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Evaluation of the Health and Growth Accelerators

Protocol version 1.1

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Evaluation summary

Title	ROSE NET evaluation of the Health and Growth Accelerators
Background	From April 2025 Health and Growth Accelerators (hereafter 'Accelerators') will be implemented in 3 Integrated Care Systems (ICS) to improve health outcomes and rates of economic inactivity
Aims	Our aim is to undertake a comprehensive evaluation of Accelerators to understand implementation, delivery and outcomes, to inform commissioning of later rounds of Accelerators and related initiatives. *Research questions* 1. What are the barriers and enablers to implementation of Accelerators? 2. What are the barriers and enablers to delivery of Accelerators? 3. Can Accelerators (a) identify an eligible cohort (b) recruit and retain into appropriate interventions (c) achieve appropriate outcomes? 4. Do the Accelerators demonstrate comparative improvements in health outcomes and rates of economic inactivity?
Design	Multi-site, multi-method study involving: Process evaluation with staff implementing and delivering Accelerators, and patients[1] receiving support from Accelerators Quantitative observational research on Accelerator cohorts Quantitative comparative research on cohorts in Accelerator and non-Accelerator sites
Sample	Three ICS Accelerators (South Yorkshire, North East and North Cumbria, and West Yorkshire) and relevant comparator sites
Timelines	Process evaluation 2025 Intermediate outcome assessment 2026 Long-term outcome assessment 2027-2028
Funding	This research is an independent evaluation undertaken by the NIHR Rose NET. Rose NET is funded via a competitive review process by the NIHR HSDR Programme (NIHR163715). The views expressed in this protocol are those of the author(s) and not necessarily those of the NIHR, NHS England or the DHSC.

[1] At this point, we use the term 'patient' for those eligible for and offered interventions in Accelerators. We accept that applying this label outside a conventional NHS context raises issues but at this point we are not convinced that other options (such as 'service users' or 'clients') are better. The best descriptor is probably 'working age adults with health conditions' but that may not cover all groups. Accelerators are ICB-led, focussed on those with health conditions and will recruit from many NHS settings (such as NHS Talking Therapies, NHS waiting lists and NHS clinics). We will adapt terminology as consensus develops in the programme, and in consultation with PPIE contributors

Evaluation context

'Economic inactivity' is defined as 'people not in employment who have not been seeking work within the last 4 weeks and/or are unable to start work within the next 2 weeks' and represent an important group alongside those employed and unemployed.[1] The scale of economic inactivity in England and strong evidence of the link between health and labour market outcomes[2 3] have stimulated both service expansion (such as additional mental health services) and policy innovation. As outlined in the 'Get Britain Working' White paper, a raft of policy innovations has been proposed including WorkWell, Trailblazers (both Youth and Inactivity) and Health and Growth Accelerators. Although these initiatives share some aims, they differ in size, scope, target populations and leadership (see Box 1).

Box 1 Policy innovations focused on reducing economic inactivity

WorkWell is an early intervention and health assessment service across 15 areas, which involves people signed off work due to health being referred for a work and health assessment and signposted to other services (e.g. physiotherapy or employment advice) with the aim of overcoming barriers to work. WorkWell is low intensity in nature and focussed on the individual. The total investment is around £57 million to support around 56,000 cases.

Inactivity Trailblazers are planned for 9 areas, focussed on people who are currently economically inactive, to provide local work, health and skills support (the range of service innovations and interventions within Trailblazers is likely to vary considerably). The total investment is around £125 million, and the individually focussed aspects of the intervention are expected to support around 23,000 cases.

Health and Growth Accelerators will be nested within 3 Trailblazer areas, where additional funding will be provided to Integrated Care Systems (ICS) with a focus on preventing people from falling out of work long term due to ill health. As with Trailblazers, the service innovations and interventions are likely to vary considerably. The total investment is around £45 million, and services have targets for return to economic activity (4,250 across 3 sites) which may imply supporting 13-17,000 cases.

