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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

What is this Quarterly Research Meeting about?

The aim of this QRM is to discuss what happens, at the points in time, when research is considered as evidence to inform public health decision-making. What other factors loom large and compete against research evidence use? What are the implications for how research evidence is created, and how it is used in practice?

In the QRM we will present findings from a recently completed, nationally funded research project, which explored the ways in which research and other types of evidence are used. The project followed public health commissioning processes in England, and a joint planning process in Scotland, as each one developed public health services or interventions to reduce alcohol related harm. The case study sites selected the research topics, which included licensing and drinking in pregnancy.

Who should attend?

This event has been designed for professionals with an interest in either public health or commissioning, including alcohol services and/or control of sales, and will be particularly useful for commissioners in Local Authority Public Health Departments, in Clinical Commissioning Groups, on Health and Wellbeing Boards or in any public health role.

Please register your attendance at this free event on the Fuse website www.fuse.ac.uk

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PROGRAMME

9.30 – 10.00	**Arrivals, registration and refreshments**
10.00 – 10.10	Welcome and introduction by the Chair
10.10-10.40	Keynote – a colleague from PH practice will address the challenges and opportunities of using research evidence in commissioning / decision making processes Speaker: to be confirmed
10.40-11.00	Background to the research project: "Research utilisation and knowledge mobilisation in the commissioning and joint planning of public health interventions to reduce alcohol related harms. (NIHR:HS&DR 09/1002/37) Rosemary Rushmer, Professor in Knowledge Exchange in Public Health, Teesside University
11.00-11.20	**Refreshment break**
11.20-11.25	Roundtable Introductions
11.25-11.45 Vignette and Discussion	***Evidence use at Strategic level*** (Karen McCabe, Sunderland University) The curious case of the waste-land and an empty city centre building - • Health vs. economic well-being • What are the boundaries of 'public health'?
11.45-12.05 Vignette and Discussion	***Evidence-use at the 'front-line'*** (Mandy Cheetham, Teesside University) The curious case of contradictory evidence, mixed messages, poor routine data and the dilemmas facing midwives - • How do professional identity and personal values influence evidence-based practice? • What is 'best' for women and who decides?
12.05-12.25 Vignette and Discussion	***Complexity within the evidence-base itself*** (Peter Van Der Graaf, Teesside University) The curious case of (inter)national evidence being ignored – • What isn't done with existing evidence? • How to make national evidence fit locally?
12.25-12.50	Open discussion
12.50-1.00	Closing Remarks
From - 1.00	Lunch

HS&DR Funding Acknowledgement: This project was funded by the National Institute for Health Research Health Services and Delivery Research Programme (project number 09/1002/37).

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Information about the Venue

Darlington Campus is a modern building and the QRM will be held on the top floor (lift access). The address is Teesside University, Vicarage Road Darlington DL1 1JW

A new walking and cycling route has recently been opened from the main railway station!
Leave the station via the path from the taxi rank which leads straight onto Yarm Road. Walk down the path towards Yarm road and then turn right onto Yarm Road. Walk up Yarm Road and on your left you will see footpath signs to Teesside University Darlington Campus. Please follow these signs which will direct you to turn left off Yarm Road onto a footpath which leads directly to the campus. The walking time is approximately 8 minutes.

Road Directions:

From the A1 North and South: exit at junction 59 onto the A167 Darlington. Stay on the A167 for a few miles until you reach a roundabout taking the second exit staying on A167 North Road. Keep on this road as it heads into Darlington town centre, going through four sets of traffic lights. Keep on A167, turning left onto B6279 Haughton Road. Half a mile up Haughton Road you will see Darlington College on your right, turn right immediately past the college onto Vicarage Road. Follow Vicarage Road as it bends round to the right, past the child care centre (on the left) and Teesside University Darlington campus will be in front of you.

Pass through the traffic light system into our car parks which are located at the front and back of the building. Car parking is **pay and display**. Please take care to park in the correct car parks. **Additional *PARKING SPACES are available at the back of the building***

From A66 Stockton/Middlesbrough: at roundabout with A1150 junction go straight across and follow sign for A1 (North), second exit. At next roundabout take first exit. Stay on this road, go straight across the first set of traffic lights. At the next set of traffic lights go straight across and then take the next left turn. Darlington College is on your right, continue on this road and Teesside University Darlington is on your right.

