

# Effects of a demand-led evidence briefing service on the uptake and use of research evidence by commissioners of health services: a controlled before-and-after study

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## Scientific summary

### Effects of a demand-led evidence briefing service

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# Scientific summary

## Background

The Health and Social Care Act 2012 (Great Britain. *Health and Social Care Act 2012*. London: The Stationery Office; 2012) has mandated research use as a core consideration in health-service commissioning arrangements. NHS commissioners are expected to use research to inform commissioning and decommissioning of services and there is a substantive evidence base on which they can draw. Building on development work undertaken as part of the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Leeds, York and Bradford and under the auspices of the then Centre for Reviews and Dissemination (CRD) core contract with NIHR, we sought to establish if having access to a responsive (demand-led) evidence briefing service would improve uptake and use of research evidence by NHS commissioners compared with less intensive and less targeted alternatives.

## Objectives

Does access to a demand-led evidence briefing service improve uptake and use of research evidence by NHS commissioners compared with less intensive and less targeted alternatives?

Do evidence briefings tailored to specific local contexts inform decision-making in other Clinical Commissioning Groups (CCGs)?

Does contact between researchers and NHS commissioners increase use of research evidence?

## Design

Controlled before-and-after study.

## Setting

Clinical Commissioning Groups in the north of England.

## Methods

Twelve CCGs were invited to participate in the study; two declined to participate and one was excluded after failing to provide staff contact details for the baseline assessment. The nine participating CCGs received one of three interventions to support the use of research evidence in their decision-making.

1. Contact plus responsive push of tailored evidence – CCGs in this arm received on-demand access to an evidence briefing service provided by the CRD.
2. Contact plus an unsolicited push of non-tailored evidence – CCGs allocated to this arm received on-demand access to advice and support but the CRD did not produce evidence briefings in response to questions and issues raised, but instead distributed evidence briefings generated in intervention A.
3. 'Standard service' unsolicited push of non-tailored evidence – the third intervention constituted a control arm. In this, the CRD used its normal processes to disseminate the evidence briefings generated in intervention A.

The evidence briefing service was provided by team members at the CRD, University of York. In response to CCG requests, the team followed an established methodology to produce summaries of the available evidence together with the implications for practice within an agreed time frame.

The intervention phase ran from the end of April 2014 to the beginning of May 2015. As this study was evaluating uptake of a demand-led service, the extent to which the CCGs engaged with the interventions on offer was determined by the CCGs itself.

Data for the primary outcome measure were collected at baseline and at 12-month follow-up, using a survey instrument devised to assess an organisations' ability to acquire, assess, adapt and apply research evidence to support decision-making. Individuals from each CCG completed the survey and scores of all responses were aggregated to represent each participating CCG.

To guard against maturation effect/bias, and to test the generalisability of findings, we administered the survey instrument to all English CCGs to assess the organisational ability of each to acquire, assess, adapt and apply research evidence to support decision-making. The most senior manager (chief operating officer or chief clinical officer) of each CCG was contacted and asked to complete the instrument on behalf of their organisation.

Baseline and follow-up assessments and the qualitative aspects of the research were undertaken by a separate evaluation team. The CRD evidence briefing team members were blinded from both baseline and follow-up assessments until after data collection was complete. Participating CCGs were also blinded from baseline and follow-up assessments and analysis.

A process evaluation combining interview, observation and documentary analysis was undertaken to explore evidence-informed decision-making processes in participating CCGs and to explore the nature and success of the interactions between those receiving and those delivering the evidence briefing service.

## Findings

Over the course of the study the evidence briefing service addressed 24 topics raised by participating CCGs (see *Chapter 3*). Because we employed a degree of flexibility in delivery (employing a combination of full evidence briefings and shorter more exploratory evidence notes in response to questions raised) we were able to deliver a number of outputs beyond the estimate made in our original protocol. Requests for evidence briefings served different purposes. The majority of requests were focused on options for the delivery and organisation of a range of services and possible interventions to support self-management of long-term conditions. Most of the requests could be categorised as conceptual; they were not directly linked to discrete decisions or actions, but instead provided knowledge and awareness of possible options for future actions. Symbolic use of research (i.e. to justify or support pre-existing intentions or actions) was less frequent and included a pre-existing decision to close a walk-in centre and to lend weight to a major initiative to promote self-care already under way. Instrumental use (i.e. explicit use of research evidence to inform discrete decisions) was limited to work to establish disinvestment policies for interventions of low or no clinical value.