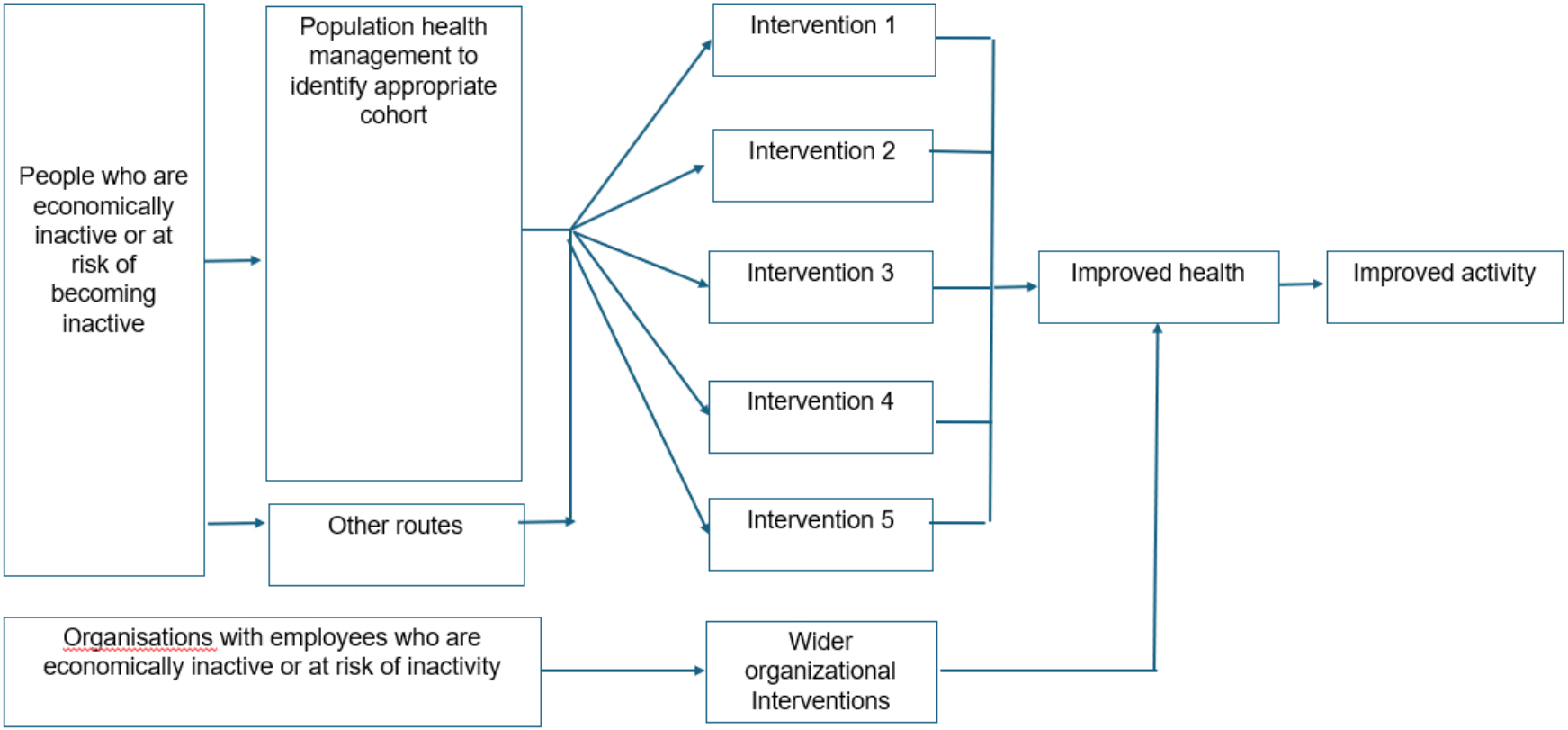
Three ICS were selected as Accelerators by NHS England, due to high levels of economic inactivity attributed to poor health (Table 1). A general schematic of an Accelerator is shown in Figure 1.

Table 1 NHS England estimates of economic inactivity due to poor health in 3 sites

ICS	**Inactive due to health (2025 estimate)**	**% adults**
South Yorkshire	78,970	8.9%
West Yorkshire	108,635	7.3%
North-East and North Cumbria	165,805	9.1%

[Source NHS England internal Accelerator report]

Figure 1 A general schematic of an Accelerator



Accelerators represent an example of policy innovation called 'large scale transformation':

> 'Large-system transformations in health care are interventions aimed at coordinated, systemwide change affecting multiple organisations and care providers, with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population-level patient outcomes'.[4]

In the case of the Accelerators, 'systemwide change' involves ICS collaborating with multiple organisations and providers within the health sector and working closely with other partners (including combined authorities and the voluntary sector) to achieve improvements in health outcomes. This is combined with the additional aim of improving economic activity among those who are, or are at risk of becoming, economically inactive due to health problems. Achieving their aims will require building collaborations across a range of services and stakeholders, identifying new patient cohorts through a variety of methods (including innovative data linkage), and improving outcomes using expansion of existing services, introduction of innovations, and better co-ordination among existing and new services.

As well as the complexity of each individual Accelerator, there is also likely to be variation between the Accelerators, due to their different populations and existing service configurations. Additionally, the co-location[2] of Trailblazer, WorkWell and other initiatives relevant to economic inactivity will need to be taken into account.