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Welcome

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

Tweet about the event by using the #tag

#fuseQRM

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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

Fuse members:

Rosemary Rushmer	Teesside University
Ann Crosland	Sunderland University
Mandy Cheetham	Teesside University
Karen Smith	Sunderland University
Peter Van Der Graaf	Teesside University

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Done
In the UK we used to drive on the Left of the road
Now we drive on what's Left of the road

The Project

Research utilisation and knowledge mobilisation in the commissioning and planning of public health services to reduce alcohol-related harms – what helps and hinders – a study in the co-creation of knowledge

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**

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UK Clinical Research Collaboration igniting our potential

Teesside University

Reflections and today's programme

We were used to say what everyone knew but couldn't say themselves…

What counts as evidence and where is it used?
…but as the morning goes on…

- What is the world like – simple & straightforward or complex & messy?
- What is *public health* – who decides?
- What are the messages for people who use evidence and those who produce it?

i.e. what do we do about this…(practical approaches)?

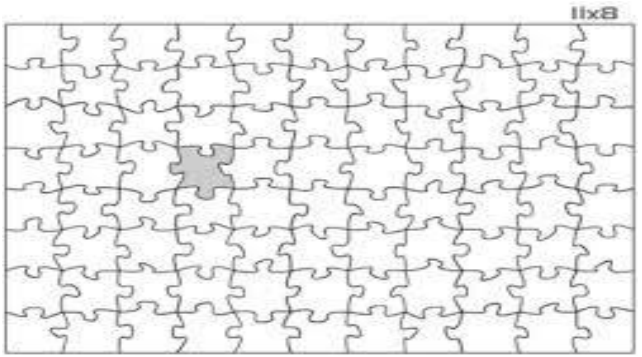
Research doesn't have all the answers…

- Gaps in the evidence-base, not timely, not answering the most pressing problems, created in very different contexts - poor fit

"Decision makers—the patients, the care providers, the managers, and the policy makers—tend to see research as a product they can purchase from the local knowledge store, but too often it is the wrong size, needs some assembly, is on back order, and comes from last year's fashion line." (Lomas 2000:130)

Commissioners' evidence needs

"…commissioners need three types of knowledge: knowledge from research ('evidence'), knowledge from data analysis (e.g. statistics) and knowledge from clinician and patient experiences. " (Muir Gray 2007).



Researchers are criticised for having an unrealistic view of the importance of research *"which is after all just one piece of a rather complicated jigsaw"* (Locock & Boaz 2004)

There are only a few official evidence-entry points (EEPs)

Officially evidence is used:

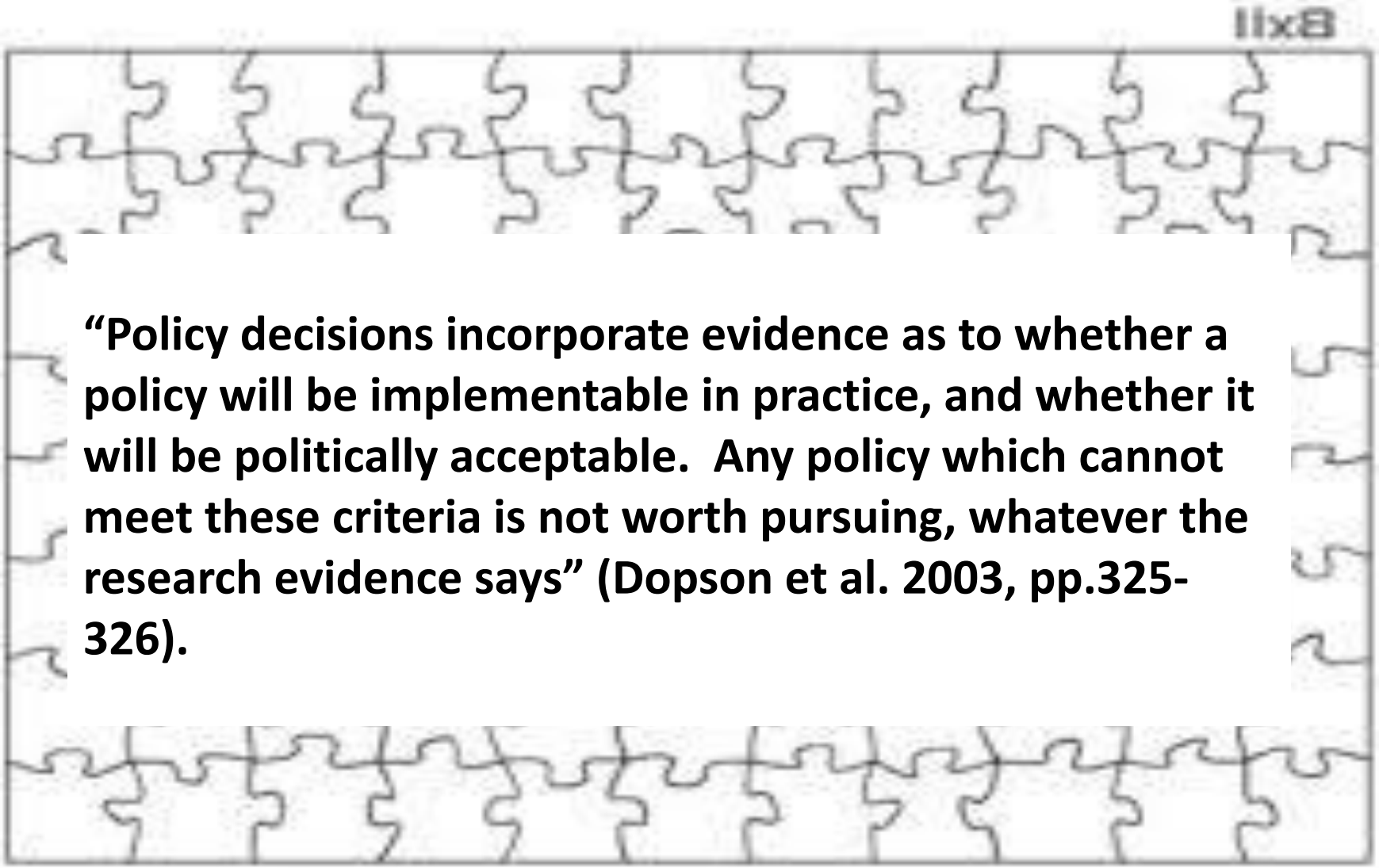
- At set times to renew strategic documents
- Detailing what the problem is, where, changes over time
- To set organisational priorities in a written record

Leading to:

- Understanding, awareness of problem
- BUT not necessarily what to do about it – actionable messages.

After that it largely depends on the individual…(***person-dependent system***), Influenced by their capacity, understanding, time, etc.

…Democratic legitimacy …



“Policy decisions incorporate evidence as to whether a policy will be implementable in practice, and whether it will be politically acceptable. Any policy which cannot meet these criteria is not worth pursuing, whatever the research evidence says” (Dopson et al. 2003, pp.325-326).

Research evidence does not speak for itself…
Selecting, 'packaging' and presenting for impact

Immediacy – here and now – champions – persuasion

- The further away and the longer-ago evidence was created the less impact it has
- Who delivers it, and how, is as influential as the content (trust, credibility, likeability)
- What evidence is, is what others can be persuaded of as proof of something.

> "Key influences on politicians and policy makers are good stories and killer facts (or killer graphs); striking, simple and compelling pieces of evidence that have clear, face validity and emphasize [sic] financial paybacks." (Macintyre 2012, p.218).

Taking action – closing off uncertainty…blending different demands…

"The public health approach is not an exact science but more an art, balancing competing voices in decision-making such as the evidence of efficacy and cost effectiveness of interventions, patient demand, clinician or speciality interests, financial constraints, collaborators' and other stakeholders' agendas, quality standards, targets and so forth" (Lee et al. 2012, p.e387).

Local culture, values, traditions, politics?

FIT? What will be acceptable, feasible, useful?

How?

Mechanisms? - commissioning, unified organisations?

When

Where?

What has worked elsewhere?

By Whom, to whom?

Time?

What does it mean?

Media?

Public money

Legal requirements

Can I tell?

What?

Did it work?

Actionable messages?

Guidelines, Strategy, policy documents PRIORITIES

What have we tried before?

What can I *DO…?*

WHAT WE SHOULD DO…

HOW DO WE DO THAT?

