The Health Foundation & The Nuffield Trust

Increasing the Impact of Health Services Research on Health Service Improvement

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EXECUTIVE SUMMARY

Introduction

This report is the result of research into ways of increasing the usefulness and impact of health services research (HSR) in England by improving the alignment of commissioners, researchers and users of HSR. It identifies existing problems and makes recommendations both for the Department of Health and for the Health Foundation and the Nuffield Trust, who are the funders of this project.

This project set out to examine:

- What HSR, relevant to the NHS, is being conducted in England

- Whether or not HSR is perceived, by various actors, to have a beneficial impact on improving health care services

- How other countries approach HSR

- How other sectors approach service improvement

- Ways in which HSR could be developed in order to improve health care services

- What roles The Health Foundation and The Nuffield Trust could have in bringing about change

Methodology

The project was conducted over a three-month period and involved desktop research, literature review, case studies and interviews with a range of contributors to, and users of, HSR.

Findings

HSR encompasses a broad set of studies – ranging from research into what health care interventions bring about the greatest impact on health to evaluative studies examining how best to deliver health care services. It is currently undertaken within a wide range of organisations – academic departments located within Universities; think tanks; charities; professional bodies; and health care provider organisations, sometimes in collaboration.

Depending on the definition adopted, HSR currently consumes somewhere between £50m and at least £200m per annum. Its funding comes from a variety of sources – the Department of Health/NHS Research & Development budget, the Medical Research Council, Higher Education Funding councils and independent bodies such as foundations and charities. Individual organisations

often have mechanisms in place to identify priorities for the funding of research but there is little coordination between these organisations.

Several factors are currently perceived to be barriers to HSR supporting the improvement of health care services. These can be summarised in the following areas:

- **Different groups have different perspectives as to what HSR is**

  Different groups have different views whether HSR includes management and policy research (also referred to as organisational or operational research); clinical effectiveness research; and public health research or only a sub-section of these.

  Further, the way in which research is conducted elicits different opinions on the relative quality and validity of the research. Some see only pure academic research as of use while others believe a broader range of studies (including audit, benchmarking, review, evaluation) is a valid contribution to building a knowledge base.

  These differences lead to conflicts within funders when making funding decisions; lead to certain types of work being criticised as invalid, so undermining the credibility of proposals based on it; confuse the people who need to use it (clinicians, managers, policy makers) and, some argue, ultimately serve to discredit the field as a whole.

- **There is a lack of research into areas of prime importance for policy makers, clinicians and managers of clinical services**.

  Some felt that most HSR has focused on clinical effectiveness studies, reviews of different treatments for specific diseases or on health care funding and structures. Some argue that this misses many of the key areas of importance to policy makers, clinicians and managers, for example how to recruit and retain a high quality motivated workforce; how to deploy IT to maximal effect; how to measure performance; how to substantially increase throughput; how to develop a customer services ethos within health care organisations.

- **Research is often inaccessible to policy makers, clinicians and health care managers.**

  Researchers and potential users of research operate in different worlds – this can result in a "culture clash" and in difficulties communicating between the two groups. For example policy makers, managers and clinicians may want to see results from research within a few months; the academic community is often working to 2-3 year time scales. Policy makers, clinicians and managers are looking for research which can be translated into actions; academics can be more focused on developing theories or concepts.

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Added to this are different media for communication - the academic community publishes its work in peer reviewed journals; front line managers, clinicians and policy makers are "touched" by conferences, seminars, and a few specific journals, for example Nursing Times, the Health Service Journal and the British Medical Journal.

- **Funding is not focused on improving health care services**.

  Often funding of HSR is driven by academic interests rather than by a need to support evidence-based improvements in health care services. In particular the reward structure of the Research Assessment Exercise (RAE) is seen to be a significant barrier to the development of research which is more relevant to improving health care services.

- **There is little demand for, or use of, HSR by policy makers, clinicians and managers.**

  There are inadequate incentives for policy makers, clinicians and managers to utilise research when seeking to change and improve services. They often lack the skills to effectively source, analyse and apply research.

Other countries approach HSR in different ways – for example supporting and encouraging closer working between managers, policy makers and academics to ensure research is targeted at improving services.

