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How is ‘evidence’ used in the planning and commissioning of alcohol-related public health interventions – what ‘evidence’ counts?

Fuse speakers:
Mandy Cheetham, Teesside University
Karen McCabe, University of Sunderland
Peter van der Graaf, Teesside University
Rosemary Rushmer, Teesside University (Principal Investigator)

Thursday 12th December, 2013

These are summary notes to accompany the presentation made by the above named speakers as one of the knowledge exchange seminar series organised by the Fuse knowledge exchange group and is to be read in conjunction with the slide set.

This seminar drew on findings from a project that has followed a public health commissioning process in England, and a joint planning process in Scotland, as each one developed public health services or interventions to reduce alcohol related harm, from planning to delivery, in order to explore the ways in which research evidence (and other types of evidence) is used. In the English site, the issue followed up was concerned with advice about reducing maternal alcohol consumption and in the Scottish case decisions about granting licences for the sale of alcohol. The funder, the National Institute for Health Research Health Services and Delivery Research Programme, is acknowledged as supporting this project and full details may be found in the disclaimer at the end of this report.

At the outset of the meeting Rosemary Rushmer explained that the focus of the seminar would be about the different types of evidence used. Slide 2 sets out the overall topics covered – an introduction to the project, the findings (allowing for their complexity and the significance of the contexts from which they were generated) and the results of sharing the findings via a Delphi process with a wider audience. The research questions are listed on Slide 3, and all were covered within the seminar apart from the health economics element. The kinds of issues addressed within the research project are what are known as ‘wicked problems’ (Slide 4) which are never fully soluble because of the context, multiple pressures and many competing solutions. Consequently, within the project the research team concentrated on two sites, so that they could harvest findings in depth. Some of the findings were transferable but not generalizable and the transferability was tested out via the Delphi process. Within the process some interesting findings emerged about perceptions, and Slide 5 illustrates how public health staff were perceived as they became part of the local government organisation, arising from the coalition government’s reforms.

The two case study sites were invited to pick their own topic within the overall subject of alcohol. Both sites faced the same dilemma regarding how to apply nationally generated evidence (see Slide 6). There are also difficulties about how evidence is delivered, especially if it is treated as a package that “speaks for itself” (see illustrative quotes on Slide 7). How does evidence get used? Evidence for commissioning may take various forms, for example,

the JSNA (Joint Strategic Needs Assessment), formal documents, the law, but it takes people to make it happen (see second quotation, Slide 8). The use of evidence is both formal and person driven; in particular people bring the evidence to life with their story or lived experience. The closer the evidence is to peoples' day jobs, the more impact it has (see quotations on Slide 9). It was clear from the two sites that research evidence is important but that it was note the whole picture, other types of information and politics would be significant, for example, if decommissioning was regarded as too sensitive to be carried through (Slide 10). One clear indication was that economic arguments would trump health arguments in regard to licensing decisions (Slide 11). This was underpinned by different groupings being established to achieve different objectives, for example, either to improve the economic activity bringing jobs in, or to improve health, and in some circumstances they would be bound to occupy different positions (see Slides 12-14).

The Delphi questionnaire

Within the research process a Delphi questionnaire was used to test out the overarching issues and see if people outside the case study sites would have the same or different views of any given statement, which had been generated by the case study site interviews. Slide 15 illustrates a series of contrasting statements alongside a nine point scale and the task of those completing the questionnaire, was to indicate at which point on the scale they most agreed with the statement(s). In addition people completing the questionnaire were asked to indicate how important they thought the issue was on a three point scale (not important, somewhat important and very important). The Delphi questionnaire was sent widely to the groups listed on Slide 16. In addition a number of corporate membership organisations kindly agreed to disseminate the questionnaire via their networks and the organisations concerned are listed at the bottom of Slide 16. By the time of a national workshop on the project held in early November, 34 responses to the questionnaire had been received. An additional publicity wave was initiated following the workshop, including the use of social media and, as a result 73 questionnaires were completed. Slide 17 gives a breakdown of the organisations and regions from which responses were received, and, in general terms it was a good spread of respondents. The results were converted to box plots (see Slide 18) where the length of each box reflects the division of opinion (with the longer boxes reflecting the greatest polarity of opinion) and the line within each box a line for the median with 25% above and below the line.