Person dependent systems…

The curious case of wasteland & empty buildings

- ***"there's real value to what [Health] can bring to the table, but it must be mapped against what everybody else brings, because we don't work in, we shouldn't work in isolation" (participant 12)***

- ***"the economic effects as well as jobs [A retailer] come into an area and as a result the actual health if you like, thing, is always competing with you know business, and business demands, … any arguments that health have got seem to be put on the back burner, ahead of votes at elections and ultimately business finance and you know the economy of the local authority area" (participant 3)***

- ***"I can guarantee you now the Licensing Board will never say the entirety of [SCSS] 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, economic development and shopping centres, etc, etc. It isn't going to happen." (participant, 13)***

Questions for discussion

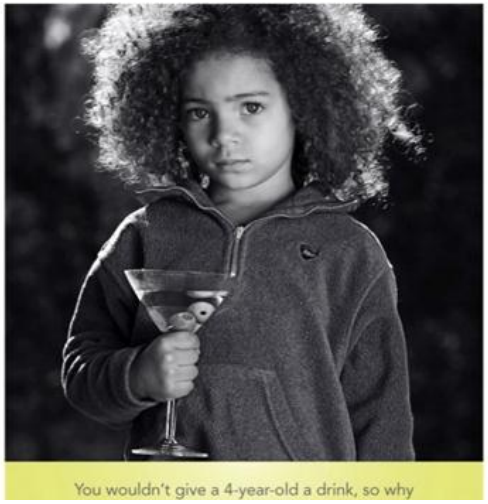
- What are the boundaries of 'public health' (and for whom) ?
- What are we trying to achieve ?
- Public health vs. economic well-being ?

Contradictory evidence & mixed messages

Being pregnant doesn't mean you have to stop drinking.

Metro

20/6/12



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Showcard 12

Dilemmas facing midwives

"It isn't just the science that's influencing decision making".

"It has an effect on the relationship they have with that mum…because it's like lecturing them".

"I feel very strongly we should be saying zero tolerance…".

"It's not an easy discussion you're having anyway, and you certainly want that woman to come back"

"Midwives generally, they're like any other nurse. They don't want to not be liked, so asking difficult questions, they're uncomfortable with."

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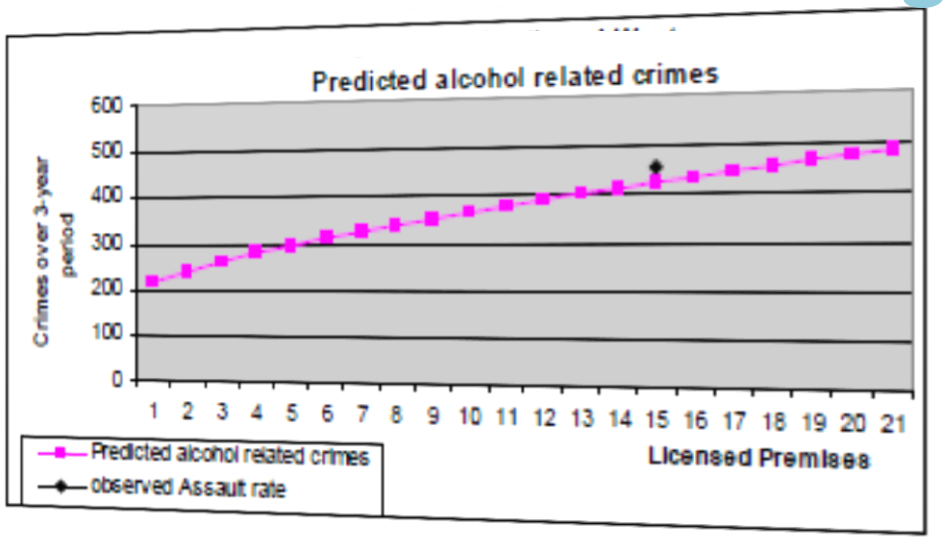
Questions for discussion

- What do we do with contested and contradictory evidence in public health?
- What is the role of professional identity and autonomy?
- Is there a place for personal values in evidence-based practice? Who decides what is best for women?

The curious case of (inter)national evidence being ignored



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Localising and tailoring evidence

"If you're a councillor, you don't have time to read a 20-30 page report. You want the headline".

"Locally relevant and internationally recognised data in a local context is the Holy Grail of public health".

