

104. Strategic clinical networks (SCNs) were established to drive large-scale change across complex pathways of care that involve many professional groups and organisations, and where a coordinated quality improvement approach is required. They are supported and funded through network support teams covering the same 12 defined

geographical areas as clinical senates, and therefore are hosted by the same NHS England area teams.

105. SCNs bring together people who use, provide and commission the service to make improvements in outcomes for complex patient pathways using an integrated, whole system approach. They serve in key areas of major health and wellbeing challenge, including:

- cardiovascular (including cardiac, stroke, renal and diabetes)
- maternity, children and young people
- mental health, dementia and neurological conditions
- cancer.

106. Each of the SCNs has appointed an associate director (SCNs/Senate) and a part-time clinical director. Many have appointed a number of clinical leads in support of the SCNs initial groupings. The field team identified the associate director and/or the appointed clinical director for all 12 SCNs and engaged with 10 of them.

107. 2013/14 was a transitional year for the SCNs – legacy programmes from the previous clinical networks were completed and also new areas of work had started. SCNs' leaders noted their networks to be at different stages of maturity; some building on existing clinical networks ('it's business as usual'), some with clinicians who are 'angry and grieving' for the old networks, and newer networks forming relationships, identifying priorities and building on work that was already happening in those areas outside of formal network arrangements.

108. Many SCNs appear to be using NICE guidance routinely to support their work, or are positive about how they will ensure routine review and use. There was interest in using quality standards and registering as a stakeholder for NICE, and a couple of requests for NICE to review the evidence on telehealth/care and to produce guidance on bundles of care, for example, the frail elderly.

109. The field team received requests for support to SCNs' clinical leads, and to contribute relevant information on NICE resources through membership of SCNs' Oversight and Planning Group.

110. SCNs have less resource than the networks they replaced, and therefore they are unable to provide a similar level of hands-on support for operational delivery. Some see the Academic Health Science Networks as a key delivery partner.

111. Although SCNs will operate at the interface between commissioners and providers, a couple of SCNs commented that they will need to place more emphasis on the needs of commissioners than their predecessor clinical networks.

Working with Academic Health Science Networks

112. NHS England designated 15 Academic Health Science Networks, to operate from April 2013. They are partnership organisations set up to provide a systematic delivery mechanism for identifying, adopting and spreading innovation and best practice – aligning healthcare delivery, teaching, research, education and training and partnership working with industry.

113. NICE has developed an overarching strategic approach to its engagement with Academic Health Science Networks and the field team helps to make that partnership and collaboration come to life at a local level.

114. The field team identified a lead for NICE in each of the 15 Academic Health Science Networks and early conversations with the leads identified a number of areas where there was potential interest in working with NICE. In May 2013, NICE offered Academic Health Science Networks the opportunity to frame our relationship in the form of a partnership agreement in which areas of mutual interest could be identified and supported.

115. Despite a lack of capacity and appointment of senior leaders in Academic Health Science Networks, coupled with lack of confirmation of Academic Health Science Networks budgets, by the end of the year the field team had made significant progress towards identifying areas for collaborative work as outlined below.

Academic Health Science Network (AHSN)	Activity
North West coast	Working with implementation consultant (IC) to develop a project to support implementation of technology appraisal (TA) guidance and clinical guidelines.
Greater Manchester	After developing their 2014/15 business plan, the AHSN is now interested in developing a partnership agreement and to explore Board engagement with the IC.
East Midlands	Several areas identified as potential areas for collaboration: • 'Ripples and Waves': Support development of skill base for putting research into practice (encourage and support implementation of NICE guidance as part of a local programme training frontline clinicians in putting research into practice). • Support evaluation and uptake of innovative technologies (refer companies with promising new or novel medical technologies [devices or diagnostics] to the Medical Technologies Evaluation Programme [MTEP] to consider the suitability for evaluation). • Improve accessibility of evidence-based guidance for primary care (share learning to help inform NICE efforts to improve accessibility of guidance for primary care). • Supporting service improvement (support implementation of NICE recommendations as part of local service improvement projects; share research findings on uptake or barriers to implementing NICE guidance. Put forward for wider dissemination any resources that are developed locally to support implementation of NICE guidance and/or use of NICE quality standards).
Eastern	Do not wish a formal partnership agreement but remain keen to work with NICE on identified projects, including: • Support for implementation of TAs through an ASHN convened 'Responsible prescribing forum' that is also looking at implementing recommendations of the formulary good practice guidance.