Across the Accelerators, there are cross-cutting issues of importance:

(a) the role of *population health management* (PHM)[5] in the context of economic inactivity. PHM has been described as a 'core enabler and function of integrated care systems in helping drive a data-led focus on person-centred care' (https://www.england.nhs.uk/integratedcare/phm/), and is defined as part of the Institute for Healthcare Improvement (IHI) Triple Aim as 'the service infrastructure designed to improve population health outcomes'[6] through use of data sources to describe a defined population, assess levels of risk and deliver evidence-based prevention and care in a co-ordinated way. The patterning of economic inactivity by geography and socio-economic groups also means that PHM is a key mechanism by which Accelerators may seek to reduce (or avoid exacerbating) existing inequalities through targeted investment and intervention. The use of PHM in the context of economic inactivity raises new challenges in understanding predictors of risk for economic outcomes and integrating data outside conventional health care systems.

(b) the role of *digital therapeutics* in achieving better outcomes in these populations.[7] Mental health is a major predictor of economic inactivity and there has been interest in the role of psychological therapies in reducing economic inactivity for many years, acting as a major driver of the development of NHS Talking Therapies.[8] Digital therapeutics are a major part of the service delivery model for NHS Talking Therapies because of the potential advantages in accessibility and efficiency, and digital therapeutics may also have a role in supporting self-management for a wider range of long-term conditions. The role of digital therapeutics in Accelerators has been identified and a proportion of the funding provided to sites is expected to support expansion of this form of delivery.

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[2] At present, the 3 Accelerators are nested within the 9 Trailblazers, whereas there is overlap between WorkWell and Accelerators in only 1 area. NHS England has initiated a group covering all three evaluations to explore overlaps in geographical and population coverage, interactions between the programmes, and the implications for evaluation

(c) *governance arrangements* for the Accelerators. Accelerator funding flows to ICS but will involve multiple organisations. ICS often involves place-based partnerships which cover sub- populations of the wider ICS population and may involve both NHS, local government and voluntary, community and social enterprises (VCSE), as well as even smaller scale 'neighbourhoods' built around primary care networks (PCNs).[9] The exact way in which the relationships between these different entities are governed may be an important factor in successful implementation and delivery.

(d) *patient acceptability and experience* of health interventions in the context of economic inactivity. Although the benefits of paid work on health are well known,[3] work is also a cause of health issues.[10] Patients may be less willing to engage with health interventions in this context, given current discourse around economic inactivity, and perceptions that economic inactivity may incur sanctions.[11 12] The PHM model may also be dependent in part on using non-health data for prediction of risk, which may exceed public expectations about use. Understanding the factors influencing acceptability of health interventions in the context of economic inactivity may be important in enhancing the 'reach'[13] of Accelerators into eligible populations and their ability to recruit and retain eligible patients into relevant interventions.

Evaluation of the Accelerators

NIHR has commissioned an independent evaluation by Rose NET to build the evidence base around health interventions and economic inactivity outcomes. The evaluation commission arrived prior to the formal start of the Rose NET contract (1st December 2024) and has had to proceed rapidly to align with the Accelerator timelines (including a start date of 1st April 2025). The development of the Rose NET evaluation has involved extensive meetings with NHS England, with the wider group supporting the Accelerators, stakeholders involved with relevant data sources (such as Office of National Statistics - ONS) and the evaluation groups involved in contemporaneous evaluations of Trailblazers and WorkWell. The protocol has also been informed by ongoing logic modelling and related discussions with the 3 ICS sites (under ethical exemption from UoM Research Ethics Policy).

A complex, phased multi-method approach will be required for comprehensive assessment of the implementation, delivery and outcomes of the Accelerators. Initially we propose a process evaluation of Accelerator implementation and delivery to inform on-going learning as well as future commissioning of further Accelerator activity (and related policy initiatives) and to inform the design of later evaluation of outcomes.

This protocol describes the process evaluation of the first year of the Accelerators, with a focus on professional partners involved in Accelerator implementation and delivery. As noted above, patient experience of health-focused inteventions in the context of economic inactivity is an important issue. At this point it is premature to design patient-focussed work, because we lack detail about how patients will access the Accelerators and what interventions they will receive. Such information will drive decisions about sampling and recruitment of participants so at this stage we outline some aspects of that work only.

We also outline plans for the outcomes evaluation, in terms of (a) an intermediate outcome assessent and (b) long-term comparative outcome assessment. The exact nature of these evaluations will evolve, as the implementation and delivery of the Accelerators develops, and as issues related to timing and data access become clear. An additional issue for the comparative outcome measurement is change in other areas and therefore the potential for comparator sites. The proposals for the intermediate outcome assessent and long-term comparative outcome assessment will be developed into more detailed protocols.

Process evaluation

Overall approach and research questions

Initial sense-making with Accelerators was based on written documentation and ongoing discussions, supported by 'logic modelling'.

