Evaluation Showcase - Specialist Polypharmacy MDT Pilot Service

Health Innovation East Midlands

Wednesday 26th June 2024

Health Innovation East Midlands

What is evaluation?

What is evaluation?

Health Innovation East Midlands

"an essential part of quality improvement and when done well, it can help solve problems, inform decision making and build knowledge"

Source: Evaluation: What To Consider? 2015, The Health Foundation

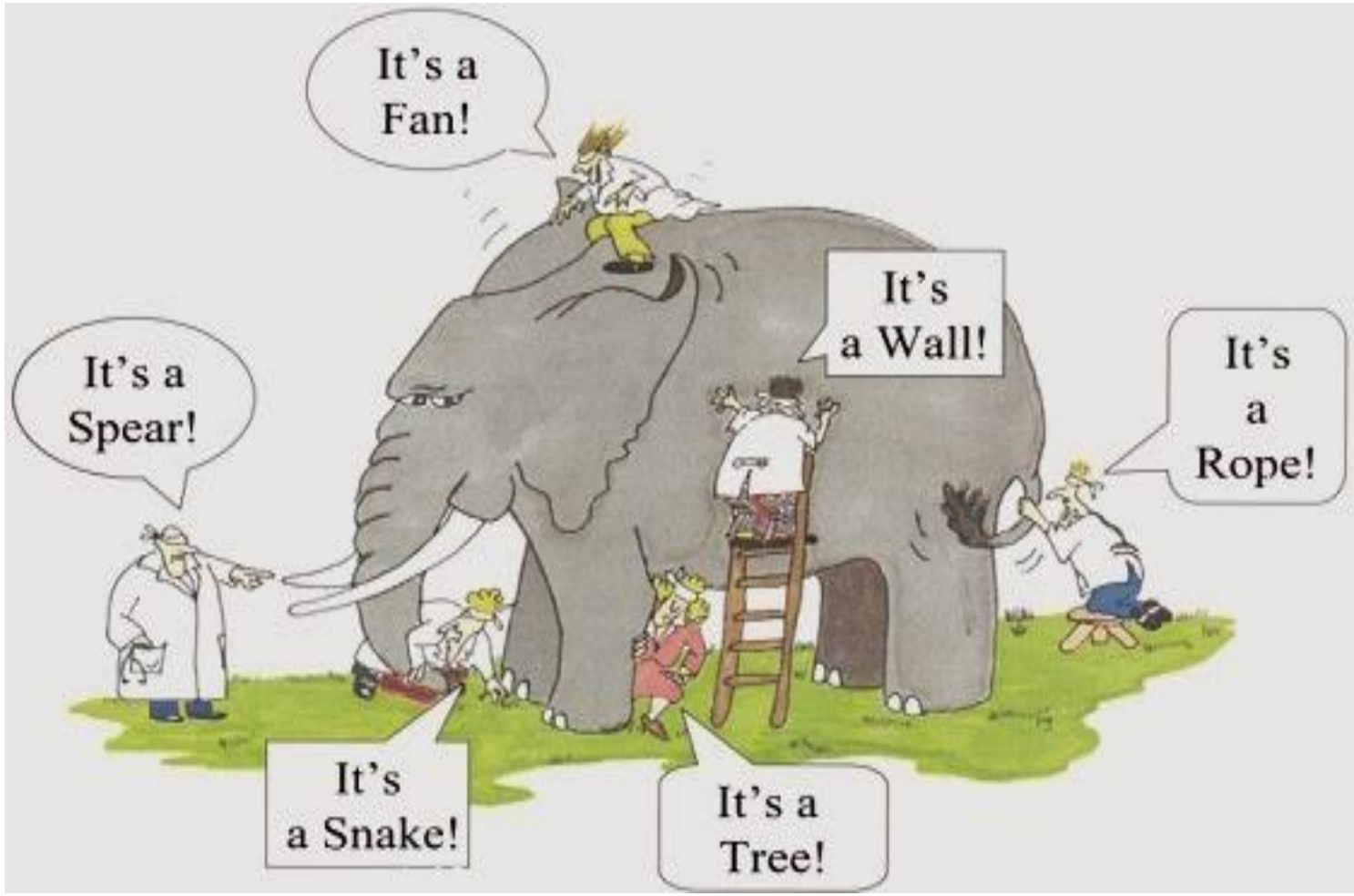
- "The process of determining the merit, worth or value of something"
- "Using systematic, data-based inquiries about whatever is being evaluated"
- "A process undertaken for purposes of improvement, decision making, enlightenment, persuasion"

What was The Evaluation Fund

Health Innovation East Midlands

- Up to £300k available in total to NHS organisations in the East Midlands to independently evaluate innovative projects already in place.
- Two Cohorts:
  - Cohort 1 – Deadline September 2022
  - Cohort 2 – Deadline February 2023

More than the sum of its parts…



- What is already known?
- What other work has been done locally or in related projects?
- What do the implementation team know?
- Synthesize into a coherent whole
- An evaluation needs all of these to work