Other organisations, outside of health care, approach improvement in equally different ways – often using "intermediaries" or "external advisors" as repositories of research and analysis about how to improve services. These "intermediaries" work with policy makers and managers to tailor research to the local situation and develop and implement local solutions based on that research.

Recommendations:

Recommendations to the Department of Health

1 Specifically, the Department of Health should undertake a comprehensive review of its commissioning of HSR in the light of:

   - issues concerning value for money
   - issues concerning the negative impact of the RAE on existing HSR capacity and capability in English universities
   - issues concerning the governance and administration of HSR funding

2 The Department of Health should consider the creation of a knowledge centre in the light of its future plans for review of the Modernisation Agency and the creation of CHAI.
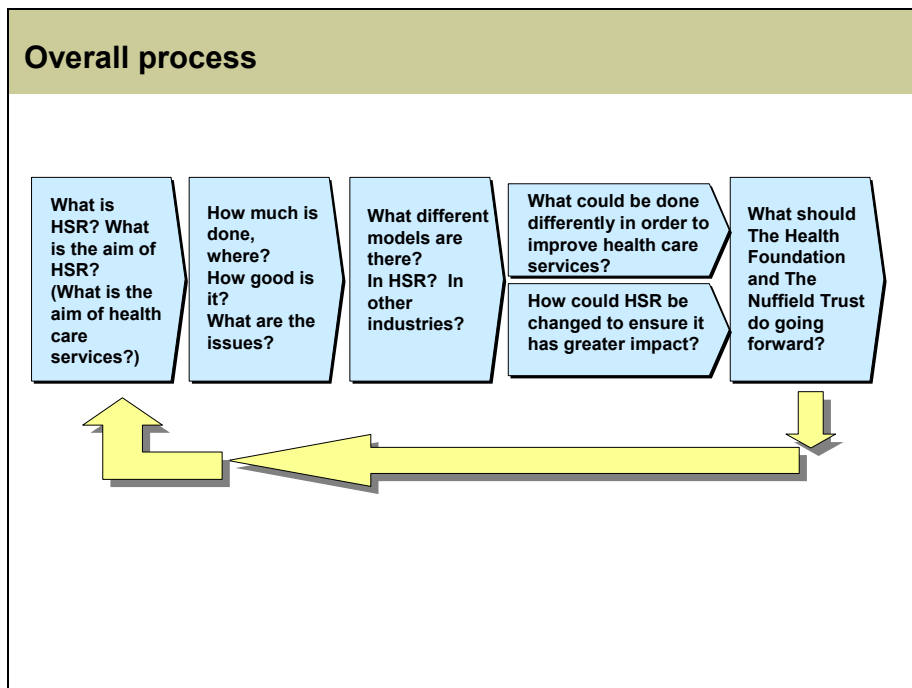
Recommendations to the Health Foundation and the Nuffield Trust

3   The Nuffield Trust and The Health Foundation should take steps to stimulate the development of a UK Academy for HSR (this could be done in conjunction with the NHS Confederation who are actively considering the creation of an HSR scientific meeting as part of their annual conference).

4   The Nuffield Trust and The Health Foundation should support the development of "translator roles", exploring ways of stimulating such roles both within NHS organisations and networks of NHS organisations, as well as in commercial environments.

5   The Health Foundation should consider the creation of senior HSR fellowships and/or strategic partnerships between NHS organisations and academic institutions to kick start the growth in applied HSR capacity.

6   The Nuffield Trust should support further policy development work looking at the interface between epidemiological research public health and HSR.

INTRODUCTION

1.1.   The Health Foundation and The Nuffield Trust are two charitable organisations operating in health care research and policy influencing.

1.2.   The Nuffield Trust has a long-standing interest in the relationship between research and, policy and practice health care services and has undertaken many initiatives in this area.

1.3.   The Health Foundation has recently appointed a new Chief Executive who has been conducting a review of the organisation's work. This has led to an increasing awareness of the potential to more closely align the work of academia, policy making and front line organisational change in the health care world to the benefit of health services.

1.4.   This project set out to explore the state of HSR in England and its connections to practice and policy, and ways of enhancing its contribution. The intention was to develop clear proposals for the future.