Slide 19 summarises the key findings as follows arising from the Delphi analysis:

- Clear favour for using **various sources;** need for **active interpretation** of evidence; using **people** and **joint planning** to draw in evidence; preferably in **co-production**; with a focus on **population health**
- Preference for **changing individual behaviour** and **informing service delivery**
- Divided opinions on: **national vs. local evidence; practical experience vs. research evidence** and **research evidence vs. politics**

Slide 20 summarises the key findings of how important the issues they had been asked to rate were. The majority rated all the statements as very important. The most important issues were about the number of sources of evidence and the level of evidence, whilst the least important issues were around people (in contradistinction to the interviews) and co-

production of evidence with the end-user. An analysis was also done of the differences in opinion by different sectors (for example, voluntary sector, local government) but the results need to be interpreted with caution because of the low numbers this involved from the Delphi respondents (see Slide 21). The research team contact details are listed on the final slide, number 23.

Discussion

Discussion took place on the following topics:

- The impact of the implementation of the coalition government reforms on the participant responses to either the interviews and/or the Delphi questionnaire. It was acknowledged that this had an effect and that perceptions were likely to be changed again as public health becomes more integrated into local government. In particular concerns about public health money not being ring-fenced and issues about getting long term changes in place were coming to the fore.
- There were real tensions around the night-time economy and balancing the economic benefits of a vibrant night-time economy vs. the health dis-benefits. There was a view that changing the Licensing Act would have more impact on decision making processes, whereas developing a licensing objective was mainly a gateway to having a seat at decision making table(s). Difficulties around finding data at the right geographical level to address a licensing proposal were referred to, and the value of hearing individual's stories.
- In regard to advising on maternal alcohol consumption there were many uncertainties aired – about the evidence itself, the value midwives put on cultivating a relationship with the women they say vs. directly challenging drinking behaviours, how to define occasional drinking, what women said and whether it was accurate and the extent to which services were in place to treat women with alcohol problems.
- The results on needs assessment demonstrated that national and local evidence was important hence the answers in the Delphi were in the middle of the spectrum. At present the Delphi respondents did not think politics were important but the audience at the seminar felt that that would change over time, as the new public health system bedded in.

AR – DRAFT as at 20th December 2013

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The Centre for Translational Research in Public Health

How is 'evidence' used in the planning and commissioning of alcohol-related public interventions - what 'evidence' counts?

Knowledge Exchange Seminar

12th December 2013

Sunderland University

Mandy Cheetham	Teesside University
Karen McCabe	University of Sunderland
Peter van der Graaf	Teesside University
Rosemary Rushmer	Teesside University (PI)

www.fuse.ac.uk

Overview

> Introduction to the project
> Complexity, 'messy' contexts and transferability
> Overarching findings
> Sharing the findings via a Delphi process

The Project

Research Questions

How, when, where and by whom is research evidence (and other information) used in commissioning and planning PH interventions?
CASE STUDIES (interviews, observations, documentary analysis)

What do 'knowledge managers' do? **INTERVIEWS**

Is there a link between how evidence is used and organsational performance?
HEALTH ECONOMICS

Are findings transferable? **DELPHI PROCESS & NATIONAL WORKSHOP**

What is involved in working in co-creation? **REFLECTIONS**

Wicked problems… that never go away

COMPLEXITY

‘messy’ contexts – multiple pressures

…multiple possible solutions

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…pause for thought…

"Some public health people are *a bit scary*, very academic…they deal in hypothesis to some extent, which I think not everyone gets in local government. We're used to dealing with real situations, *not in a decade, this might happen"*

Usefulness of local vs. national evidence

> *What comes out gives you some guideline, it [research] doesn't give you the specifics of how you apply that to a commissioned piece of work or a service specification, so you know, it's up to us to go away and really think well, what does that actually mean to us when we're designing this piece of work*

> *We start to collate national evidence, […] but what we don't know is then locally, if that evidence (applies), so that's then where we will then go and speak to people to gain our local evidence around the subject matter…we don't know unless we, we ask our local population "*

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Evidence 'speaks for itself'?

> "One of my issues with the work from the Universities, [it is] very heavy on the thud factor, putting stuff on the table. And everyone goes, that's very nice, thank you very much, and it never gets looked at… "

> "One of the things I'm kind of conscious of, particularly for the Council environment, is that we don't just go, here you go, here's some data. It has to come with that kind of interpretation and kind of explanation."

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People or Systems draw evidence into decision-making?