"We bring a real time understanding, a lot of it is very practical".

"Policy makers will continue to make decisions based on anecdotal evidence, if we can't as analysts bring that to life".

"Just make it simple: what works and feed that back into the operational and strategic environments, so resources can be better targeted".

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Questions for discussion

- What is not done with existing evidence?
- Which evidence is preferenced?
- How to make national evidence fit locally?

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Announcing the next QRM

Managing Public Health Spend: can Health Economics add value?

Thursday 3rd April – 9:30-13:00

Research Beehive

Newcastle University

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Acknowledgements

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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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Quarterly Research Meeting – Summary Report

Using public health research evidence – how difficult can it be?

Thursday 23rd January 2014 – 9:30am-1:00pm

Darlington Campus, Teesside University

Introduction

This report summarises the keynote speaker's presentations, individual scenarios presented for discussion by the audience, and the concluding open discussion session at the January Quarterly Research Meeting held on the topic of "Using public health research evidence – how difficult can it be?" The QRM was organised by Fuse, and the work presented related to a NIHR research project (full disclaimer and summary information at the end of this report). This summary report is to be read in conjunction with the slide set kindly provided by our speakers, also on the Fuse website. The slides are cross-referenced in the summary account, below.

Using public health research evidence – how difficult can it be?

Professor Rosemary Rushmer opened the meeting by posing questions about if and how research evidence is currently considered when formulating policy and practice. It is recognised that evidence often is not being reflected in practice and therefore it is reasonable to think about the consequences, namely:

- Why are we spending all this money on research?
- Why accept sub-optimal service delivery?
- Why are the best things not being done?

Her slide statements (Slide 3) 'In the UK we used to drive on the Left of the road' and 'Now we drive on what's left of the road' demonstrated how we appear to talk about the same thing but in different contexts its meaning can very different. Differences in understanding between academe and policymaking may underpin why research evidence is not successfully implemented in practice.

Rosemary continued by explaining the research that she and colleagues had undertaken looking at research utilisation and knowledge mobilisation in the commissioning and planning of public health services to reduce alcohol-related harm. She outlined the research questions (Slide 4) and methodology for the study and the research team's reflections on their findings (Slide 5). From this they identified a number of key points:

- That research doesn't have all the answers (expanded on in Slide 6)
- That commissioners need different types of knowledge of which research evidence is only one type (see illustrative quotations on Slide 7)
- That there are a few official evidence-entry points but after that the process of using research evidence is person-dependant (see Slide 8)
- That research evidence needs to be presented in a way that has impact - timely, clear compelling story-telling, from an influential source (see Slides 9, 10)

- Public health research is not an exact science but an art, balancing competing voices in decision making (see Slide 11, 12)

In the discussion that followed a number of thoughts were put forward:

- Rosemary suggested that the common response that research evidence 'will never work here' is a response to the wrong question. In practice it is not that the approach would fail to produce the stated outcomes but that locally there may not be the know-how to get the approach 'up and running'
- Sometimes it may be difficult to translate a research finding into practice, for example and incentivised randomised control trial compared to a non-incentivised introduction in the real world
- There was some disagreement as to whether the lower-staff turnover in rural areas was more likely to result in greater or lesser resistance to the introduction of new ideas and practices. It is often stated as a reason for resistance to change, but in practice long-established relationships may create an environment of stability and trust providing strong foundations for the introduction of new ways of working
- Commissioning organisations are risk averse and might be less willing to go ahead if there is no clear story, conflicting evidence, limited research, too much scrutiny. It was suggested that there was a need for systematic reviews of implementation studies to show that an approach can work in a range of environments
- To be publishable, research papers have to tell the full story and must set out the shortcomings of the study. Hence their findings are equivocal. Shorter and clear cut policy reports with definitive recommendations are better for policy makers, but do not meet the needs of academic researchers
- Some research evidence may be too controversial or economically unviable in the real world
- Adoption of research evidence is more likely if it is championed by a respected or trusted source.

Following Professor Rushmer's introductory session, three separate scenarios were described to the audience and delegates at the tables invited to discuss the implications and issues raised by each example.