A summary of the areas examined as part of the project is shown below:

Overall process

| What is HSR? What is the aim of HSR? (What is the aim of health care services?) | How much is done, where? How good is it? What are the issues? | What different models are there? In HSR? In other industries? | What could be done differently in order to improve health care services? How could HSR be changed to ensure it has greater impact? | What should The Health Foundation and The Nuffield Trust do going forward? |

2. BACKGROUND

2.1.   While scientific and medical research has been carried out for hundreds of years, the first research conducted across the health care system came with the advent of the NHS when the Minister of Health was given the powers to "conduct research or assist by grants, research into matters relating to the causation, prevention, diagnosis of illness or mental defectiveness"[1]

2.2.   By the early 1970s questions were raised about the effectiveness of medical research and in his report Lord Rothschild recommended the introduction of a customer/provider relationship to align the work of government research establishments and the needs of government departments[2]. While this resulted in a quarter of the MRC's budget being transferred from "science" research to "health" research, the concept of the "informed purchaser" and a substantial shift in research to more clinical relevant areas did not emerge.

2.3.   At the same time, users, providers and policy makers started to question the ways in which health care services were delivered, and have sought to move health related research away from pure science research "what causes this disease, how can we treat it" to more applied research "how effective is this treatment" and, more recently, to looking at delivery mechanisms "how can services be structured to best deliver this treatment".

2.4.   Some of the earliest health services researchers focused their attentions on examining variations in health care – looking at differences in length of stay or different interventions used between different health care providers and sought to compare the effectiveness of different approaches[3]. The main focus was on clinical aspects of care – rates of surgery for different procedures, time taken to discharge patients, levels of prescribing of different drugs. Very little research was done looking at the ways in which health care structures and services were managed.

2.5.   The advent of general management in health care in the 1980s brought managerial concepts into health care. The role of general managers was to organise and manage services in order to achieve maximum benefit for the users of those services. The introduction of the internal market in 1991, created new incentives for this.

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[1] National Health Service Act, 1946

[2] Lord Rothschild, The organisation and management of government research and development. Cmnd 4814. London HMSO 1971

[3] Effectiveness and Efficiency. Random Reflections on Health Services. A.L. Cochrane. The Royal Society of Medicine Press. 1971.

2.6.   Health services researchers responded to these changes and during the 1980s and 1990s started to expand their area of research into the organisation and management of care. In recent years this work has increasingly attracted both managerial and political interest as different groups have shown that organising services in different ways can have substantial impact on the quality of care.

2.7.   Black argues that there have been three main driving groups behind the increased role of health service research: payers [in order to decrease costs], clinicians and the public.[4]

2.8.   Over the last twenty years there have continued to be extensive reviews of medical research more generally. In 1988 the Science and Technology Committee of the House of Lords[5] identified a number of failings in the organisation and management of medical research "remarkably there appears to be no coherent means of setting priorities beyond that which is provided by the MRC in conjunction with the DHSS". They recommended the setting up of an independent body but the government of the day did not accept this.

2.9.   Instead, in 1991, the NHS's first R&D strategy was established within the Department of Health. The strategy set the DH funded R&D programme in the context of government policy and priorities.

2.10.   In spite of its major impact, there have continued to be claims that the R&D budget is opaque. The Culyer Report in 1994[6] and a subsequent report in 1998[7] noted that there was "no system for prioritising research areas and no guarantees as to the quality of work done – most work was not monitored at all". This led to the introduction of a financial levy for R&D on the NHS.

2.11.   In 1999 Professor Clarke reviewed the levy and suggested that there needed to be a "clearer focus on NHS needs and priorities and systematic involvement of wider health communities and consumers in NHS R&D". It was also noted that there was a "shortage of experienced health services researchers".

2.12.   In 1999 the Department of Health set up a new body, the National Coordinating Centre for Service Delivery and Organisation. This body was charged with commissioning research on behalf of the Department of Health aimed at examining the evidence base for different methods of structuring and delivering health care services.