- "…he [practitioner] would be saying latest research shows, and he would disseminate that, and say you know this may well change practice. It's generally you know a conversation or if […] we've then changed a guideline, he may be involved in saying, I'll tell you why we've changed this guideline…"

"…where people actually go and tell their stories, and I don't know what's, what the Licensing Board have done with all of that, but I certainly understand they found it incredibly powerful. *So those telling of stories probably has had a bigger impact than the evidence that we presented* . But that's good, because then you're getting a holistic picture, not just one set of information to be able to tell a story"

What generates the most valuable knowledge - practical experience or academic research?

- “…this Trust will take account of that [research] as well as what we know anecdotally and from experience and knowledge of our own population, so obviously research has a part”

- “I’m quite, more than happy to do evidence-based medicine and […] we do that every day in our lives, and obviously we get NICE guidelines, which we follow, but I’m always happier when I’ve tried it, and I know that it does work.”

Research evidence versus politics

- You'll get a public health argument saying, lots of concentrated off-sales are bad, we need to do something about it. You've got the Chamber [of commerce] at the other end saying, it's a free market, if the demands are out there, have the supplies out there, make sure you've got the supplies. *So that's always the balance you have*

- "…there's a political element, I suppose, to what's commissioned [….] I would probably suggest that some things are allowed to continue, maybe with a weaker evidence base, because politically it might be quite sensitive to withdraw services. *So it's a constant balancing act really about, where the evidence is, but also with the politics in the background."*

Health or Economic well-being?

> "I can guarantee you now, the Licensing Board will never say the entirety of [case study site] has overprovision. Sorry, there are all sorts of economic reasons and developmental reasons, why doing that would be suicidal and the rest of the Council would be on the Licensing Board like a ton of bricks. Because you would stop any hotel, you would stop every major, err, economic development and shopping centres, etc, etc. It isn't going to happen."

Structurally set-up to pursue different objectives?

> “The reason given was that licensing brings in money and I challenged her by saying how much does it cost to deal with the problems related to alcohol and she responded by saying, she didn’t have the data and she stopped at that and then she said if you’re going to go down the route of there shouldn’t be any more licensed premises in [the Scottish case study site].”

Where should public health focus – individual behaviour change or national policy?

> they [Board] are looking at individual premises, [health] are looking at a population basis so [health] have tried to have more influence at a national level, rather than at a local level"

Delphi questionnaire

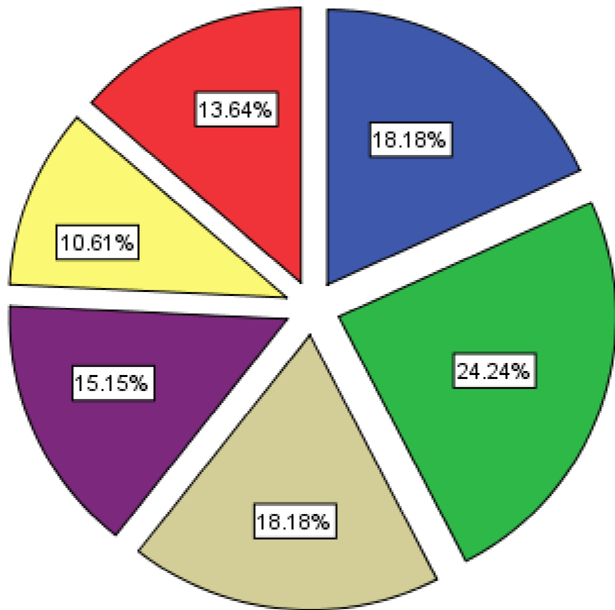
On balance, place your X to reflect which statement you agree with most (CLICK ON A BOX) Clicking the middle box will show you equally agree with both											**Importance (CLICK HERE)**		
											Not Important	**Somewhat important**	**Very important**
I find national evidence most useful in my decision-making on Public Health issues	☐	☐	☐	☐	☐	☐	☐	☐	☐	I find local data and information most useful in my decision-making on Public Health issues	☐	☐	☐
I typically go to one trusted source of evidence	☐	☐	☐	☐	☐	☐	☐	☐	☐	I typically draw upon a wide variety of evidence sources	☐	☐	☐
It's people that make sure evidence is drawn into decision-making in my organisation	☐	☐	☐	☐	☐	☐	☐	☐	☐	It's the organisational systems and processes that ensure evidence is drawn into decision-making in my organisation	☐	☐	☐
Mostly the evidence 'speaks for itself'	☐	☐	☐	☐	☐	☐	☐	☐	☐	Mostly the evidence needs active interpretation to pull out key messages	☐	☐	☐
The most valuable knowledge comes from practical experience	☐	☐	☐	☐	☐	☐	☐	☐	☐	The most valuable knowledge comes from robust academic research	☐	☐	☐
Commissioning across a purchaser-provider split makes it easier to secure evidence-informed interventions	☐	☐	☐	☐	☐	☐	☐	☐	☐	Joint Planning across unified organisational arrangements makes it easier to secure evidence-informed interventions	☐	☐	☐
Public Health should be focussed on changing national policy	☐	☐	☐	☐	☐	☐	☐	☐	☐	Public Health should be focussed on changing individual behaviour	☐	☐	☐
Research evidence best informs strategic planning	☐	☐	☐	☐	☐	☐	☐	☐	☐	Research evidence best informs service delivery	☐	☐	☐
Research evidence 'trumps' politics	☐	☐	☐	☐	☐	☐	☐	☐	☐	Politics 'trump' research evidence	☐	☐	☐
The health of the population is most important when making decisions	☐	☐	☐	☐	☐	☐	☐	☐	☐	The economic well-being of the population is most important when making decisions	☐	☐	☐
Research evidence should be produced *for* me	☐	☐	☐	☐	☐	☐	☐	☐	☐	Research evidence should be produced *with* me	☐	☐	☐

