

Commentary

Why research findings are not used by commissions—and what can be done about it*

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Introduction

In looking at why research findings are not used by commissions I believe there are four main issues: (1) the research is not there; (2) many managers are not 'knowledgeable'; (3) public health (and others) does not act as a product champion of knowledge; (4) change is more difficult than expected; purchasing is only one lever.

Research is not there

One of the reasons that commissions do not use research is that at the time they need answers to a particular question the research is not available. Let me give you examples of some key questions that a number of commissions are worried about at present:

- (1) The movement of services into primary care: commissioners are asking for evidence about whether it is safe and cost effective to shift particular services; often the answer is not available.
- (2) Accident and emergency services are another major issue. What services do you need, at a minimum, around an accident and emergency department? What should be the geographic configuration of what types of emergency services?
- (3) The new drug beta interferon and its use with multiple sclerosis. What evidence do we have about its effectiveness?

These are burning questions for people in commissions, and if we in the health service are going to make sure that we find answers to those questions then we need to involve commissions in priority-setting exercises that would determine what is needed in R&D. I believe the national R&D strategy has gone quite a long way to try

to involve many different people in setting priorities but it is very important that managers of all sorts, and I include public health within this, make sure that they are involved in these exercises, and are prepared to say what are the urgent problems in managing the service in clinical areas, as well as basic management questions. This is equally true at more local level with the regional R&D programmes. It is very important that commissioners become involved in saying what research they need, but of course then we must make sure that the research that is undertaken at this level is done as well as it needs to be to obtain proper generalizable answers to some of these questions.

The second issue is that the research has to be done in a timely way to answer the questions that managers have. This really is complex. First, when managers assess their needs for research they often need the answers immediately. Of course, research is not done in that way, even if there are good links with researchers who could turn managers' questions into researchable questions. To obtain better answers, I believe the researchers will need to improve their approach. There are some real challenges here in obtaining answers that are good enough for managing compared with the 'gold standard' of the full randomized controlled trial. I am pleased that under Professor Sir Miles Irving the Standing Committee on Health Technology now has a methodology group looking at how we can improve techniques so that we do obtain answers to our questions. Also, if research is going to be used then it is no good if the research findings are not easily available to managers. What managers need is research

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*Based on a lecture given at the spring conference of the Faculty of Public Health Medicine, 1995.

in a synthesized form that is easy to read. They need that information at their fingertips. They need to know that if the information has been synthesized it has been done properly, but do not necessarily need to know the details of the research nor how it has been synthesized. What they need is people in the organization who can access it, in particular, people in public health medicine. Managers do not need to know all the research themselves, nor for that matter do the public health people, but the latter must know how to retrieve it. Again, I am pleased that the Cochrane Centre in Oxford and the Reviews and Dissemination Centre in York are working hard to make sure that information on effectiveness is synthesized and becomes available in forms that are much easier to read. Again, this is an area where we need work on what is the best way to give managers relevant information. Just because an effectiveness bulletin has become available does not mean that it relates to an urgent question that a manager has. How do we make sure that managers can obtain information just when they need it?

Many managers are not knowledgeable

I believe that many (but not all) managers in the health service need a strong background in health services and what is effective in health services. This does not mean detailed knowledge, but managers should have an idea about what evidence of effectiveness means, and more knowledge about health services and their development. If that is to be achieved we will have to alter many of the management training programmes. IHSM has made a start in this with their Medicine for Managers Programme, but there is much more to do; in particular, there is a need to train managers in critical appraisal of literature, and the critical appraisal programme is one way of doing that. If managers become more comfortable with evidence and how to discuss it, then they have more of an incentive to use it.

Often the question arises about the effort needed to change (increase or decrease) the use of a particular procedure, based on evidence. The level of investment that may be needed to bring about such changes may seem large considering the benefits. However, that is because we are in the very earliest stage of using evidence in commissioning. We are choosing some topics which are relatively small but where the evidence is more secure, and where we can practise how to bring about change. I think that if managers are to be convinced about all this effort, we will need to 'crack' a few big topics to show that there really are benefits. I believe, too, that as we understand more about how to bring about change and have the medical profession working with us, this high level of investment will not

be needed, and the process will gradually become part of the culture. I believe that this is already beginning to happen.

Public health as champions of knowledge

There is a central role for public health in commissioning. Public health doctors can provide the evidence, they can work alongside the clinicians in provider units in bringing about change, and they can ensure that in the development of strategies, evidence is used to determine which directions to go in. However, if public health is to do this, it has to be more engaged with the evidence and more prepared to champion the evidence with others. Nobody in public health should hold back from making sure that they are promoting evidence in every possible area of their work. Equally, however, they have to understand that there are managerial imperatives too. Sifting the evidence should not be seen as a separate academic exercise – not actually part of the priorities of a commission or in the main areas of the strategy development. Unless public health is thoroughly integrated with the priorities, then the work of the commission is weak. Public health doctors have to become engaged with the overall agenda of the commission, and should not see themselves as something apart and separate. I also think there should be strong alliances between public health, librarians and information scientists, to act as the information resource for commissions.