Following this, a qualitative process evaluation will be conducted on *implementation* (with Accelerator site leads, focussing on the overall strategy and organisation of the Accelerator in each ICS) and *delivery* (with local staff involved in the actual roll-out of Accelerator interventions and services) to answer the following research questions:

1. What are the barriers and enablers to implementation of Accelerators?

    a. What are the governance arrangements for Accelerators? How do they vary across Accelerator sites? How do governance arrangements act as barriers and enablers to implementation and delivery?

    b. How did the design of the Accelerator originate, and what aspects of regional service history drove design and delivery? How is the Accelerator expected to interact with other relevant programmes such as Trailblazers?

    c. What PHM capacity exists in sites at present? How will limitations in PHM capacity be managed? What future PHM developments are planned to meet Accelerator aims?

    d. What is the role of digital therapeutics in the Accelerator? What is the current level of digital maturity in local organisations? How will further developments be supported?

    e. How are the views of patients and communities being reflected in Accelerator plans and implementation? How are regional inequalities around health, economic inactivity and access to care reflected in Accelerator plans? What impacts on inequality are expected?

    f. How is medium and long-term sustainability of the Accelerator managed?

2. What are the barriers and enablers to delivery of Accelerators and the interventions?

    a. What specific interventions are being delivered in the Accelerator?[14] What services are new, or variations of existing services? What wider organisational and cultural changes are expected?

    b. What workforce, technology or other resources need to be put in place for delivery? What challenges are being faced?

    c. How are patients identified and recruited? What methods are used to encourage engagement in an equitable way?

    d. How are service performance and outcomes assessed and reported? What were the main barriers to achieving targets set for performance and outcomes?

Methods

Selection of participants

Accelerator site leads will include ICS staff involved in the implementation of the Accelerator programme, and other stakeholders involved in implementation (which may extend beyond the ICS). Rose NET have been in close contact with members of the ICS staff (such as programme and data leads) and will develop further key contacts on the basis of discussions with those staff and contacts developed through the initial logic modelling. We expect to interview around 5-6 staff in each Accelerator.

Accelerator delivery leads will be staff involved in the delivery of interventions funded by the Accelerator programme. Rose NET will develop these contacts through discussions with Accelerator site leads and knowledge about Accelerator interventions developed through the initial logic modelling and on-going information gathering through Accelerator programme meetings. We expect to interview around 10-12 staff in each Accelerator, although it will depend on the number of interventions funded. If the number of interventions within an Accelerator are very large, we will sample on a range of characteristics (such as the relative funding of each and their expected patient throughput) to ensure we cover the main interventions within each Accelerator.

Data collection

The process evaluation will involve semi-structured qualitative interviews with Accelerator site leads and local delivery staff. This will be complemented by the logic modelling already conducted by or with the sites, and through access to relevant documentation from the Accelerators related to issues of implementation and delivery.

Analysis

A coding framework around barriers and facilitators to implementation and delivery will be iteratively developed as the interviews continue, through discussion at regular analysis meetings and with reference to relevant theory and conceptual frameworks. These will include Consolidated Framework for Implementation Research (CFIR),[15] the INTENTS framework to structure any assessment of spillover effects and unintended consequences,[16] the Health Disparities Framework to explore determinants of inequalities in access and outcomes,[17] and ‘candidacy’ to explore access and utilisation.[18]

Procedures

Recruitment of participants

The contact details of Accelerator site leads will be provided by NHS England and the sites themselves. Potential participants will be approached initially by an e-mail invitation from Rose NET researchers that will include a copy of the information sheet and consent form. Those indicating interest in participation will then be contacted and interviews will be arranged at a time to suit the participant – verbal consent will recorded at this point (see below). Snowball sampling will be used to recruit other participants who meet our criteria and are involved with Accelerator implementation and delivery at each site (in many cases this will be stated explicitly in Accelerator documentation). Indicative participant numbers are 5-6 participants per site for implementation and 10-12 per site for delivery of Accelerators.

Informed consent, confidentiality, anonymity and data protection

All potential respondents who are recruited for interviews will receive verbal and written information (an information sheet) regarding the study and will be encouraged to ask questions prior to taking part. It will be made clear that participation is purely voluntary and respondents are able to withdraw from the evaluation at any time, without giving a reason. We will obtain verbal consent before undertaking the telephone or Teams/Zoom interview which we will audio-record separately to the interview audio-recording.

With consent, all interviews will be audio-recorded using a secure University provided encrypted audio device. We will follow the University of Manchester's standard operating procedure for taking recordings of participants for evaluation: http://documents.manchester.ac.uk/display.aspx?DocID=38446). Recordings of the consent process and interviews will be transferred from the device as soon as possible to secure University servers (so that de-identified data is stored separately to consent data) and then deleted from the device. Any transcription of audio-recordings will be undertaken by a University of Manchester approved external transcription company. Audio recordings will be uploaded to the transcription company via a secure server. We will remove any personal identifying information (such as names, places) from transcriptions once they are returned. We will securely destroy the audio-recording of each interview, once an interview has been transcribed and the research team has checked the transcription for accuracy.