LLR Polypharmacy MDT pilot

Gill Stead Head of Medicines Optimisation LLR ICB

Background

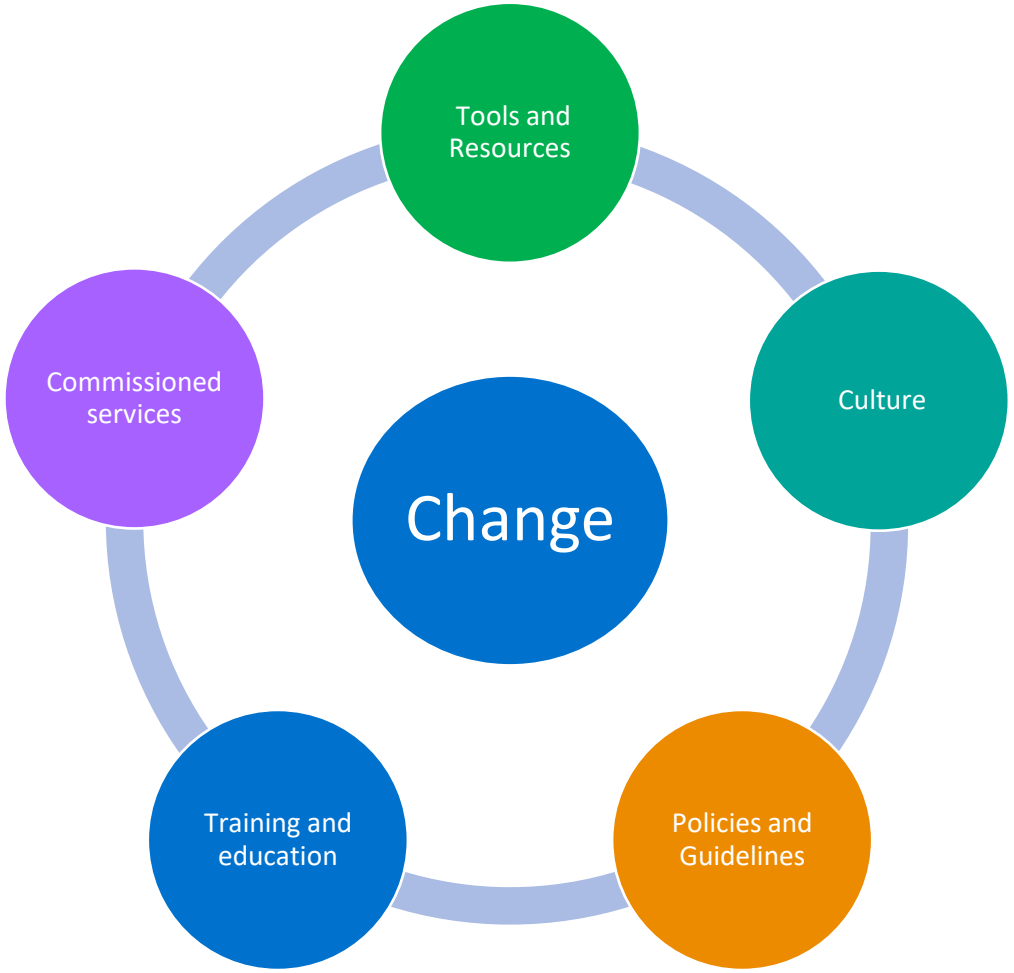
Department of Health & Social Care

Department of Health and Social Care. Good for you, good for us, good for everybody: [online], 2021. Available: https://www.gov.uk/government/publications/nationaloverprescribing-review-report

- Systemic and cultural changes needed to enable systems to reduce overprescribing:
- The report estimated that at least 10% of the total number of prescription items in primary care need not have been issued, highlighting the need to build safety into prescribing through patient level medicines optimisation, structured medication reviews, medicines reconciliation and deprescribing.
- Clinicians felt that it is difficult to determine inappropriate polypharmacy without specialist training.

Policy	Description
NICE Guidance	NG5 (2015) Meds Op: the safe and effective use of meds to enable the best possible outcomes NG56 (2016) Multimorbidity: clinical assessment and management NG27(2015) Transition between inpatient hospital settings and community or care home settings for adults with social care needs NG 76 (2009): Medicines adherence involving patients in decisions about prescribed medicines RPS 2013Helping patients make the most of their medicines. Polypharmacy Guidance, Realistic Prescribing
NICE Medicines Optimisation Quality Standard (QS120)	**Quality Statement 1** People are given the opportunity to be involved in making decisions about their medicines. **Quality Statement 4** People who are inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission. **Quality Statement 5** People discharged from a care setting have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued. **Quality statement 6** Local healthcare providers identify people taking medicines who would benefit from a structured medication review.
NHS Patient Safety Strategy 2021 (link)	Update-develop a programme (as part of MedSIP) to reduce problematic polypharmacy for the most at-risk populations, which can be delivered from Q1 2023-24
IPMO	IPMO expectation is that Pharmacy Profession will have a leadership role in tackling overprescribing
EEPRU Research Report 062 (2019)	Evidence for the impact of interventions and medicines reconciliation in problematic polypharmacy: a rapid review of systematic reviews and scoping to inform the Overprescribing review. Looked at Burden, interventions, implementation activities to increase uptake of interventions , handover between primary and secondary care Taking many medicines is related to having a greater risk of death. This may be because people with poorer health take more medicines and also due to their poorer health are at greater risk of death
NHS Overprescribing Review(awaited)	Review in problematic polypharmacy commissioned in December 2018 by the Secretary State for Health. There are specific actions aimed at reducing that risk that required strong pharmacy leadership
PHE report published 2019: Report: Evidence for dependence on, and withdrawal from, prescribed medicines.	The review covered adults (aged 18 and over) and 5 classes of medicines: •benzodiazepines (mostly prescribed for anxiety) •z-drugs (sleeping tablets with effects similar to benzodiazepines) •gabapentin and pregabalin (together called gabapentinoids and used to treat epilepsy, neuropathic pain and, in the case of pregabalin, anxiety) •opioids for chronic non-cancer pain •antidepressants
Antimicrobial Resistance National Action Plan	Renewed emphasis on de-prescribing and avoiding overprescribing

Polypharmacy



Scoping exercise

LLR population

- LCCCG – Above national averagefor number of unique meds per patient per year and highest amongst 10 similar CCGs for 10 + unique medicines
- Females 35-64 years and over 80 years are disproportionately prescribed 10 or more medications
- Chronic conditions and multi-morbidities associated with polypharmacy.
- Hypertension, lipid disorders, diabetes, depression and asthma.
- Increase in number of unique meds per patient.

LLR Commissioned Services

- PCN DES 20-21: use tools to identify patients who would most benefit from an SMR.
- PQIS Undertake SMRs in patients>10 meds.
- LLR Care Home Pharmacy Team

Resources, Policies and Guidance

- Eclipse risk stratification tool.
- SMR template on GP prescribing system
- PrescQIPP
- National Polypharmacy Guidance
- LLR APC **Overprescribing/ Deprescribing**

Improving Medicines and Polypharmacy Appropriateness Clinical Tool (IMPACT) Improving Medicines and Polypharmacy Appropriateness Clinical Tool (IMPACT)Overprescribing- Bulletins and Deprescribing Algorithms Overprescribing- Bulletins and Deprescribing Algorithms Behaviour change strategies and Consultation support tool Behaviour change strategies and Consultation support toolPolypharmacy and Deprescribing Webinars Polypharmacy and Deprescribing Webinars

Gaps

Specialist Support

- 12 months MDT pilot project:
- Capacity to review 200 patients over 12 months
- 6 PCNs across LLR

Develop training for health care professionals

- AHSN Action Learning Sets (ALS)

Change culture

- Everything counts
- Patient Survey
- Evaluate

Aims

Service user

- Reduce inappropriate polypharmacy prescribing and any potential associated adverse outcomes
- Improve safety and quality of prescribing

Financial

- Reduce prescribing cost of inappropriate medication and medicines waste
- Potential saving from reduced medicines related hospital admissions

Workforce

- Provide access to specialist advice relating to polypharmacy
- Facilitate partnership working across the system