	• Delivering introductory sessions to clinical interest groups about NICE and how our resources can support their work. • Contributing to NICE work on defining compliance.
West of England	Has signed a partnership agreement. Areas for collaborative working agreed as: • Uptake and compliance of TA • Using evidence to guide practice (hip joints, tocolytics for delayed pre-term birth) • Implementation of new oral anticoagulants (NOACs) (especially with regard to atrial fibrillation) • Being pilot sites for adopting new technologies (for example, faecal calprotectin). Outcomes to be determined by the number of organisations signing up to similar projects. Outcomes for each area of work are defined by the AHSN in very broad terms, for example, research evidence successfully implemented.
Yorkshire and Humber	Has agreed to a partnership agreement in principle and identified the following priority areas for potential inclusion: • Faecal calprotectin uptake • Exploring barriers to the uptake of NICE guidance • Implementing NOACS in a trust and sharing the learning/barriers/success for wider roll-out of implementation across the region • Establishing a NICE TA network to support reducing variation in implementation • Implementing high-impact innovations – inditherm.
Oxford	Has agreed in principle to a partnership agreement and has indicated a couple of areas for collaborative working such as medical technologies (evaluation, uptake) and encouraging referrals to NICE programme.
West Midlands	Is positive about working with NICE
Kent Surrey and Sussex	Partnership agreement drafted and going through AHSN governance processes – areas for collaboration include: • NICE TA uptake • patient safety • care homes.
South West	Has signed a partnership agreement. Areas for collaborative working agreed as: - Supporting evidence-based care – frail elderly (NICE support in identifying relevant guidance and improvement measures) - Improving uptake of NICE guidance – developing methods to measure uptake.
Wessex	Continues to explore a formal partnership agreement and identifying areas for joint work.
Imperial	Continues to explore areas for collaborative working with

	NICE.
South London Health Improvement Network	Continues to work with the IC on implementation of guidance, and may consider a formal partnership agreement.
UCL Partners	Have agreed in principle to a partnership agreement. Areas for joint working include providing upstream support for innovative devices being developed through their research programmes. Their interest centres on working with NICE's Centre for Health Technology Evaluation (CHTE) and Health Technologies Adoption Programme (HTAP).
North East and North Cumbria	Partnership agreement is drafted and awaiting formal sign off by the AHSN. Areas for collaborative working agreed as: • Implementing NICE guidance – contributing to a best practice partnership that will support collaborative approach to improving uptake and implementation. Measures have been included in the PA such as number of participating stakeholders, agreement on measurement of impact. • Support for adoption of high impact innovations (detail to be worked up) • Medicines optimisation and implementation of TAs.

Working across NICE

116. Providing regular feedback to NICE is an essential part of our role. This section of the report describes the variety of ways in which the implementation consultants provide this feedback.

Providing feedback to NICE

117. Our visits are designed to ensure that organisations have the opportunity to give feedback on their impressions of NICE, our guidance and the resources that we have developed to support it.

118. To ensure that this feedback reaches the appropriate parts of NICE in a timely and relevant way, we have developed a variety of communication channels:

- A **monthly report** is produced by the impact and evaluation team, extracted from the field team database and circulated to the field

team and implementation programme director. This enables us to detect emerging themes as campaigns progress.

- We produce a suite of **quarterly reports**, which are widely circulated within NICE. These reports summarise the findings from the preceding quarter and present feedback tailored to individual centres and directorates. They include the implementation of consultants' observations and suggestions for change. The observations and suggestions are discussed quarterly with each directorate or centre, helping to ensure that findings from the field are incorporated into each centre or directorate's decision-making. The quarterly reports are available on the NICE intranet.
- A **summary of the quarterly reports** is prepared for NICE's Senior Management Team and a field team member attends the Senior Management Team meeting to discuss the report and actions proposed by directors.
- **Bi-monthly briefings** to NICE's Board are given by the implementation consultant covering the patch where the Board meeting is taking place. Recent findings from the field are presented, with a particular emphasis on the locality.
- Each implementation consultant has links with a NICE centre or directorate and provides regular updates on findings from the field. NICE staff are encouraged to accompany implementation consultants on their field visits and several members of staff have taken this opportunity, including members of the Senior Management Team.

Working in NICE

Lead areas

119. The implementation consultants contribute to a variety of work in NICE, within and outside the Health and Social Care Directorate. In 2013/14, we contributed significantly to:

    - the management of service-level agreements with Northern Ireland and Wales

- the operation of the NICE Fellows and Scholars Programme
- the work of the Implementation Strategy Group
- developing closer links with the pharmaceutical industry via the Association of British Pharmaceutical Industries.