Once a respondent enters the study, they will be provided with a unique identifier. This means that data including field notes, audio recordings, transcriptions and demographic data will be identified only by their unique identifier. The 'pseudonymisation key' to the unique identifier and respondent's details (name, contact details, site and job title), will only be accessible to members of the research team and stored electronically on a University of Manchester secure server, separate to the de-identified data. Electronic data (such as digital audio-recordings, transcriptions, field notes, and demographic data) will be stored on a University of Manchester secure server. Hard copies of consent forms and demographic data will be kept in a locked cabinet in a secure room on University premises. Once the study is finished, data will be archived securely for 10 years, and then securely destroyed.

The research team will maintain the confidentiality of the data produced from interviews with participating individuals and will publish findings that are anonymised and aggregated. Within reports and papers individual participants are assigned a unique numerical identifier and each organisation will be given a pseudonym. However, due to the small sample size and some participants being site leads, it will be made clear to participants that maintaining anonymity may not be possible.

Patient and public involvement and stakeholder engagement

Within Rose NET, there is a PPIE Advisory group to advise on the operation and direction of the national evaluation team, and to develop a PPIE strategy: They have provided initial feedback on this protocol. We will also mobilise a specific group to support the Accelerator evaluation (with members from the PPIE Advisory group and wider stakeholders to reflect the Accelerator population). This group will in turn develop a strategy to support the evaluation. We expect their focus will be on the eventual development of research exploring patient access to and experience of Accelerator interventions (our preliminary plans in this regard are broadly outlined later). The group may support the development of patient-facing resources and advise on the optimal ways to engage participants, highlight priority areas for exploration, support intepretation of data and effective patient engagement as results become available.

Dissemination and Knowledge mobilisation

We will co-produce evaluation and dissemination plans by collaborating with all relevant stakeholders, with an initial focus on the key policy customers within the Accelerator programme. This will ensure that we can maximise the relevance of the work, and that opportunities to iteratively feedback insights to inform decision making processes are built in from the outset. Co-production will be facilitated by (i) our practice and policy networks, which offer extensive content expertise and frontline perspectives and (ii) our extensive community engagement partnerships.

Impact and deliverables

We will deliver by late 2025:

- Summary of barriers and facilitators to the implementation of Accelerators
- Summary of barriers and facilitators to the delivery of Accelerators

Ethics and governance approvals

Approval for the process evaluation was received from University of Manchester Ethics Committee.

We do not anticipate that HRA approval will be required for the evaluation as at present there is no patient contact. Appropriate governance approvals will be sought ahead of any contact with individual NHS Trusts.

The University of Manchester has insurance available in respect of research involving human subjects that provides cover for legal liabilities arising from its actions or those of its staff or supervised students. The University also has insurance available that provides compensation for non-negligent harm to research subjects occasioned in circumstances that are under the control of the University.

Timeframe

Estimated timeframe: 9 months – April – December 2025

Process evaluation (patients)

Overall approach and research questions

As noted above, patient experience of access to Accelerators (including proactive case finding through data linkage) and the experience of the interventions are likely to be important drivers of the success of the Accelerators. We have experience of the assessment of patient experience of policy interventions, including Whole Systems Demonstrators,[19] NHS Talking Therapies,[20] and the NHS Diabetes Prevention Programme (NHS DPP).[21]

At present, it is difficult to be precise about the approach to the process evaluation with patients. As noted previously, Accelerators will involve expansion of existing services, innovations, and improved co-ordination. At present, it is difficult to predict where the bulk of the patients will be recruited from, and what forms of support they will receive. Sampling of patients will need to both reflect the numbers of patients in different parts of the Accelerators, as well as reflecting the range of different types of support.

Information on the process by which patients receive Accelerator interventions, and the types (and relative numbers) of interventions received will be gathered through the preceding parts of the process evaluation, and will inform potential recruitment processes, sampling frames and the methods used. We will ensure that sampling and recruitment reflect the eligible populations as far as possible[22] and may oversample to explore particular socioeconomic groups.

We expect to have an extension to this protocol in late 2025 to provide additional information on the methods to be used, drawing on our developing understanding of the Accelerators and their patient populations and the expertise of our PPIE contributors.

It should be noted that Accelerators plan to deliver at least some of the interventions to NHS staff who are at risk of economic inactivity. For simplicity, we will refer to staff receiving Accelerator interventions as 'patients' to distinguish them from research participants from professional organisations implementing or delivering Accelerators.