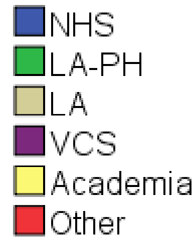
Who received the Delphi?

- Questionnaire emailed to contact list:
  - Participants in case study sites
  - Co-applicants and advisory group members
  - Chairs of HWBs, CCGs, Licensing Boards
  - Alcohol Commissioners in LAs
  - Local Supervising Authority Midwifery Officer
  - Addiction charities
  - PHE, Health Scotland
- Invitation published in newsletters by NHSCC Press, ADPH, LGA, SpR Public Health (BHPH), VONNE, ILG

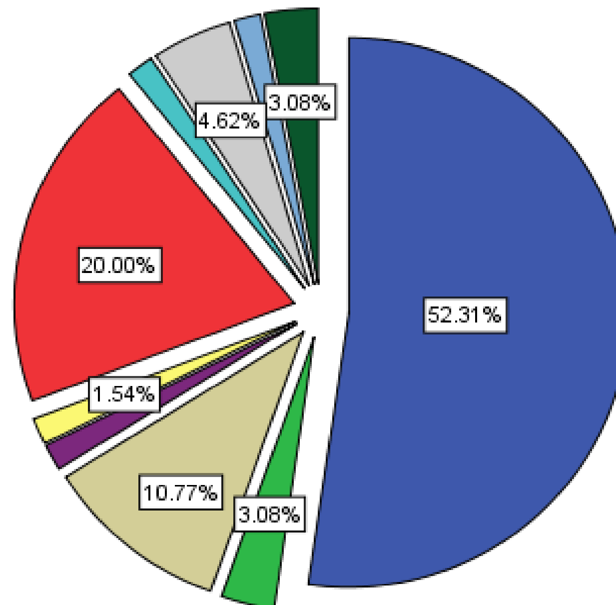
Who responded? (n=73)

All sectors represented





Strong representation from the North East



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What did they say?

I find national evidence most useful in my decision-making on Public Health issues	I find local data and information most useful in my decision-making on Public Health issues
I typically go to one trusted source of evidence	I typically draw upon a wide variety of evidence sources
It's people that make sure evidence is drawn into decision-making in my organisation	It's the organisational systems and processes that ensure evidence is drawn into decision-making in my organisation
Mostly the evidence 'speaks for itself'	Mostly the evidence needs active interpretation to pull out key messages
The most valuable knowledge comes from practical experience	The most valuable knowledge comes from robust academic research
Commissioning across a purchaser-provider split makes it easier to secure evidence-informed interventions	Joint Planning across unified organisational arrangements makes it easier to secure evidence-informed interventions
Public Health should be focussed on changing national policy	Public Health should be focussed on changing individual behaviour
Research evidence best informs strategic planning	Research evidence best informs service delivery
Research evidence 'trumps' politics	Politics 'trump' research evidence
The health of the population is most important when making decisions	The economic well-being of the population is most important when making decisions
Research evidence should be produced *for* me	Research evidence should be produced *with* me

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Key findings

- Clear favour for using **various sources**; need for **active interpretation** of evidence; using **people** and **joint planning** to drawn in evidence; preferably in **co-production**; with a focus on **population health**
- Preference for **changing individual behaviour** and **informing service delivery**
- Divided opinions on: **national vs. local evidence; practical experience vs. research evidence;** and **research evidence vs. politics**

How important is it?