120. We regularly brief other teams across NICE and in the implementation programme, giving detailed feedback on developments in the field and on how tools and support have been received. Giving internal teams information on how the external environment is changing has been increasingly important at this time of change in the NHS and local government.

121. We continue to provide support to NICE International and have briefed a number of visiting overseas delegations on the work of the implementation programme and contributed to NICE International assignments.

122. We have established links with the NICE medicines and prescribing centre's team of 4 regional technical advisors and we will build a close working relationship with them to help improve the uptake of NICE medicines guidance.

Into practice guide

123. In 2013/14, the NICE field team revised the web-based Into practice guide to provide more detailed advice on how to use NICE quality standards.

124. During the revision, the following 2 new sections were also added:

- Using NICE guidance and quality standards in provider organisations.
- Using NICE quality standards to commission quality services.

125. The guide provides clear messages about the purpose of NICE guidance and quality standards and how to use them to improve quality in both provider and commissioning settings across health and

social care. It was approved by the Publications Executive in March 2014 and was launched at the NICE annual conference in May.

Adopting more efficient ways of working

126. We have explored using new technology more effectively to reduce the amount of time spent travelling by the team. Where appropriate we can conduct meetings by telephone or video conference. We also seek to meet with groups of representatives of health economies where that can be beneficial for both sides.

External meetings and conferences

127. The team represented NICE at a wide variety of external events, including the conferences of the Local Government Association, the Royal College of General Practitioners, the Royal College of Midwives, NHS Clinical Commissioners and the NHS Confederation. We also provided teaching sessions on 3 Master's degree courses and judged entries for the NICE Shared Learning Awards.