Scenario 1 - The curious case of wasteland and empty buildings – Karen McCabe, Researcher, Sunderland University (Slides 13-15)
Karen described the dilemmas created in taking decisions about regenerating empty buildings and derelict land, when proposals were put forward, for, for example, a high-end restaurant (that would serve alcohol) or a retail outlet (which would also serve alcohol). Which was better, a new development generating wealth creation and improving the environment and quality of the neighbourhood, or, refusing planning permission because the development would promote alcohol consumption? Representative quotes from interviews conducted with decision makers were shown (Slide 14) as a stimulus for debate.

Scenario 2 – Contradictory evidence and mixed messages – Mandy Cheetham, Researcher, Teesside University (Slides 16-18)

Mandy described the range of conflicting messages put forward regarding drinking in pregnancy (illustrated by advertisements in Slide 16) and the issues and dilemmas this created for midwives in terms of what they said to women in their care, shown by the representative quotations in Slide 17. Questions for debate revolved around dealing with contradictory evidence, the role of the professional and any discretion that they might exercise in the interests of maintaining a relationship with women, over and above giving specific messages about reducing or ceasing drinking during pregnancy.

Scenario 3 – The curious case of (inter)national evidence being ignored – Peter Van Der Graaf, Researcher, Teesside University (Slides 19-21)
Peter described the different types of evidence and the levels at which it might be presented (varying in technicality and geographical reference). Some of the quotations shown in Slide 20 indicated how much evidence needed to be packaged or tailored for busy decision makers. This raised questions for debate about the uses of evidence and why certain types of evidence are preferred in different contexts.

Open Discussion
In summary the following points were made from the floor in the concluding open discussion part of the meeting:

- Evidence is "preferenced" based on what case the individual wishes to make, and, in addition charisma is also important. So, in light of these points how do you identify and properly use evidence? A good idea persuasively made becomes the reason, assuming it is evidence based. If someone is an influential advocate should they be 'used' to get a certain point about evidence across?
- Data has precedence in academia
- Two skill sets to consider – studying and changing/influencing/implementing social policy
- Do we need to be more thoughtful about the economics and politics relating to disseminating the evidence?
- There was discussion about the best way to get the messages across. Examples included capturing the essence in 5 bullet points (but without over-simplifying), a headline, of presenting at what was termed the 'middle level'. Research users had no time to read large documents. A suggested was made that the verbal presentation trumps the written brief. Some people have natural gifts for summarising and keeping the topic interesting.
- There was a discussion about values – evidence will be ignored as personal values are stronger. The values brought by NHS staff transferring into Councils were not necessarily the same as those of the host organisation staff were moving to and were subject to challenge across the spectrum. The speaker hoped to influence local authorities in the future to apply those values they had come with.
- An example was given of a "flexible, common sense" approach in the police, which applied to the medium/long term. As a commissioning body, the police were used to working in partnership and agreeing common aims and not therefore pulling in different directions. The process was easier now that public health was part of local government.

- A new phrase in the public service lexicon “re-profiling services” was introduced. It’s therefore of importance to know what doesn’t work, and this kind of information is actually helpful in relation to knowing what to cut.
- Do we need to have the discussion earlier on? This referred to starting to work in partnership earlier and the need to consider evaluation at an earlier stage. There was a secondary discussion about the difficulties and dilemmas around publishing and disseminating ‘bad’ messages about something that actually wasn’t working in practice. If something isn’t based on evidence, but on innovation it will need to be evaluated and challenge those working in local government.
- Leading on from the point immediately above, a suggestion was made that a framework approach was needed for public health interventions incorporating what was described as pitfalls or ‘signs of weakness’. The analogy was made of the near-miss or red flag concept to illustrate failed programmes, based on information sharing protocols which could restrict who viewed the data, if needed. This was an important source of learning. The culture of organisations where it was too dangerous to fail (e.g.; airlines) needed to be imported into the public health.

Take Home Messages

- Recognition that Board level decisions were trade-offs between various factors, the political and economic as well as what the evidence says. It’s a complex situation.
- There need to be creative ways of persuading people, for example, lobbying, using local champions (who also happen to be decision makers), rather than relying on a presentation of the research standing for itself
- It was suggested that trigger points were needed to help people identify when to consider the evidence.

HS&DR Funding Acknowledgement: This project was funded by the National Institute for Health Research Health Services and Delivery Research Programme (project number 09/1002/37).

AR – Draft as at 4th February 2014