ABSTRACT

This article examines the challenges of and barriers to generating and implementing evidence-based policy and practice in health services. It describes how one of the NHS R&D programmes – on service delivery and organisation – is attempting to get evidence into policy and practice.

KEY WORDS: HEALTH SERVICES; SERVICE DELIVERY AND ORGANISATION; RESEARCH METHODS

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Introduction

There are several key questions that need to be addressed in the health service in relation to knowing ‘what works’. What do we know about how best to do things at the level of the organisation (structures), at the level of the specific intervention or service model (techniques) and at the level of the practitioner (competence)? And even if it does ‘work’ at some or any level, is it actually what users or carers want?

The challenges of generating knowledge to answer these questions and then to ensure that this knowledge is actually used are numerous.

If it makes a difference, why does it?

First, many evaluations of interventions or models of care are of ‘expert’ or particularly committed innovators – practitioners who are at the top of their skills and knowledge. Yet we might guess that, in the larger service environment, skills and knowledge are normally distributed; some people are poor, some people are average and some people are above average. How much do we know about the extent to which average and below-average practice can deliver the same outcomes as the evaluated interventions? And how do we ensure that the space between best and worst is as narrow as possible? The ways in which good practice can be spread and then sustained are thus key questions in this area.

Second, many evaluations filter or triage people before they receive a particular service or intervention and this is perhaps most common in areas where there is much reliance on randomised controlled trials. We thus produce evaluations where perhaps fewer than half the patient or user group is actually included. What then happens if we apply the intervention or service to the total patient or user group? We could probably guess that we would get a dilution of any effect that the evaluation had identified. Alternatively, we could filter or triage the user group in the same way that the evaluation did, in order to achieve demonstrated benefits. But if we do this, what do we do with the rest of the potential users? This becomes a particular issue if the evaluated intervention actually costs more to achieve benefits, reducing resources for the service users who would be deemed less likely to benefit from the intervention. A current example of this problem will be the ‘rolling out’ of specialist stroke care, as required by the National Service Framework on older people. Most of the trials of specialist stroke care that have shown
improvements in mortality and morbidity included only the least dependent patients.

Third, there is the tendency to evaluate ‘black box’ services, without necessarily identifying the particular elements of those services that contribute to benefits. Stroke units, again, provide a good example of this. There is clear evidence that death rates are lower in stroke units, but we still do not know what element of stroke unit care actually delivers this outcome. Is it better clinical care? It could be, but none of the trials has actually tested this. Further, when there are discrete elements in a service or model of care, we also need to know something about how each of them can be done best. This can then help us institute training and audit that aim to improve overall outcomes by ensuring the best outcomes for each element.

How do we get to know what we know?
The second challenge in generating knowledge to influence policy and practice is actually ensuring that it does so.

There is a longstanding debate about the impact of research on policy, and in places it clearly has had a substantial impact. A good example of this is care management and the care programme approach. But it is also possible to argue that research had such an impact on policy in this area because the right research was in the right place at the right time, that is, it fitted the political Zeitgeist. At other times we can see that the impact of research has been more about influencing the climate of opinion, with a more subtle and longer-run influence on policy. For example, research on carers carried out in the late 1970s and 1980s was used to great effect by carers’ organisations to influence policy and opinion. At yet other times, policy processes run well ahead of evidence. The danger here is that research is always running behind, trying to catch up with policy development and, as a result, being seen (unfairly in my view) as slow and irrelevant.

The impact of research on practice is also long-debated. Generating knowledge about what works only has an impact if we then:

- apply tested interventions or processes
- make sure that tested interventions or processes are carried out competently
- are sure that it is what users and carers actually need and want.

However, getting evidence into practice in this way is easier said than done, and raises almost as many research questions again.

Horses for courses
The third challenge is in identifying and using appropriate research methods and designs.

The randomised controlled trial (RCT) is now seen as the ‘gold standard’ for evaluating interventions in clinical care. But it was a research design originally invented for testing seeds in field trials and, while it may be adequate for testing drugs and single clinical interventions, it has some inevitable limitations for evaluating more complex interventions – and particularly services. The RCT seems particularly unsuitable for evaluating services where there are substantial variations in practice from place to place and where it is important to identify system-wide effects of new services.

But the RCT also has its strengths; there are internationally agreed standards of quality which, if applied, ensure rigour and replicability and, with that, a degree of reassurance about the validity of findings. Even if we cannot hope (or indeed would want) to use RCTs in most evaluations of services or models of care, we can at least strive for optimum standards of rigour in design and methods. This is important, not least because it would open up far more opportunities for systematic review of evidence than is currently possible. Important new developments in assessing the quality of qualitative research are key here.

To say that the RCT may not be the most appropriate approach in the area of service delivery and organisation research does not, therefore, let us off the hook in terms of rigour in thinking about appropriate and new designs, methods and forms of analysis.
The NHS R&D Programme on Service Delivery and Organisation

Having looked briefly at some of the challenges of providing and then implementing research for policy and practice, I now want to move on to describe how the NHS R&D Programme on Service Delivery and Organisation is working to address serious gaps in knowledge in this area.