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[4] Black NA. Health services research: saviour or chimera. Lancet 1997; 349:1834-1836

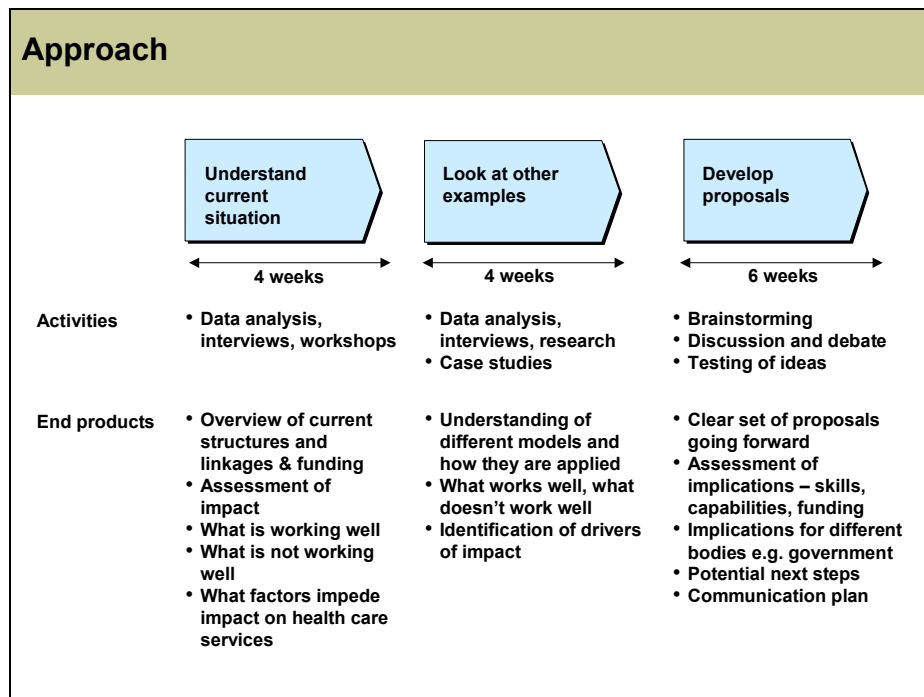[5] House of Lords Select Committee on Science and Technology (1988) Priorities in medical research. HMSO. London.

[6] Culyer A. Funding research in the NHS. York. 1994.

[7] Culyer A. NHS R&D as a public good. Discussion paper163. University of York, 1988.

2.13.   This report examines the current state of play of health services research, what is done where, what the issues are perceived to be. It makes comparisons with other sectors, and suggests some ways in which health services research could be changed in order to bring about greater improvements in health care services.

3. METHODOLOGY

3.1.   This project was carried out over a 3-4 month period. The approach taken is shown in the diagram below:

Approach

	Understand current situation	Look at other examples	Develop proposals
	4 weeks	4 weeks	6 weeks
Activities	• Data analysis, interviews, workshops	• Data analysis, interviews, research • Case studies	• Brainstorming • Discussion and debate • Testing of ideas
End products	• Overview of current structures and linkages & funding • Assessment of impact • What is working well • What is not working well • What factors impede impact on health care services	• Understanding of different models and how they are applied • What works well, what doesn't work well • Identification of drivers of impact	• Clear set of proposals going forward • Assessment of implications – skills, capabilities, funding • Implications for different bodies e.g. government • Potential next steps • Communication plan

3.2.   A combination of literature review, desktop analysis and extensive interviews was undertaken to draw out the conclusions laid out in this report. Organisations involved in health services research in other countries were examined. A number of case studies were prepared, comparing the approaches to service improvement in commercial organisations and NHS related organisations.