A variety of methods will be considered to explore patient experience, including conventional interviews and focus groups, as well as observational methods where appropriate. We expect issues of access and engagement to be important and analysis will be informed by the candidacy framework.[18]

Potential research questions will include:

1. What is the experience of patients in accessing Accelerator interventions? Why do patients take up or refuse Accelerator interventions? How does uptake and refusal vary by clinical, socio-demographic and employment characteristics?[3]

2. What is the experience of patients of the delivery of Accelerator interventions? How does experience vary by clinical and socio-demographic characteristics?

[3] The proportion of patients in Accelerators who are also in receipt of social care was raised during review of this protocol. We conducted analysis of the UK Health and Lifestyle Survey to explore this. Among the working age population who were off work that week due to ill health but in employment, around 7% reported having accessed some kind of social care within the last 12 months. There are limitations to this analysis (including a small N which makes the estimate imprecise) but it suggests that the proportion of those in receipt of social care is relatively small. We will continue to explore this issue in our process evaluation to make judgements as to the priority to place in social care use in our qualitative and quantitative data collection and analyses.

Intermediate outcome assessment

Overall approach and research questions

Although a comparative assessment of the effects of the Accelerators on health and economic outcomes provides the most rigorous assessment of the impact of the programme, it is likely that many of those impacts will occur in the longer term and will not be demonstrated until 2027 onwards. Nevertheless, there will be a need to make decisions about further commissioning of Accelerators in the shorter term.

The intermediate outcome assessment is designed to deliver results for policy makers and commissioners in 2026, between the 2025 process evaluation and the 2027-28 comparative outcome assessment. As noted earlier, the protocol for the intermediate outcome assessment is developing based on an evolving understanding of the Accelerators, the cohorts being identified for intervention, and wider issues of data availability and governance within and outside the Accelerators. This will continue through 2025-2026 to support further development of this protocol.

The overall aim of the interim outcome assessment is to explore whether it is plausible that the investment in Accelerators will lead to substantial changes in health and economic activity over the longer term.

To make this assessment, we propose an evaluation of the ability of Accelerators to:

(a) identify an appropriate eligible patient cohort (in size and diversity). This would require data on participant numbers and details of their demographic, clinical and occupational/economic characteristics. Comparison of the characteristics of the eligible cohort and those who were offered, accepted and completed Accelerator interventions would allow detailed assessment of the ability of sites to recruit and retain equitably (or indeed to over-recruit from certain populations).[23]

(b) recruit participants to the interventions in each Accelerator and deliver a suitable 'dose' of an 'evidence-based' intervention. This would require data on the types of interventions provided, as well as uptake of and adherence to Accelerator interventions.

(c) improve outcomes. This would require standardised measures of health and economic activity outcomes e.g. health could be measured using EQ5D-5L at baseline and end of treatment. If Accelerators were unable to provide standardised measures of outcomes (as this requires primary data collection), assumptions would have to be made that uptake of and adherence to an evidence-based intervention from (b) would lead to improved outcomes.

Methods

We propose an observational quantitative study, which would be similar to others conducted alongside large scale policy interventions, including NHS Talking Therapies,[24] and the NHS DPP.[25 26] In both cases, routine systems were used to collect data on the patient cohort and their short-term outcomes in an observational, before-and-after design. In both cases, these studies provided decision-makers with confidence about the initial operation of the programme, although in both cases a formal, comparative assessment was also conducted subsequently to strengthen the evidence-base in the longer-term.[27-29]

There are significant challenges in replicating these earlier analyses with the Accelerators. Both NHS Talking Therapies and NHS DPP were fairly standardised interventions working to a common protocol and managing a clinically defined group of patients assessed in standardised ways. It is likely that the Accelerators will display much more variability in their service delivery in relation to all of those features.

The rigour of the interim outcome assessment will depend on a number of factors, including (a) whether sites are able to collect data across a significant proportion of their funded interventions, and the participants using those interventions (b) whether they are able to collect outcome data (such as EQ5D and economic activity) alongside demographic and process measures (such as uptake and adherence).

Through NHS England, we are in negotiation with sites about the collection of a minimum data set for Accelerator interventions including EQ5D 5L at baseline and end of intervention.

The interim outcome assessment would not provide a comprehensive assessment of Accelerators. There are aspects of Accelerators that are not ‘interventions’ delivered to individuals and may impact on different ‘levels, such as health professionals managing eligible patients, employers and organisations. Some estimates of the scope and size of these additional impacts could be made based on the developing logic models and the size of the investment in those areas, but these effects would only be formally assessed in the 27-28 comparative outcome assessment.