Service delivery

- 0.1 WTE (1 session) UHL acute medicine Consultant
- 0.1 WTE (1 session) 8A UHL Pharmacist
- 0.1 WTE (1 session) band 4 administrative support /project coordinator

Equipment cost - 1 laptop, SystmONE/EMIS access for laptops - (estimated £1000)

Investment £24,000

MDT Clinic Process

GP Practice to identify target patients on Eclipse who have unresolved or complex medication related issues requiring specialist support

GP Practice to obtain consent from patient to discuss at MDT and request a pre-medication review questionnaire to be completed

GP Practice to complete PRISM referral form at least 4 weeks before scheduled MDT clinic

UHL Consultant and Pharmacist to review PRISM referral along side the patients GP clinical system records

PCN will be sent a clinic list for GP and/or Pharmacist and an MS Teams link to join MDT to discuss their patient

During the MDT clinic the UHL Consultant and Pharmacist will agree recommendations with the patients GP and/or Pharmacist. GP/Pharmacist to document discussions on the patient record

UHL Consultant will send a clinic letter outlining the recommendations and/or deprescribing advice/directions

GP or Pharmacist to discuss, implement the recommendation from MDT clinic with the patient where acceptable. Clinical system records to detail interventions implemented and reasons not implementing where necessary.

UHL Pharmacist to follow-up with GP practice e.g. 3 months after MDT clinic to collect data on interventions for the service evaluation

Challenges

- Alignment of the pilot with the planning round and submitting a business case for funding
- PCN engagement and commitment
- MOU for PCNs and UHL
- Service specification
- Intra-operability
- DPIA
- DSA for evaluators, UHL and ICB
- Roles and responsibilities -admin support with clinic re-scheduling

Pilot project evaluation

- Patient questionnaire
- GP Practice/PCN feedback questionnaires and post pilot meeting
- EMASHN funded evaluation (third party) using anonymised data
- KPIs and outcome monitoring included in service specification
- Business case for substantive service

NHS

Leicester, Leicestershire and Rutland

Integrated Care Board

A proud partner in the:

Leicester, Leicestershire and Rutland

Health and Wellbeing Partnership

NHS
University Hospitals of Leicester
NHS Trust

Polypharmacy MDT Clinic

Binita Bhakta – Acute Frailty Lead Pharmacist
Anna Delf – Lead Geriatrics Pharmacist

June 2024

Pilot Clinic Structure

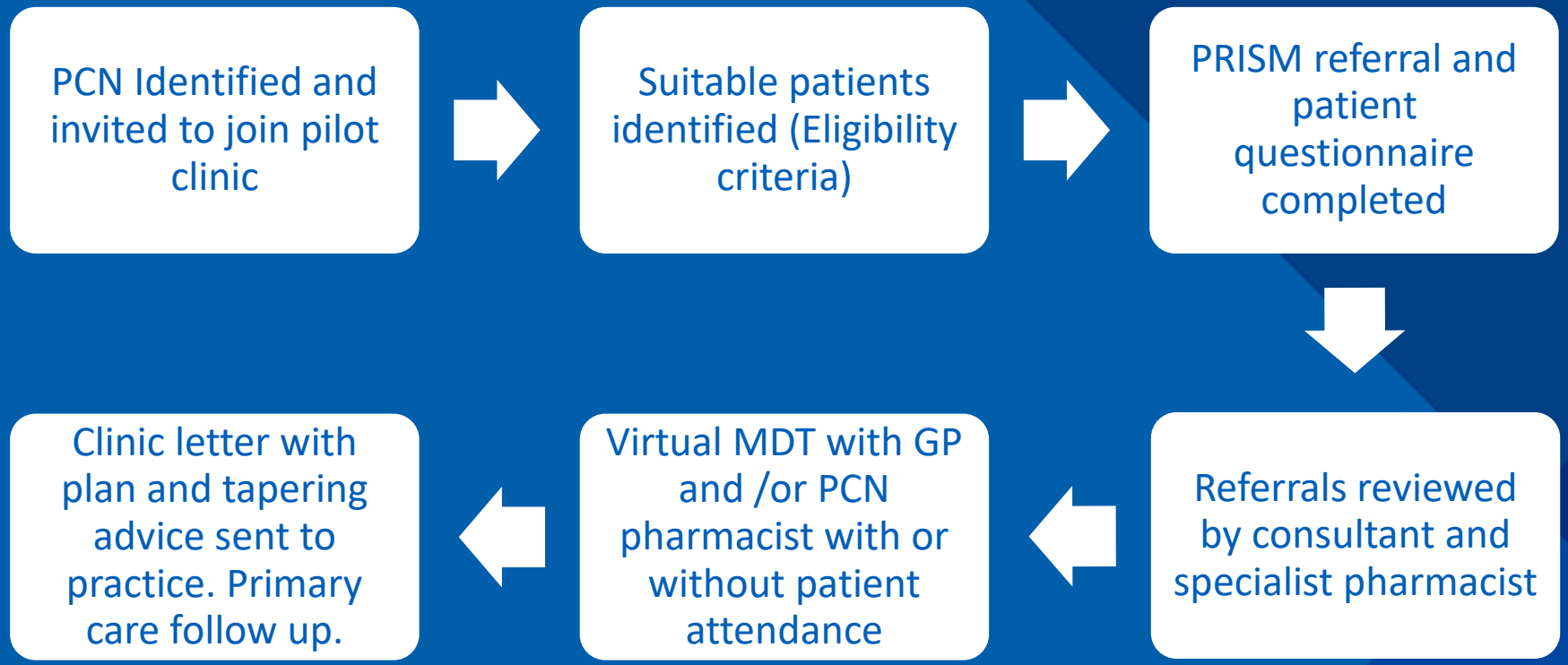
Multi-Disciplinary Team

- Consultant with a specialist interest in polypharmacy
- Specialist Hospital Pharmacist (experienced in polypharmacy / deprescribing)
- PCN representative (GP / PCN pharmacist)

Clinic Arrangement

- 4-8 patients per clinic (4 if patient attending)
- Week 1 (afternoon reviewing PRISM referrals and draft action plan)
- Week 2 (virtual MDT with PCN representative with or without patient)

Process Map


PCN Identified and invited to join pilot clinic
Suitable patients identified (Eligibility criteria)
PRISM referral and patient questionnaire completed
Referrals reviewed by consultant and specialist pharmacist
Virtual MDT with GP and /or PCN pharmacist with or without patient attendance
Clinic letter with plan and tapering advice sent to practice. Primary care follow up.