3.3.   A total of 35 interviews were conducted. This included:

- 9 with academics currently working in the field of health services research
- 3 with think tanks which both conduct and fund health services research
- 8 with other organisations which undertake and fund health services research
- 8 with policy makers and front line managers who use health services research
- 7 with other individuals/organisations involved in health services research
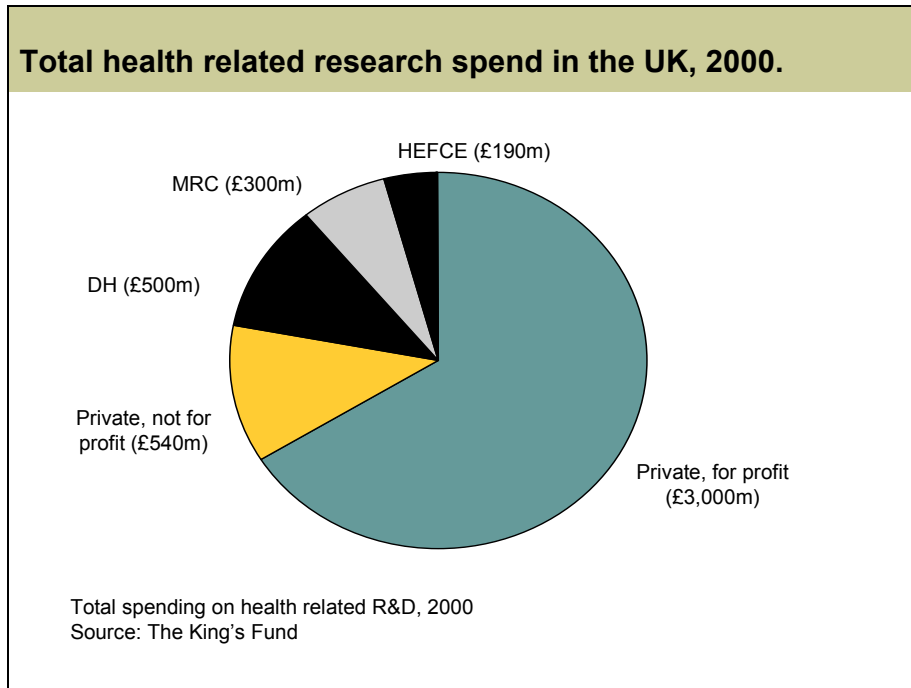
4. CURRENT WORLD OF HEALTH SERVICES RESEARCH

4.1.   Health services research is carried out in a spectrum of organisations across the UK. These can be broken down into academic organisations, think tanks, professional bodies, charities and front line organisations.

4.2.   Different types of organisation tend to carry out different types of research, though it should be noted that there is often collaboration between different sectors in conducting health services research.

4.3.   All these organisations receive funding for research from a variety of sources. The main sources are the Department of Health R&D funding budget and the MRC.

It is difficult to estimate exactly how much funding goes into health services research because records are often incomplete. Difficulty quantifying the amount spent is compounded by different definitions of health services research.

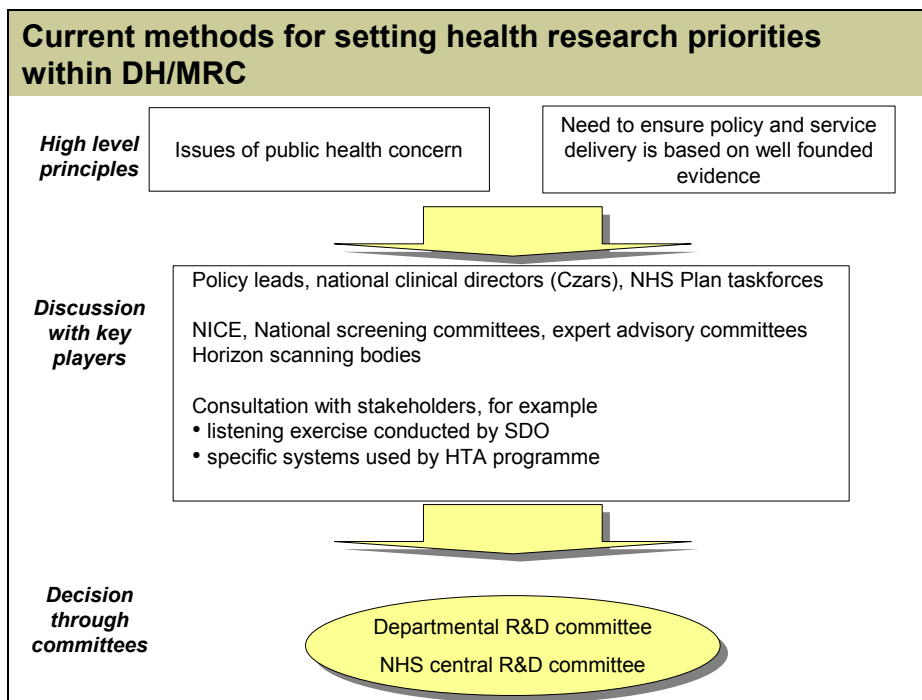4.4.   The following table shows the approximate amounts of funding available for HSR.