Timeframe

Estimated timeframe: 12-18 months – 2026 onwards

Long-term comparative outcome assessment

Overall approach

A long-term comparative assessment of the effects of the Accelerators on health and economic activity outcomes provides the most rigorous assessment of the impact of policy innovation. As noted earlier, the protocol for long-term comparative assessment is developing based on an evolving understanding of the Accelerators, the cohorts identified for intervention, and wider issues of data availability and governance within and outside the Accelerators. This will continue through 2025-2026 to support further development of this protocol. Here, we outline two approaches and core issues related to each approach.
One is a person level analysis, assessing the impact of receiving an Accelerator intervention compared to no intervention, and provides the most rigorous assessment of the impact of identifying and intervening in this patient group. Although providing a rigorous assessment of the impact of Accelerator interventions, the person level analysis would not provide a comprehensive assessment of Accelerators. As noted previously, there are aspects of Accelerators that are not 'interventions' delivered to individuals, and which may impact on health professionals managing eligible patients, as well as employers and organisations. The person-level analysis will therefore be most appropriate for the cohort of individuals identified through PHM approaches. The wider impacts on health professionals, employers and organisations would only be captured in site level analyses. A site level analysis would therefore complement the person level analysis.

1. *Person level analysis*

Anticipated research questions:

1. What is the impact of receiving an Accelerator intervention compared to no intervention in eligible patients, on health and economic activity?

2. How does the impact of Accelerator interventions vary between interventions, and between different patient groups?

Proposed data sources: The most rigorous approach to the analysis of Accelerator interventions will involve analysis of data held by ONS, which includes linked data at person level - including Hospital Episode Statistics (HES), HMRC Census and Department of Work and Pensions (DWP) data. Assuming Accelerators can provide lists of NHS numbers from patients in Accelerator interventions, that could be linked to ONS data to allow us to compare measures of their long-term health and economic activity outcomes versus a suitably matched comparison group. We could explore a range of comparators including patients within or outside Accelerator areas.

Challenges: This approach is possible if individual NHS numbers are made available, or if engagement in Accelerator interventions is routinely coded in data sources included in the ONS data set. Although ONS will have detailed data on economic activity and some measures related to health outcomes (diagnoses, admissions, mortality), it will not include health-related quality of life assessments such as EQ5D. That data can only be obtained through primary data collection by Accelerator sites and would not be available for comparators.

Current activities: We are in discussion with Accelerator sites and NHS England about the possibility of collecting and sharing NHS numbers and have had discussions with the ONS team about access to the data.

2. *Site level analysis*

Anticipated research questions:

1. What is the impact of Accelerator programmes compared to areas without Accelerator programmes on wider health and economic activity outcomes?

Proposed data sources: Site level analyses would use ONS data to assess the impact of the Accelerator programmes (not interventions). We would identify a suitable cohort in the ONS data in each site (based on known eligibility criteria within the Accelerators) and compare their economic activity and measures related to health outcomes versus a matched comparison group from areas without Accelerators (potentially including those with and without related interventions such as Trailblazers and WorkWell). This analysis has the advantage of potentially capturing all effects of Accelerators. However, there are also disadvantages. There is significant potential for the true effect of Accelerators to be diluted when we examine a larger cohort, many of whom may not have been treated by an Accelerator programme.

Challenges: A key challenge will be to identify a suitable Accelerator and comparator cohort in ONS, which accurately reflects how Accelerators identify eligible patients. Modelling across various cohorts and comparators will be necessary.

Current activities: We are in discussion with the ONS team about access to the data, which would allow early work on how appropriate samples could be created.

Timeframe

Estimated timeframe: 18-24 months – 2027-2028

References

1. Powell A. Understanding statistics on employment, unemployment and earnings (Commons Library Research Briefing): House of Commons Library, 2024.
2. Pinna Pintor M, Fumagalli E, Suhrcke M. The impact of health on labour market outcomes: A rapid systematic review. *Health Policy* 2024;143:105057. doi: 10.1016/j.healthpol.2024.105057 [published Online First: 20240326]
3. Waddell G, Burton A. Is work good for your health and well-being? An independent review of the scientific evidence (https://assets.publishing.service.gov.uk/media/5a7c41a540f0b62dffde0df7/hwwb-is-work-good-for-you.pdf). London: The Stationery Office, 2006.
4. Best A, Greenhalgh T, Lewis S, et al. Large scale transformation in health care: a realist review. *Milbank Quarterly* 2012;90(3):421-56.
5. Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, And Cost. *Health Affairs* 2008;27(3):759-69. doi: 10.1377/hlthaff.27.3.759
6. Swarthout M, Bishop MA. Population health management: Review of concepts and definitions. *Am J Health Syst Pharm* 2017;74(18):1405-11. doi: 10.2146/ajhp170025
7. Cuijpers P, Kleiboer A, Karyotaki E, et al. Internet and mobile interventions for depression: Opportunities and challenges. *Depress Anxiety* 2017;34(7):596-602. doi: 10.1002/da.22641 [published Online First: 20170504]
8. Layard R. The case for psychological treatment centres. *BMJ* 2006;332:1030-32.
9. Naylor C, Charles A. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/place-based-partnerships-explained, 2022.
10. Bambra C, McNamara C, Munford L, et al. To get Britain working we need to get Britain healthy. *BMJ* 2025;388:r76. doi: 10.1136/bmj.r76
11. Fadyl JK, David A, Kirk R, et al. Living with a long-term health condition and seeking paid work: qualitative systematic review and thematic synthesis. *Disability and Rehabilitation* 2022;44(11):2186-96. doi: 10.1080/09638288.2020.1826585
12. Osborne RM. Labour is peddling the “work cure” for mental health—are we back to Victorian times? *BMJ* 2025;389:r738. doi: 10.1136/bmj.r738
13. Glasgow R, McKay H, Piette J, et al. The RE-AIM framework for evaluating interventions: what can it tell us about approaches to chronic disease management? *Patient Education and Counseling* 2001;44:119-27.
14. Hoffmann TC, Glasziou PP, Boutron I, et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ* 2014;348
15. Damschroder LJ, Aron DC, Keith RE, et al. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation science* 2009;4(1):50.
16. Francetic IA-O, Meacock R, Elliott J, et al. Framework for identification and measurement of spillover effects in policy implementation: intended non-intended targeted non-targeted spillovers (INTENTS). *Implement Sci Commun* 2022;3(2662-2211) doi: https://doi.org/10.1186/s43058-022-00280-8
17. Kilbourne AM, Switzer G, Hyman K, et al. Advancing health disparities research within the health care system: a conceptual framework. *Am J Public Health* 2006;96(12):2113-21. doi: 10.2105/ajph.2005.077628 [published Online First: 20061031]