Edge Health

HIEM Evaluation Showcase

Specialist Polypharmacy MDT Evaluation

Health Innovation East Midlands

Edge Health

26th June 2024

Summary

1 Evaluation Approach

2 Key Findings

3 Recommendations

1

Evaluation Approach

Evaluation Approach

Contextualising Polypharmacy Reviews

Prior to the commencement of any evaluation, we first conduct a literature / data review. This enables us to understand the challenges the intervention is trying to solve. Key in this case was:

Rising Polypharmacy Rates

Polypharmacy rates have been increasing across the UK.

Demographics of LLR make it particularly vulnerable to high polypharmacy rates, due to both age and deprivation risk factors.

Wider System Challenges

Demand for services across the NHS is high. This means that the health service is less resilient to additional pressures, such as from rising polypharmacy,

Additionally, polypharmacy is a challenge that spans many healthcare professions and settings. System working is a challenge within the NHS.

Identifying At-Risk Patients

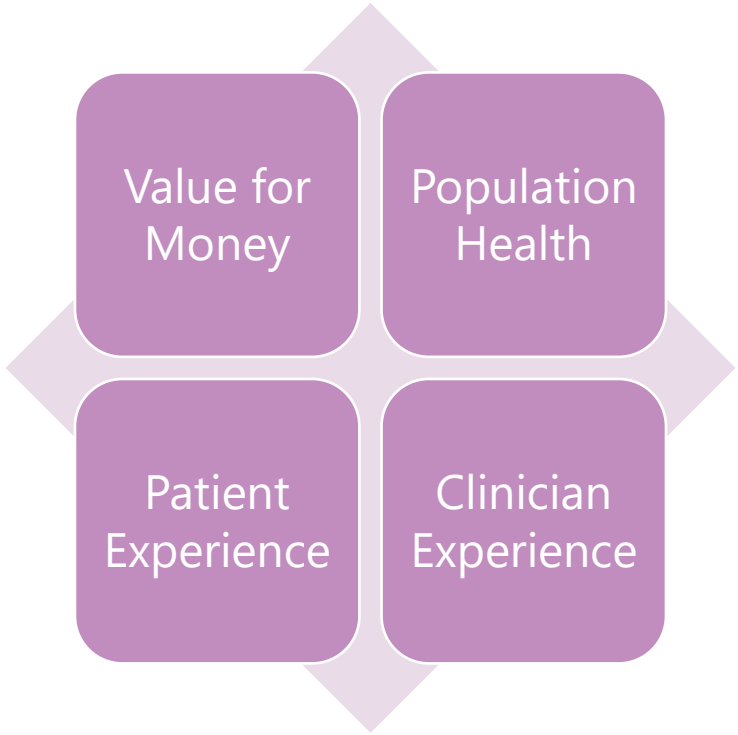
"Assumptions that polypharmacy is always hazardous and represents poor care should be tempered by clinical assessment of the conditions for which those drugs are being prescribed"

Therefore, identifying patients at risk of polypharmacy is more complex than just identifying patients who are on >10 medicines.

Low Confidence in Deprescribing

It is also known that there is low confidence in deprescribing by both patients and healthcare providers (HCPs). This creates barriers and challenges to reversing the worrying upward trends in polypharmacy rates.

Development of Evaluation Framework



Quadruple Aim Framework

In the Health and Care Bill, the Triple Aim was a proposed common duty for NHS bodies that plan and commission services and that provide services. The hope was this framework would help align NHS bodies around a common set of objectives.

The Triple Aim is a framework aiming to optimise health system performance through assessing against 3 core areas:

- Population health;
- Patient Experience; and
- Value for Money.

This has been updated in the literature to also add emphasis on clinician experience, creating the Quadruple Aim Framework. This is important in the context of the NHS workforce crisis.

This framework was agreed for use in this evaluation as it is recognisable to NHS leaders and the outputs could support commissioning decisions going forward.

Evaluation Approach

Initial Engagement

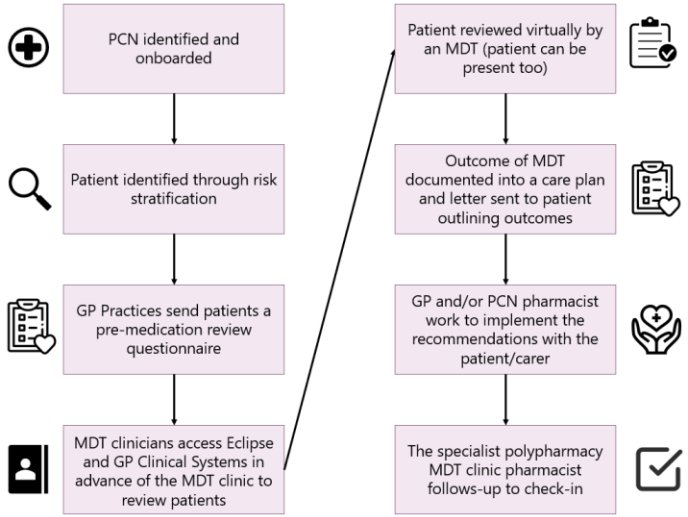
Our team then spoke with key stakeholders (identified by the Trust) to gain a deeper understanding of the MDT reviews and its impact.

We held semi-structured interviews with the following groups:

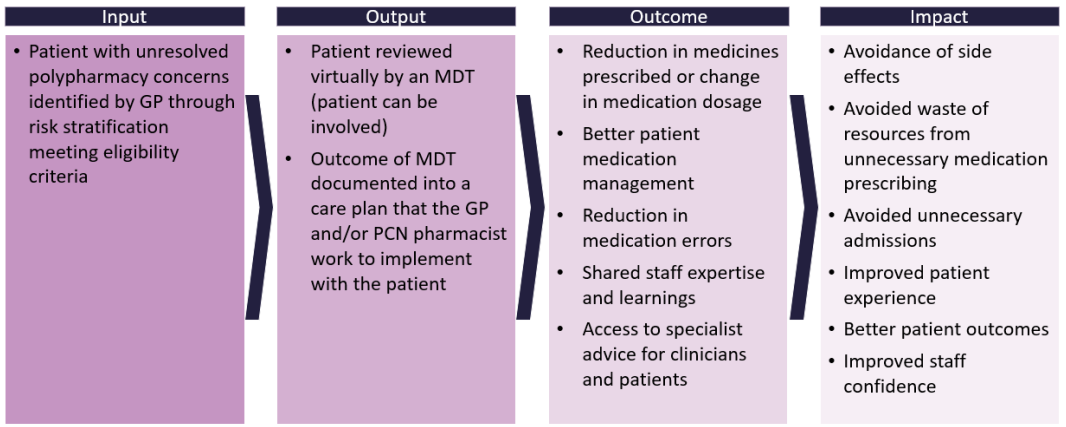
- ICB Pharmacy Leads
- Trust Consultants
- Practice GPs

This led to the development of detailed pathway change diagrams and impact pathways.