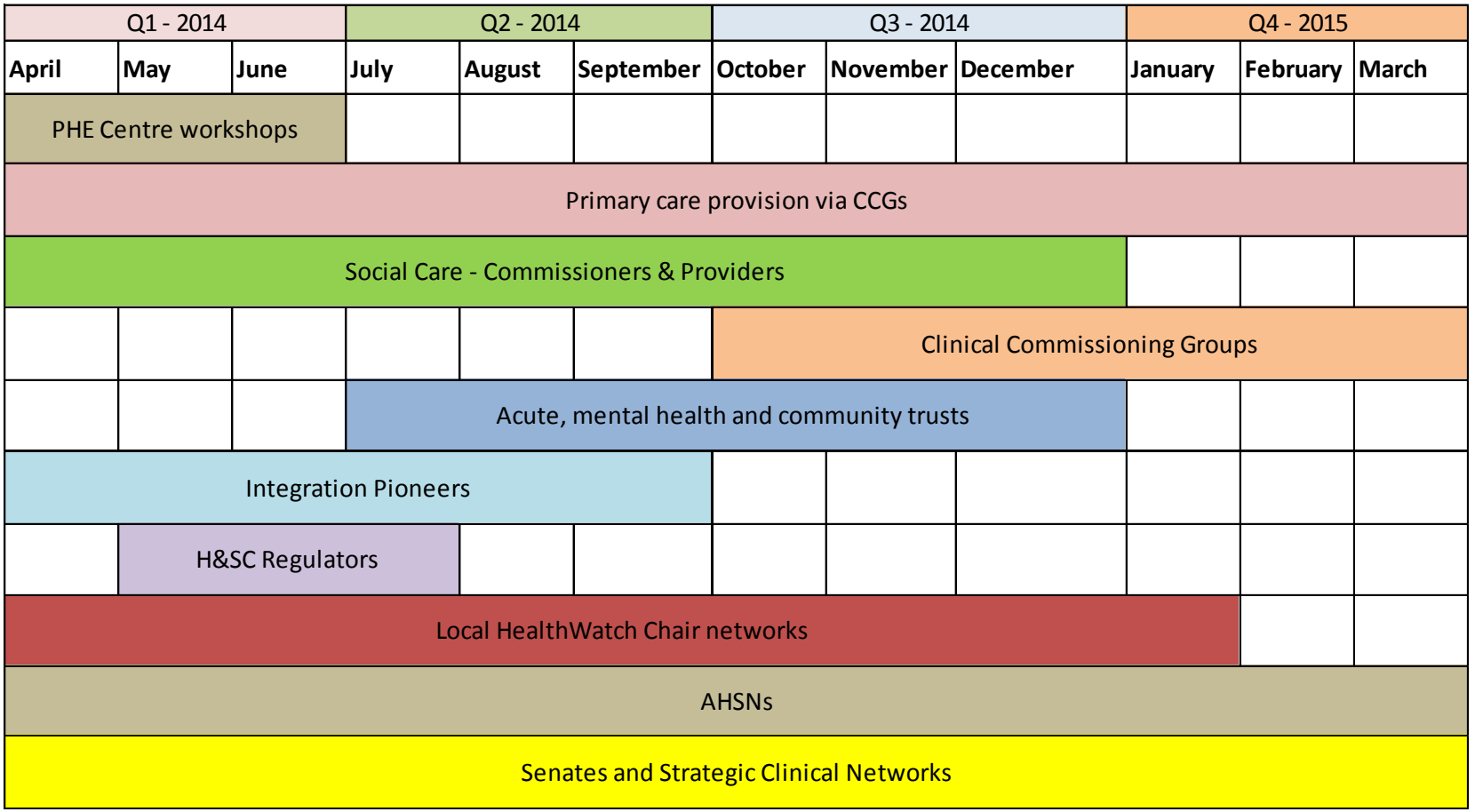
Future work programme

128. The team met in January to develop its engagement strategy for 2014/15 and was joined by colleagues from the quality standards and indicators programme, the medicines prescribing centre and the communications directorate. The programme is summarised in figure 2 and highlights include:

- A series of workshops with Public Health England centres and local public health teams focussed on a public health priority identified by the local public health team
- Describing to CCGs how they can use NICE guidance to improve the quality of primary care services
- Working with local networks of social care providers to raise their awareness of the contribution NICE can make to their work
- Helping CCGs develop local approaches for using NICE guidance and quality standards as commissioners

- Describing to NHS provider trusts how NICE guidance can help improve patient safety with a particular focus on safe staffing guidelines
- Meeting with the 14 integration pioneers to explore how NICE guidance and quality standards can help with their work and contribute to the use of the better care fund
- Working with local networks of Healthwatch to help them understand how they can use NICE guidance and quality standards in their oversight of local health and care systems
- Ensuring links are maintained with the health and social care regulators to enable NICE guidance and quality standards to be used as an effective component of the regulatory framework
- Maintaining links with strategic clinical networks and taking forward the agreed work priorities between NICE and the academic health science networks

Figure 2 Field Team Engagement Strategy 2014/15



Appendix 1

External engagement success criteria – annual progress report

Progress against the objectives for 2013/14 are set out below.

Audience	Objective	2013-14	Progress at 31 Mar	Notes
NHS England Area Teams (ATs)	To use NICE to inform their commissioning of primary and specialist services and to encourage CCGs to apply it to their commissioning activities.	A named lead for NICE identified by 80% of Area Teams and contact established by local Implementation Consultant.	27 ATs visited; 27 NICE leads (100%) identified.	
Clinical Commissioning Groups (CCGs)	That CCGs routinely incorporate NICE guidance, advice and standards into their commissioning processes.	A lead for NICE identified for 80% of CCGs and regular communication maintained as agreed with the lead. 20 examples of CCGs working with NICE Quality Standards (QS) identified.	202 NICE leads identified (95%). 32 examples of CCGs using (QS) identified.	

Audience	Objective	2013-14	Progress at 31 Mar	Notes
Strategic Clinical Networks (SCNs)	To use NICE to inform commissioning and service review activities.	A named contact for NICE identified for 80% of SCNs and a meeting with the local IC to have taken place to explore role of NICE guidance and QS in the work of SCNs and how SCNs can contribute to the work of NICE.	Meetings taken place with 11 (100%) networks and leads identified.	
Clinical Senates	To use NICE guidance, advice and quality standards to inform service reviews and recommendations.	A lead for NICE identified for 80% of Clinical Senates and contact established by local IC.	Meetings have taken place with 11 (100%) senates and leads identified.	
Primary Care Providers	Primary care providers routinely use NICE guidance, advice and quality standards to inform their practice and deliver clinically and cost effective services for patients *(success criteria to be measured via ATs).*	80% of primary care providers are developing a policy to embed the use of nice guidance, advice and standards into practice.	Proposal discussed at area team level.	Area Teams offered model policy for using NICE in primary care commissioning. Limited capacity for quality improvement activities. Being pursued via CCGs in 2014/15