18. Mackenzie M, Conway E, Hastings A, et al. Is 'Candidacy' a Useful Concept for Understanding Journeys through Public Services? A Critical Interpretive Literature Synthesis. *Social Policy & Administration* 2013;47(7):806-25. doi: https://doi.org/10.1111/j.1467-9515.2012.00864.x

19. Sanders C, Rogers A, Bowen R, et al. Exploring barriers to participation and adoption of telehealth and telecare within the Whole System Demonstrator trial: a qualitative study. *BMC Health Services Research* 2012;12:220. doi: https://doi.org/10.1186/1472-6963-12-220

20. Irvine A, Drew P, Bower P, et al. 'So just to go through the options…': patient choice in the telephone delivery of the NHS Improving Access to Psychological Therapies services. *Sociology of Health & Illness* 2021;43(1):3-19. doi: https://doi.org/10.1111/1467-9566.13182

21. Howells K, Bower P, Burch P, et al. On the borderline of diabetes: understanding how individuals resist and reframe diabetes risk. *Health, Risk & Society* 2021;23(1-2):34-51. doi: 10.1080/13698575.2021.1897532

22. Treweek S, Banister K, Bower P, et al. Developing the INCLUDE Ethnicity Framework—a tool to help trialists design trials that better reflect the communities they serve. *Trials* 2021;22(1):337. doi: 10.1186/s13063-021-05276-8

23. Chatzi G, Whittaker W, Chandola T, et al. Could diabetes prevention programmes result in the widening of sociodemographic inequalities in type 2 diabetes? Comparison of survey and administrative data for England. *J Epidemiol Community Health* 2023;77(9):565-70. doi: 10.1136/jech-2022-219654 [published Online First: 20230623]

24. Clark D, Layard R, Smithies R, et al. Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy* 2009;4(11):910-20.

25. Howarth E, Bower PJ, Kontopantelis E, et al. 'Going the distance': an independent cohort study of engagement and dropout among the first 100 000 referrals into a large-scale diabetes prevention program. *BMJ Open Diabetes Res Care* 2020;8(2) doi: 10.1136/bmjdrc-2020-001835

26. Marsden AM, Bower P, Howarth E, et al. 'Finishing the race' – a cohort study of weight and blood glucose change among the first 36,000 patients in a large-scale diabetes prevention programme. *International Journal of Behavioral Nutrition and Physical Activity* 2022;19(1):7. doi: 10.1186/s12966-022-01249-5

27. Ravindrarajah RA-O, Sutton MA-O, Reeves DA-O, et al. Referral to the NHS Diabetes Prevention Programme and conversion from nondiabetic hyperglycaemia to type 2 diabetes mellitus in England: A matched cohort analysis. *PLoS Med* 2023;27:1549-676. doi: 10.1371/journal.pmed.1004177

28. McManus E, Meacock R, Parkinson B, et al. Population level impact of the NHS Diabetes Prevention Programme on incidence of type 2 diabetes in England: An observational study. *Lancet Reg Health Eur* 2022;19:100420. doi: 10.1016/j.lanepe.2022.100420 [published Online First: 20220529]

29. Parry G, Barkham M, Brazier J, et al. An evaluation of a new service model: Improving Access to Psychological Therapies demonstration sites 2006-2009 - Final Report. London, 2011.