Pathway Change

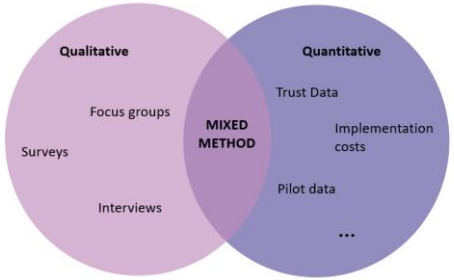


Detailed Impact Pathway



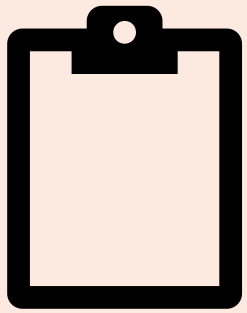
Evaluation Approach

Data Collection & Analysis

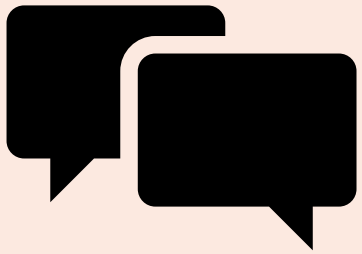


Using the Quadruple Aim Framework and the impact pathways we developed alongside key stakeholders, we then undertook our analysis.

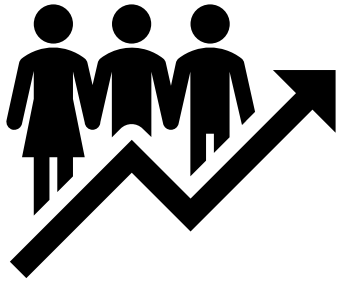
The first step in our analysis was determining what data was required. We determined for **a mixed method analysis** we would need:



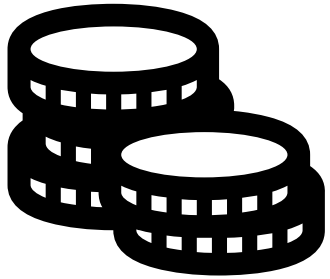
Bespoke Survey Data



Staff Interview Data



MDT Data Collection Tool



Cost Data

2

Key Findings

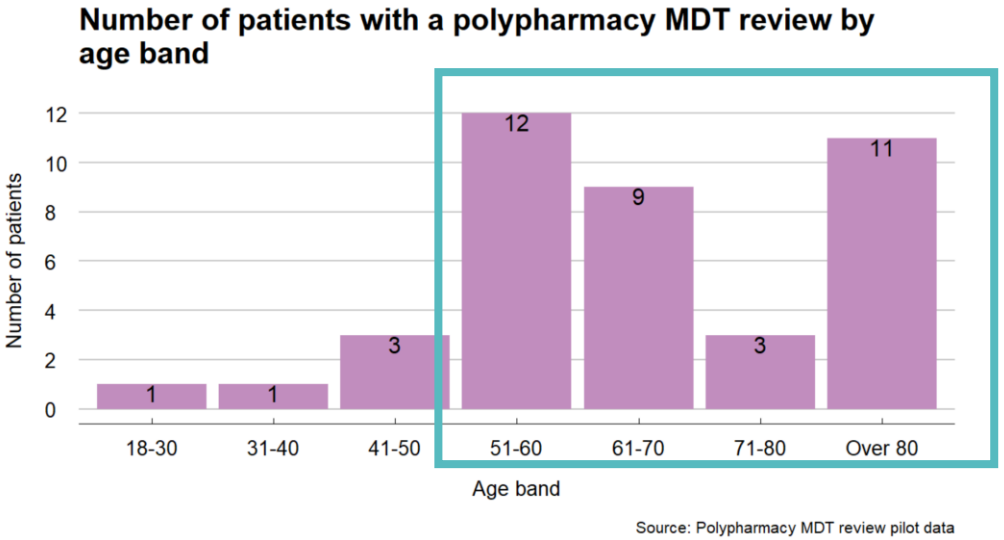
Key Findings

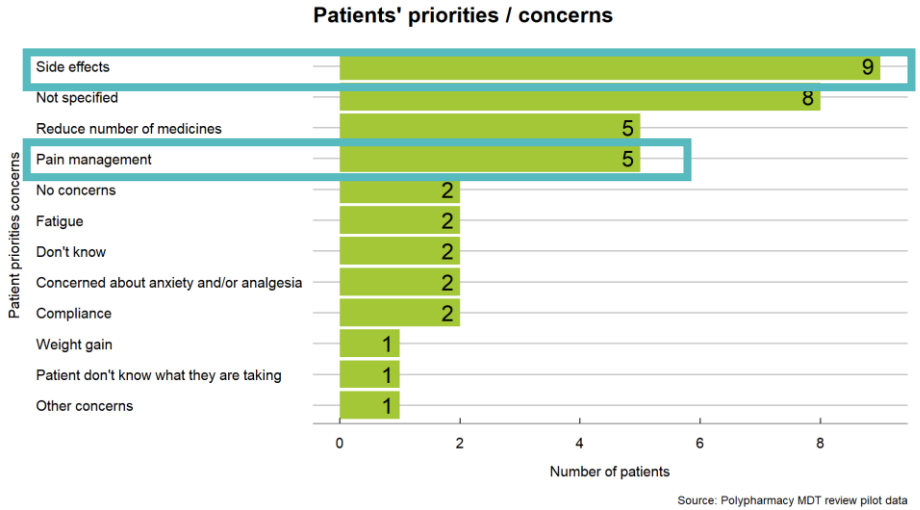
Patient Demographics

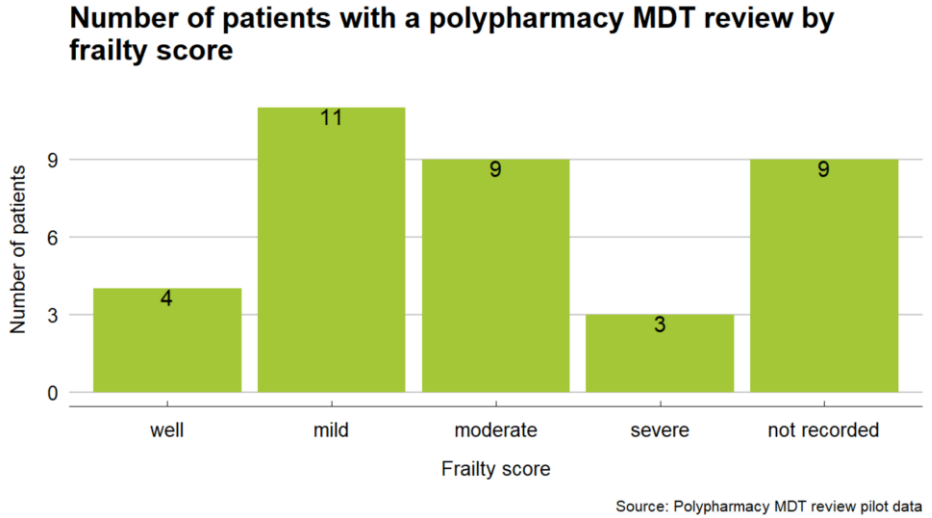
A total of **40 patients** had been reviewed by the MDT at the time of this evaluation.