Change is more difficult than you expected

When people begin to realize that there is evidence available, and they wish to use it in changing services, they are often naive about making the change. I think it is worth thinking more about what makes people change.

First, there are the characteristics of the change itself; any individual will think about the advantages and whether they outweigh the disadvantages of the change. This is not just in the clinical sense – what might be better for patients will be taken into account; that is the essence of the health service. However, many other factors will come into consideration. Does the change disrupt routines? Does it mean that other policies will have to be changed as well? Does it alter someone's status? All these things will be considered by someone contemplating change.

The easier changes are those that conform to peoples' beliefs. For example, it is not difficult to have a new drug added to what doctors are already prescribing,

because that fits in with the whole ethos of their practice. However, stopping the use of a procedure that people have believed in for a number of years is a much more difficult to bring about. A wide variety of people may have to be involved. There are also other factors such as whether it can be observed elsewhere, and whether it can be tried out first. Perhaps most importantly, can it be adapted to the local environment? For example, if one is working with clinical guidelines, can they be adapted for the local circumstances without losing the central evidence base? If so, they are going to be much more acceptable.

Having then assessed the change itself, we also know a certain amount, but need more good evidence about what we can do to bring about change. People often think when they start that simply providing information will bring about change. It is clear that, in most circumstances, information, although necessary, is not sufficient on its own to bring about change. We know that the underlying educational ethos that people have, particularly in their professional training, is going to influence their view about whether they accept evidence and about their reaction to specific evidence. We know too that local opinion leaders are influential in helping to bring about change. Those opinion leaders are people who are respected and whose practices other people will follow. If you can bring them onto your side and get them to work with others, you have some chance of bringing about change. Other pressures include peer pressure: if everybody else is doing something, people will change. There may be pressure from patients too and, of course, there are political and performance pressures through the managerial system. We know that financial incentives and constraints can influence what can be done, but on the whole this seems to me to be a rather dangerous path to go down. We want people to use evidence as a routine; we do not want them to take on a particular change just because they are paid to do so. That has the possibility of leading us into the worst excesses of the fee for service healthcare systems where procedures are over-used because of payment incentives. There is already much information on what will bring about change, and more work is going on now to try and determine how we go about it. Clearly, if one is trying to make services evidence based, one needs to be aware of this literature, as in any endeavour.

I would like to finish by noting the work that has gone on with Getting Research into Practice and Purchasing (GRIPP), in what was the old Oxford Region. This was a project to find evidence on specific topics, each one being taken up by a particular county. The aims included sharing the learning about bringing about change, but as people worked through the detail, for example, to develop guidelines on a particular topic,

it was hoped that this could be shared across the other counties, not necessarily being adopted outright but with the appropriate modifications for local circumstances. The topics include corticosteroids for use in pre-term labour, grommets, D&Cs in women under 40, stroke treatment and, as an addition thrombolytic therapy.

Some of the lessons from GRIPP can be grouped under eight headings:

- choosing the topic;
- finding the evidence;
- consulting with professionals;
- collecting baseline information;
- developing guidelines or specifications;
- developing patient information;
- implementing – professional, public, contracts;
- evaluating and identifying further areas of work.

It is obviously very important to choose the topic correctly. The original topics were selected because the evidence was thought to be strong. In the future, the topic ought to be chosen in conjunction with professionals who are going to bring about the changes. In any case, there has to be consultation with the professionals concerned, and that does not just mean doctors, but all the professionals. It does not just mean in hospitals either: for D&Cs and grommets it is at least as important to involve people in primary care as those in hospitals. Also, one needs to know what the current situation is – the baseline of current practice – and evidence needs to be turned into guidelines or specifications, by working with the people concerned. Ideally, I believe that patient information should be developed alongside this, so that when the changes are being discussed and implemented on the professional front, patients are being simultaneously informed through leaflets, the local media, or whatever route is available. Having done all this groundwork, the commission of course can use the contract, but I think what has been learnt from GRIPP is that the contract is the end rather than the beginning of trying to bring about change in the clinical area.

Finally, as we go through those processes, we need to evaluate what has been done and to use that to help identify further areas of work. GRIPP took a small number of specific examples, and it may seem that the efforts needed to bring about change are disproportionate to the benefits. I do not think that we should be daunted. We can use these specific examples to understand how we bring about change and to change the culture itself. That is the most important development if we are going to achieve an NHS which is truly knowledge based.