First, how does the SDO Programme fit in the national picture of R&D?

- **HTA** – the Health Technology Assessment Programme – as its name suggests, is concerned with evaluating specific health-related technologies. It commissions a programme of systematic and rapid reviews plus major empirical projects.

- **NEAT** – New and Emerging Applications of Technology – carries out horizon scanning work, identifying new technologies before they become embedded in the service system.

- **The Policy Research Programme (PRP)** is run from within the Department of Health (DoH), is often close to policy development, runs the DoH research units and furthers its work largely through commissioned programmes and projects.

- **Service Delivery and Organisation (SDO)** is a relatively new and small programme within this ‘stable’, but has big ambitions.

In addition, and much larger than all the above in total, is the research money currently embedded in NHS trusts.

The SDO programme was established in 1999, its main work programme starting in 2000. It aims to consolidate and develop the evidence base on the organisation, management and delivery of services. It identifies its potential customers or stakeholders widely, to include health service managers and professionals, voluntary organisations, service users, carers and the research community.

The programme’s first task was to set priorities for research and it did this through a national ‘listening exercise’, carried out in the winter of 1999/2000. The aim was to understand the issues most important to those who deliver, organise and use health services, and to build ownership of the programme in those groups. The methods used were:

- an expert forum, which set the overall agenda and advised on the composition of focus groups
- sixteen regional focus groups and six specialist groups that involved over three hundred and fifty people
- debate of the findings from the exercise, using the expert forum, policy makers and shapers and other forms of feedback.

The largest groups included in the exercise - around two-thirds of the total - were service users/members of the public, clinical staff and middle managers. They were asked to identify key issues in the NHS for delivery and organisation of services and to address how the SDO programme should be delivered.

The messages from the listening exercise were many and various, but four main themes emerged: access to care, continuity of care, eliciting users’ views and change management. They have been supplemented recently by a theme from one of the national service frameworks - mental health and carers - and a more responsive theme on innovations in health care.
Within these main themes, the research questions that the programme addresses include the following.

- How do we deliver services appropriately and efficiently?
- What impact does the organisation of care have on relationships between users and professionals?
- How can different care professionals work in ways to provide more integrated care to users?
- How best should we implement changes to services?

In answering these questions the programme expects researchers to use a wide range of existing designs and methods and to contribute to the development of new ones. The recent publication of a methods handbook for SDO research (Fulop et al., 2001) signals clearly just how widely we expect people to look for appropriate approaches. It include chapters on organisational studies, organisational psychology, organisational economics, qualitative research, epidemiological methods, policy analysis, economic evaluation, historical research, operational research, action research and synthesis of research evidence.

The programme has also adopted a non-traditional style for its commissioning. We see this as a key part of ensuring that research addresses important issues and that messages then influence practice and policy. The commissioning board has only a small proportion of researchers, and all members, regardless of the constituency they represent, are part of commissioning sub-groups which take forward the individual programmes.

This has its challenges. The time commitment for board members is high, non-researchers are not always confident of their ability to assess research proposals, and there are inevitable questions about what non-academics feel they can gain from their involvement. Nonetheless, the model is working, although, as befits a programme committed to improving policy and practice, we are also committed to reviewing its effectiveness.

Figure 2, overleaf, shows how the programme gets from ideas to actual projects. Scoping exercises and reviews inform the development of research commissioning briefs, which are worked on initially by members of the National Co-ordinating Centre (NCCSDO). They are then taken to the commissioning board for prioritisation and approval. The research needed can be of very different forms - short, medium and longer-term, reviews and synthesis, as well as major empirical work.

Once research is completed, a wide range of stakeholders is targeted to receive its messages. Communication is flexible and active, using close links with partners, and different audiences are targeted with different techniques - reports, reviews, briefings and seminars are used, as well as the usual academic activities (figure 3, overleaf). We also use expert communicators to ‘package’ research messages, where this is appropriate. NCCSDO maintains a Web site where details of the research programme and its outputs can be found (www.sdo.lshtm.ac.uk).

Progress to date

The programme is now well under way, with substantial reviews completed in the continuity of care stream and major empirical studies commissioned. Topics covered in the latter include continuity of care in stroke, cancer, severe mental illness and in primary care.

The first output from the change management theme - a book and leaflet on methods of change management - has been very successful, some 8,000 copies having been requested from NCCSDO in the five months since publication. A review of user involvement in change management and two projects on large-scale change in multi-professional organisations will be commissioned in late 2001.

In the access theme, two scoping exercises are complete and the brief for a programme of reviews and projects is being advertised in December 2001. Research asked for includes examining ways of measuring and reducing differences in access to health care among different groups and evaluating current NHS initiatives to improve access.

Initial scoping exercises and reviews in the other themes are also leading to the preparation of briefs for programmes of work to be commissioned throughout 2002.
Conclusion
Just as there is a need to ensure that only evidence-based interventions are used in practice, so there is a need to ensure that models of care, services and care organisations themselves are also based on best evidence principles. The challenges in producing this evidence and then making sure that it influences policy and practice are substantial but not insuperable. The SDO programme sees itself as a key part of the research community that welcomes and responds to such challenges.

Reference