Analysis of patients discussed at an MDT showed:

- Majority of patients either 51-60 or over 80.
- Patients across all frailty scores, from well to severe. Majority of patients were mild to moderately frail.
- Majority of patients were concerned about side effects of their medications; however, some were also concerned by pain management.







Key Findings

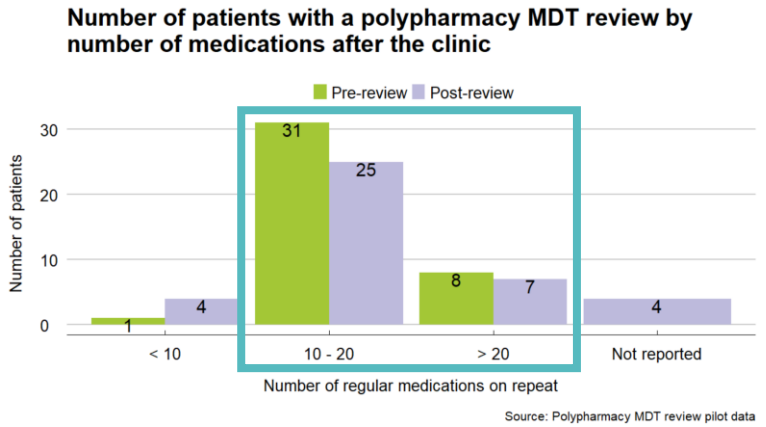
Population Health

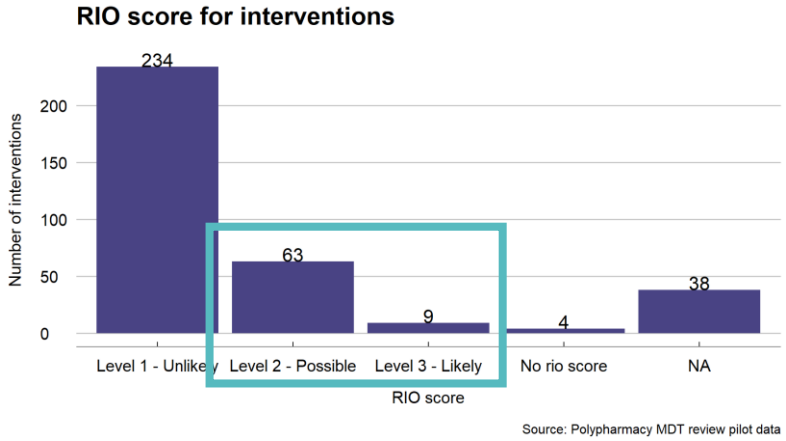
The number of patients reviewed by the MDT at the time of the evaluation was low (n=40). However, we have been able to track some outcome measures.

Firstly, the number of medications patients were on dropped. For example, the number of patients on 10-20 and >20 dropped by 6 and 1 respectively.

The medication type most deprescribed were ACE inhibitors and antacids/simethicone. A total of 62 medications were deprescribed through the MDT.

Additionally, the RIO Score assessment gave 63 recommendations (18.1%) resulting in a possible and 9 (2.5%) in a likely admission avoidance.





Deprescribed drugs	Count
Angiotensin-converting enzyme inhibitors	8
Antacids and simeticone	7
Antihistamines	4
Antimalarials	4
Antiplatelet drugs	4
Anxiolytics	3
Biguanides	3
Cardiac glycosides	3
Control of epilepsy	2
Drugs used in nasal allergy	2
Drugs used in nausea and vertigo	1
Gout and cytotoxic induced hyperiuicaemia	1
Hypnotics	1
iron supplements	1
Lipid-regulating drugs	1
Mucolytics	1
Multivitamin preparations	1
Non-opioid analgesics and compound preparations	1
Opioid analgesics	1
Oral iron	1
Osmotic laxatives	1
Other antidiabetic drugs	1
Proton pump inhibitors	1
Selective beta(2)-agonists	1
Sulfonamides and trimethoprim	1
Thiamine hydrochloride (B1)	1
Thiazides and related diuretics	1
Tricyclic and related antidepressant drugs	1
Urinary-tract infections	1
Vitamin B compound	1
Vitamin C (ascorbic acid)	1
Vitamin D	1
Total	**62**

Key Findings

Improve Value for Money

For this analysis we looked at the pilot to date and an upper and lower bound. This is because the avoided hospital admissions used the RIO toolkit where the outcomes are “unlikely”, “possible” and “likely” hospital admission avoided. The medication cost reduction stays constant and was calculated by the consultant pharmacist.

- **Lower bound:** assumed that no intervention results in hospital admission avoidance and the only quantifiable benefits from the polypharmacy MDT review pilot are coming from medication deprescribing.
- **Pilot to date:** only the 9 interventions flagged as likely to prevent an admission have been assumed to prevent one, resulting in average savings for the healthcare system of £200 per patient.
- **Upper bound:** assumes that in addition to the 9 changes likely to prevent a hospital admission 50% of the “possible” (63 interventions in total) also prevent a hospital admission.

Description	Pilot to date (£) Lower bound	Pilot to date (£)	Pilot to date (£) Upper bound
Medication cost reduction	£7,244	£7,244	£7,244
Avoided hospital admissions	£0	£1,800	£6,300
Total quantified benefits (to date)	£7,244	£9,344	£13,544
Total costs (to date)	£8,000	£8,000	£8,000
Benefit cost ratio	0.9	1.1	1.7

Key Findings

Further Benefits

Environmental savings

There are also potential environmental benefits from a reduction in medicines prescribed. Greener NHS estimates that approximately 48% of general practice's carbon footprint comes from prescribing pharmaceuticals. Therefore, opportunities to optimise patient prescriptions whilst also supporting the deprescribing goals of Greener NHS should be suitably considered. The data estimates that 62 medicines were deprescribed across the 8 clinics conducted during this evaluation phase.