Audience	Objective	2013-14	Progress at 31 Mar	Notes
NHS Trusts	To use NICE guidance advice and standards in a systematic way to inform the provision of clinical services.	Visit 80% of NHS trusts, maintain and develop effective working relationships with medical directors to support the strategic use of NICE products. 20 examples of trusts using quality standards are identified	206 visited (86%). 57 examples of trusts using quality standards identified.	
Academic Health Science Networks (AHSNs)	All AHSNs are enabling and encouraging the use of NICE guidance, advice and standards across local health and social care economies.	All AHSNs have identified a nominated NICE lead and 3 key areas for collaboration for each AHSN.	NICE lead identified in all AHSNs. Areas of collaboration being identified as part of development partnership agreement with each AHSN.	Varying rates of development of AHSNs did not allow collaboration to take place across 3 areas for all AHSNs
Health Education England	To use NICE guidance and products to inform the education and development of healthcare professionals.	Identify key local/regional bodies and undertake 4 “fact finding” visits in each reach region to inform the development of an engagement strategy.	No local engagement	National engagement with HEE to be established prior to local activities – meeting with HEE MDs being scheduled.

Audience	Objective	2013-14	Progress at 31 Mar	Notes
Public Health England (PHE)	That PHE uses NICE to inform public health policy and works with NICE to develop new guidance, advice and standards where needed.	A lead for NICE identified in all PHE Centres and regular communication maintained as agreed with the lead. PHE referring topics to NICE for guidance and quality standards.	Leads identified in 15 PHE centres (100%) and meetings taken place with 14.	Meeting with outstanding PHE centre to take place in Q1 2014-15. Delay due to delay in appointing centre director.
Local Authority (LA) Public Health Teams	To use NICE to inform the commissioning and provision of public health programmes.	A policy for the use of NICE PH guidance exists in 50% of LAs.	88 PH teams visited.	Lack of enthusiasm for formal policy at local authority level. Models for working with NICE guidance developed and being offered to PH teams.
Health and Wellbeing Boards (H&WBs)	To use NICE guidance advice and quality standards to improve the health and wellbeing of their population.	Lead officer identified for all H&WBs and regular contact maintained as agreed with a lead officer.	Lead identified for 152 (100%) H&WBs and an offer made of a briefing session for the board.	
Social care commissioners	That NICE guidance, advice and standards are routinely incorporated into the social care commissioning process.	The positioning of NICE guidance and quality standards within the adult and children's social care commissioning sector will be described and communicated.	124 social care visits undertaken.	

Audience	Objective	2013-14	Progress at 31 Mar	Notes
Social care providers	That NICE guidance, advice and quality standards are used to routinely inform the planning and provision of social care services.	Key adult and children's care provider organisations will be identified and prioritised for engagement. Positioning of NICE guidance and quality standards within the adult and children's social care commissioning sector will be described and communicated.	14 social care providers met (target is one per region =7) and exploratory discussions commenced.	

Table 1 Implementation consultants' total visits April 2013 to March 2014

	Patch								
Organisation	**North West**	**West**	**East**	**North**	**London**	**Northern Ireland**	**South West[a]**	**South East[b]**	**Total for all areas**
Academic Health Science Networks	8	3	8	11	8	0	6	7	51
Acute and community trusts	50	25	43	27	32	67	20	12	276
Ambulance trusts	1	1	2	1	2	2	1	1	11
Area teams	20	7	10	9	6	0	5	8	65
Clinical commissioning groups	61	31	56	47	6	0	17	18	236
Community health trusts	4	2	4	0	4	0	0	3	17
Local authorities	67	13	35	80	92	0	30	11	328
Mental health and community trusts	16	9	7	15	8	0	6	2	63
Networks	8	1	1	5	4	3	0	2	24
Others	35	26	20	40	40	136	10	27	334
Public Health England centre	6	2	3	2	2	0	2	5	22
Social care providers/Social enterprises	3	0	0	7	0	2	0	2	14
Strategic clinical networks and Senates	2	3	0	1	0	0	1	1	8
Total	**281**	**123**	**189**	**245**	**204**	**210**	**98**	**99**	**1449**

[a] The implementation consultant for the South West was on sick leave between late September and late December 2012.

[b] The implementation consultant for the South East manages the team and consequently has a smaller territory.

Table 2 Proportion of organisations visited in each sector

Organisation	Total number of organisations	Unique visits	% penetration
Academic Health Science Networks	15	15	100
Acute and community trusts	165	137	83
Ambulance trusts	11	10	91
Area teams	27	27	100
Clinical commissioning groups	211	144	68
Community health trusts	14	11	79
Local authorities	152	136	89
Mental health and community trusts	55	48	87
Public Health England centres	15	14	93
Strategic clinical networks and senates	12	8	67