- Majority rate all statements as very important
- <u>Most important:</u> **focus** of public health; number of **sources**; and **level** of evidence are considered most important issue
- <u>Least important:</u> **system** of decision making; **people vs. systems**; and **co-production**

national policy vs individual behaviour
one vs various sources
national vs local evidence
population health vs economic well-being
speaks for itself vs active interpretation
research evidence vs politics
strategic planning vs service delivery
practical experience vs academic research
purchaser-provider vs joint planning
people vs systems
produced for vs with me

.0
20.0
40.0
60.0

% Very important

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Differences between sectors

NHS: Stronger preference for ***academic research***, and believe that ***research evidence*** trumps politics More divided on ***people vs. systems***; and ***national policy vs. individual behaviour***	**Academia:** ***national evidence*** is more useful in decision making, slightly stronger preference for ***academic research*** More divided on ***national policy vs. individual behaviour***
Local Authority-Public Health: Stronger preference for ***practical experience*** More divided on ***people vs. systems***; and ***research evidence vs. politics***	**VCS:** ***politics*** trump evidence, ***national evidence*** is more useful in decision making
Local Authority (non PH): ***research evidence*** trumps politics; ***practical experience*** and ***local evidence*** provide more valuable knowledge. More divided ***people vs. systems***	**Other:** ***practical experience*** and ***local evidence*** provide more valuable knowledge More divided on ***national policy vs. individual behaviour***; and ***strategic planning vs. service delivery***

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Quarterly Research Meeting

"Using public health research evidence - how difficult can it be?"

9.30am – 1.00pm Thursday 23rd January 2014

4th Floor Seminar Suite, Teesside University, Darlington Campus, DL1 1JW

Registration now open on the Fuse website!

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PI: Professor Rosemary Rushmer (Teesside University)

Co-applicants: Lynda Cox (NHS England),Professor Ann Crosland (University of Sunderland), Dr Joanne Gray (Northumbria University), Mr Liam Hughes (Local Government Group, retired), Professor David Hunter (Durham University), Dr Pete Seaman (Glasgow Centre for Population Health), Professor Carol Tannahill.

Researchers: Mandy Cheetham (Teesside University), Karen McCabe (University of Sunderland), Peter van der Graaf (Teesside University).

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Announcing the next Knowledge Exchange Seminar…

**Thursday 12th December 2013 – 2:00-3:00pm – Priestman Building (102)
Sunderland University, City Campus**

Speakers: Rosemary Rushmer, Professor in Knowledge Exchange & Public Health (pictured right) and research team members Mandy Cheetham, Peter Van Der Graaf (based with Professor Rushmer in Teesside University) and Karen McCabe (Sunderland University). The team will be reporting on a current NIHR project, due to complete at the end of November 2013, which means this seminar is especially timely to debate the issues "hot off the press".

HOW IS EVIDENCE USED IN LICENSING DECISIONS AND TO REDUCE ALCOHOL CONSUMPTION IN PREGNANCY?

The seminar will be designed to share and debate findings in the interests of promoting lessons that are useful in practice.

Services based on research evidence of what works lead to better patient outcomes. In public health, evidence of what works well may not be available, or may not apply in all settings making it difficult to know precisely what services to support for the best outcomes. This seminar will draw on findings from a research project that has followed a public health commissioning process in North West England, and a joint planning process in Scotland, as each one developed public health services or interventions to reduce alcohol related harm, from planning to delivery, in order to explore the ways in which research evidence (and other types of evidence) is used. Research questions addressed by this project were:

(1) How, when, where and by whom is research utilised and other forms of knowledge mobilised in the commissioning and planning of public health services? What is their perceived impact?
(2) What is involved in working collaboratively with research participants to co-create knowledge?
(3) What are the individual and organisational factors that support or hinder research use in the planning and commissioning of services?

Registration is ***now*** available for this seminar on the Fuse website at
http://forms.ncl.ac.uk/view.php?id=5068

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