Reduction in side effects

Alongside the reduction in risk of admission demonstrated, there may also be a reduction in severe side effects from unnecessary medications. All medications have listed potential side effects which can decrease quality of life. Due to a lack of patient feedback during this evaluation, it is not possible to quantify this impact at this time.

Quality of care improvement

Finally, one of the key benefits of introducing the polypharmacy MDT is improving the quality of care for patients. Expert advice on prescriptions ensures that patients receive improved and personalised care. This is further supported by ensuring the patient's voice is taken into account when making changes to prescriptions.

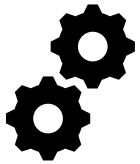
3

Recommendations

Recommendations

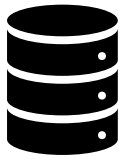
Future Considerations

1. Set-up and planning



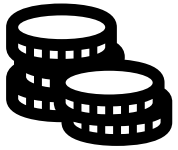
This was a new service so many of the documents and processes had to be developed from scratch, often with limited understanding of the time required to complete each task. Therefore, a key learning from the pilot was to ensure planning for resources and recruitment is completed at the business planning stage. It is also suggested that a realistic "go-live" date is in place to reduce the risk of unavoidable delays.

2. Data collection



The MDT team developed a bespoke data collection tool as part of this work. Completing this data collection tool proved a challenge. This was due to the amount of data being captured, period of no access to necessary systems and poor data quality. Getting this collection right going forward is essential.

3. Lack of PCN funding and communication of benefits to stakeholders



Many PCNs originally expressed interest in taking part but withdrew due to a lack of funding for PCNs to participate in the MDT and limited capacity to release clinicians to take part. One PCN even withdrew from the pilot after being involved in some clinics.

Given the lack of funding, the team faced direct criticism from colleagues about the value of releasing time for their team to deliver the service. Communication of the benefits is key to combatting this skepticism.

Future Considerations

4. Admin support

During the pilot, these tasks were picked up by the implementation teams, mainly by a senior pharmacist at UHL. However, this is not sustainable long-term. The learning here is the requirement for dedicated administrative support.

5. Data governance

The set-up of the pilot also required sign-off against all legal Information Governance (IG) documents. This included a Data Protection Impact Assessment (DPIA), Data Sharing Agreement (DSA), Service Specification and Memorandum of Understanding (MoU) for the pilot project.

This process caused delays as it took longer than anticipated and the team did not have experience completing these documents.

6. Patient and staff experience data

As part of this evaluation, staff and patient feedback questionnaires, available in the Appendix of this report were developed to gather insights into their experience throughout the pilot. However, no responses were collected. This limited data collection to the experiences of staff obtained via the data collection tool and a singular interview.

Case Study: Referral Form

Polypharmacy MDT Referral					
Name	Harriet	**Gender**	Female	**Age**	59
Reason for referral	Deprescribing advice				
Prescribers concerns about medication	High level of potentially sedating medications				
Patient Questionnaire – Pre Medication Review					
Describe difficulties with taking medications	I think I am taking a lot of medicines and it is hard to always remember the times when I need to take them				
Do you forget to take any of your medications?	Sometimes, I am forgetting to take them more often these days				
Do you get any side effects?	Worried about memory				
List any medications you feel you no longer need	Unsure				
What would you like to discuss with your healthcare professional at your medication review	Stopping/changing medications Reducing or increasing dose Discussing non-medication options				

Case Study: Referral Form

DRUG ALLERGIES	NKDA

Current Repeats:
Zolpidem 5mg ON
Zolmitriptan 2.5mg as directed
Tramadol 100mg QDS
Salazopyrin EN-Tabs 1g BD
Pregabalin 150mg BD
Pizotifen 3mg ON
Lansoprazole 30mg BD
Hydroxychloroquine 200mg BD
Folic acid 5mg six days per week
Fexofenadine 180mg OD
Fenbid 5% gel TDS
Diazepam 2mg - 8mg daily
Co-codamol 30mg/500mg 2 tablets QDS
Amitriptyline 30mg ON
Adcal-D3 1 tablet BD

Current Acutes:
Avamys 27.5micrograms/dose nasal spray once daily

PAST HEALTH

Active Major Problems:
Rheumatoid Arthritis
Migraines

Past Major Problems
Drug Overdose

Height 1.70 m
Weight 92 Kg
BMI 28.39 Kg/m²

Case Study: Advice

Medication / Dose (Indication)	Considerations and Recommendations	Tapering Advice
Diazepam 2-8mg at once a day **Zolpidem 5mg take one at night**	• Establish usage • Counsel on long-term effects of hypnotics e.g. tolerance, headache dependence, memory loss, depression. Contributing to worsening memory / migraines • Co-administration with opioids and pregabalin increases risk of sedation / respiratory depression. • Zolpidem maximum usage 3 times per week (tolerance) • Diazepam to stabilise on a set dose then try to wean down • Counsel Harriet on lifestyle / sleep hygiene e.g. refer to NHS sleep app. Recommend slow wean if Harriet in agreement	• Agree tapering plan with patient , consider reducing diazepam by 1mg every 1-2 weeks. (NICE CKS Benzodiazepines) • Zolpidem — Suggest trialling on alternate nights for 2 weeks and then every 3 nights to continue to wean down to stop

Case Study: Advice

Medication / Dose (Indication)	Considerations and Recommendations	Tapering Advice
Amitriptyline tablets, 30mg At Night (Unclear Indication)	• Linked to Harriet's memory impairment / drowsiness? High anticholinergic burden - cognitive impairment / constipation • Limited evidence for analgesic efficacy. No evidence of nerve related pain (osteoarthritic pain) • Serotonin syndrome risk (concomitant medications) • Recommend deprescribing (risk vs benefit profile) slow taper	• Rapid withdrawal may produce symptoms associated with cholinergic rebound (e.g. agitation, headache, sweating, gastrointestinal symptoms). • Agree plan e.g. reduce by 10mg a week depending on patient symptoms (Medstopper)
Folic acid 5mg once a day 6 times a week	• Methotrexate stopped earlier in year as per rheumatology advice • Remove from repeat	

Case Study: Advice

Medication / Dose (Indication)	Considerations and Recommendations	Tapering Advice
Co-codamol 30mg/500mg tablets One taken four times a day as required (Generalised Pain in joints) **Tramadol 100mg capsules, Two Every Four Hours When Necessary.** **Pregabalin 150mg Twice a day**	• Establish usage • Chronic opioid use increases risk of fractures, falls, fatigue and depression (fpm) • Limited evidence for efficacy of opioids / pregabalin in rheumatic disease / osteoarthritis • Deprescribe co-codamol and prescribe regular paracetamol (opioid sparing) • Taper tramadol (serotonin related effects) • Non pharmacological advice on pain management: Advise on weight reduction / physio referral • Establish frequency of flare ups / Rheumatology referral	• Opioids are commonly associated with withdrawal symptoms if discontinued suddenly. • Slow weaning required depending on usage.