In terms of the primary outcome measure (see *Chapter 4*), baseline and follow-up response rates among participating CCGs were 68% and 44%, respectively. Response rates for the survey used to collect benchmarking data from other national CCGs were much lower at 39% and 15%, respectively. Overall, the evidence briefing service was not associated with increases in CCG capacity to acquire, assess, adapt and apply research evidence to support decision-making. The secondary outcomes were also not associated with positive changes in relation to individual intentions to use research findings or perceptions of CCG relationships with researchers.

Regardless of the intervention received, at baseline participating CCGs indicated that they lacked a consistent approach to their research-seeking behaviours, and capacity to acquire research remained the same at follow-up. At baseline, CCGs were non-committal (neither agreeing nor disagreeing) about whether or not they had the capacity to assess the quality, reliability and applicability of research for use in decision-making. This perception remained unchanged at follow-up. There was also no change between baseline and follow-up on perceptions of CCGs' capacity to adapt and summarise research results for use in decision-making with responding staff neither agreeing nor disagreeing that their CCG had the capacity to do so. Finally, individual's perceptions that their CCG did not have systems and processes in place to apply research routinely remained unchanged.

Exposure to the evidence briefing service did not appear to have any impact on individuals' intentions to use research evidence in decision-making or their perceptions of a shift in collective CCG norms towards the use of research for decision-making. Regardless of intervention received, these measures were positively orientated at baseline and were sustained at follow-up.

Most discussions between contacts in CCGs and the evidence briefing team were informal and rarely involved minuted meetings or formal gatherings of CCG staff. Analysis of records supporting the more formal executive and governing body meetings provided little information about sources used or the decision-making process itself. The 'unseen and informal spaces' of decision-making processes, the small numbers of staff involved and the reality that no audit trail existed for sources used meant that there was little or no 'traceability' of use of evidence briefings at an organisational level.

## Limitations

The respective baseline and follow-up response rates of 68% and 44% are not unreasonable given the number of competing requests for information with which CCGs are routinely faced. However, we acknowledge that we experienced considerable attrition between baseline and follow-up. Survey length may have contributed to the lack of completeness in the data collected. Taken together, these limitations mean that we have been suitably cautious in our interpretation of the findings.

## Conclusions

This study has provided further insight into how and where services packaging evidence derived from systematic reviews may be most efficiently deployed to inform decision-making processes in a commissioning context. Overall, access to a demand-led evidence briefing service as constituted in this study did not improve the uptake and use of research evidence by NHS commissioners compared with less intensive and less targeted alternatives.

Given the large resource requirement and the particularity of process and unpredictable timing of decision-making in individual commissioning organisations, resource intensive approaches to providing evidence may best be employed to support instrumental decision-making at the meso (regional) level. Otherwise, it may be better to invest far more in identifying commissioning priorities and uncertainties from key informants with local credibility. In the cases examined in this study, this would include members of local public health teams. Identified priorities could then be more efficiently serviced by less intensive approaches that optimally package research messages and target not only commissioners but intermediaries with local credibility and influence.

## Recommendations for research

This study suggests that commissioners are well intentioned but that they work in a setting lacking in the necessary skills and infrastructure to make use of research evidence routinely. Further research is required on the effects of interventions and strategies to build individual and organisational capacity to use research.

Resource-intensive approaches to providing evidence may best be employed to support instrumental decision-making. Otherwise, less intensive but targeted strategies to deliver optimally packaged research messages should be pursued. The comparative evaluation of such strategies is warranted.

Disinvestment decisions relating to interventions of no or low clinical value remain high on the commissioning agenda. No established process appears to be in place for assessing research evidence to inform the generation of local policies. Rather than have local settings developing their own distinct approaches, it would seem sensible if a country-wide approach was taken to identify and then summarise the evidence for interventions of no or low clinical value. Methodological research is therefore required to establish an optimal, transparent and standardised approach that identifies and contextualises research evidence that can then be used to inform local decision-making processes.

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