Case Study: Advice

Medication / Dose (Indication)	Considerations and Recommendations	Tapering Advice
Lansoprazole capsules, 30mg twice a day (Gastro protection)	• ?Still symptomatic ?reason for high dose • Long term use associated with fractures, gastro side effects, C.difficile infections, community acquired pneumonia etc. • Non pharmacological advice for reflux • Consider prescribing tapering to 15mg OD then reviewing to stop • Alternatives e.g. peptac?	• Gradual step down reduces the risk of rebound hyperacidity and the need to reinstate. • Advise there may be an increase in symptoms for a few days when dose lowered. (PrescQIPP PPI deprescribing tool)
Avamys Nasal Spray **Fexofenadine 180mg Once a day**	• ?Expired indication - Remove from repeat • Steroid related side effects if long term use	N/A
Hydroxycobalamin 200mg Twice a day **Salazopyrin EN 1g Twice a day**	• Having regular rheumatology appointments • Plan is to wean off with rheumatology support	• As per Rheumatology plan

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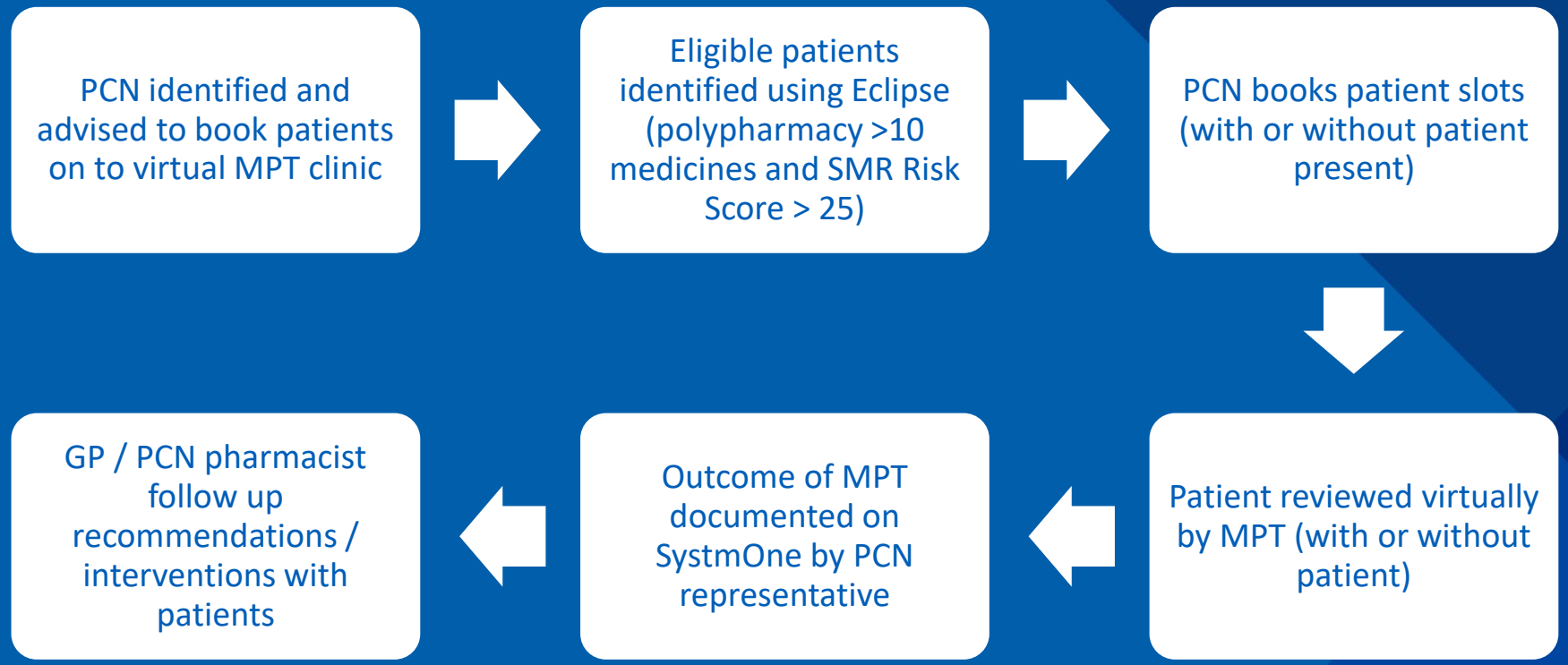
Clinic Structure Going Forward

Process Map for MPT Clinic Going Forward



Benefits to Patients, Staff and the wider Healthcare system

- Reduced hospital admissions and subsequent bed days
- Medicines optimised and evidenced-based practice
- Patient education, reassurance and increased compliance
- Reduced ADR — falls, anticholinergic burden, cognitive impairment etc.
- Reduced pill burden and carbon footprint
- Better monitoring/flagging of patients with high risk polypharmacy
- Collaborative working / expertise sharing between primary and secondary care, HCP education

Limitations

Limitations	Potential Solutions
• UHL staffing numbers	• More reliable pharmacist / consultant cover once substantive service and part of job plan
• PCN engagement	• Removal of PRISM referral forms • Ability to book patients in from GP side will improve uptake
• Current reach of the service	• Eliminating review week will double patients that can be seen per annum. • Potential to expand in future

What does the Future look like?

- 2612 patients that will benefit from this clinic
- Expanding the number of clinics = more accessibility
- QOF/KPIs
- Production of patient education materials
  - PILs
  - Material for HCPs within LLR
  - Social media campaigns
- Patient feedback

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Summary

To summarise….

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- Evaluation is a highly worthwhile activity and the only true way to measure whether the reality matches up to the intended benefits
- It is important to ‘best fit’ the methodology and outputs to the type of work you are doing and what you need to measure
- It is best to factor flexibility in to the contracting and into the evaluation plan
- You can never consider data and data collection too early!
- Involve information/data colleagues early on to discuss what is possible, and IG to enable safe data access
- You do not have to be an expert in evaluation or have conducted evaluations in the past, lots of support is available

We can help you with

Health Innovation East Midlands

- Advice and guidance
- Benefits workshops
- Writing evaluation plans and outlines
- Conducting the tendering process – and knowing who to ask for bids
- Selecting an evaluator

Contact the team for more information: healthinnovation-em@nottingham.ac.uk

Health Innovation East Midlands

Thank you for listening

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