Source	Approx funding (per annum)	Comment
DH	£50m	Includes funding for • SDO (~£5m) • HTA (~£15m) • Policy research programme (~£30m) • Other including NEAT
NHS R&D	Unclear	Approx £300m allocate to NHS organisations to support R&D. Unclear what projects specifically are supported
Higher Education	Unclear	Funding for academic institutions based on historical factors, and the research assessment exercise (RAE). Difficult to untangle amount spent on HSR versus other areas of research
MRC	~£5m	Around £60m goes into "people and population studies" of which some will be for HSR type projects
Foundations, Charities, Think tanks	~£10m	

4.5.   This level of funding is small compared to the levels of funding available for mainstream medical research. In their recent publication, Harrison and New[8] estimate the total amount of money available for medical research in the UK. This is shown in the diagram below:

Total health related research spend in the UK, 2000.

HEFCE (£190m)

MRC (£300m)

DH (£500m)

Private, not for profit (£540m)

Private, for profit (£3,000m)

Total spending on health related R&D, 2000
Source: The King's Fund

4.6.   At most, HSR represents about 2-3% of this total. Even within this small amount many funders are more focused on clinical effectiveness work rather than management and policy level research. For example health technology assessment (HTA) is included within health services research funding by the Department of Health.

4.7.   Funding decisions are based on different criteria within different organisations. In the Department of Health (the largest funder of HSR) funding decisions are based on "issues of public health concern" and the need to "ensure policy and service delivery is based on well founded evidence". The current method for funding decisions with the Department of Health is shown below:

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[8] Harrison and New

Current methods for setting health research priorities within DH/MRC

High level principles

Issues of public health concern

Need to ensure policy and service delivery is based on well founded evidence

Discussion with key players

Policy leads, national clinical directors (Czars), NHS Plan taskforces

NICE, National screening committees, expert advisory committees
Horizon scanning bodies

Consultation with stakeholders, for example
• listening exercise conducted by SDO
• specific systems used by HTA programme

Decision through committees

Departmental R&D committee

NHS central R&D committee

5. ISSUES IDENTIFIED WITH HEALTH SERVICES RESEARCH

Throughout the interviews and desktop research a consistent set of issues emerged. These are summarised below:

- Different perspectives as to what health services research is, and what it is trying to achieve

- Research not conducted into areas of prime importance for policy makers and front line managers

- Research is often not accessible to policy makers and front line managers

- Lack of "intelligent commissioning", funding decisions not aligned to improving health care services

- Lack of "pull" from front line managers, clinicians and policy makers

- Little/no dialogue between the managers, clinicians, policy makers and academics

5.1. *Different perspectives as to what health services research is and what it is trying to achieve*

An understanding emerged that HSR can be seen as comprising three broad areas:
- Management research or organisational research
- Clinical effectiveness research
- Public health research.

There are considerable areas of overlap as the diagram below illustrates:

Different perspectives as to what HSR is

Management & Policy Research
Analysis of what structures, processes and organisation of health care services result in improvements in the output or quality of care

Clinical Effectiveness Research
Examination of different types of health care interventions, technologies or treatments to determine their impact on health outcomes

Public Health Research
Examination of the determinants of ill-health and what can be done to prevent illness

The table below summarises different types of research within each area:

Management and policy research	Clinical effectiveness research	Public health research
• Operational research • Theory of change • Economics – macro and micro • Benchmarking studies • Strategy development • Process evaluation • Service evaluation • Activity base analysis • Performance measurement & improvement	• Health technology assessments • NICE reviews • Cost benefit analyses • Meta-analysis • Systematic reviews	• Population studies • Assessments of health status • Epidemiology • Aetiology of disease • Health promotion • Health prevention

Different informants tended to emphasise different perspectives. For example, some see health services research as research into the structure, organisation and management of health care services:

> *'Any kind of research that helps to develop health care processes and /or leads to a more cost effective NHS' (NHS /DH)*

Some referred to a pubic health research model of health services research:

> *' Investigation of the health needs of the community and the efficiency / effectiveness of the provision of service to meet those needs' (other)*

However, some preferred broader, all encompassing definitions:

> *'HSR operates at two levels: <u>micro level</u> – work directly relevant to individual patients, where there is clear overlap with clinical research: and the <u>macro level</u> – work on policy / big system issues such as how to re-invent the NHS so that it works. The macro level includes policy work and connections between micro and macro work are crucial in order to translate HSRC research into something that affects policy.' (other)*

Definitions of health services research in the literature are equally broad and vary between North America and Europe and between institutions in the UK. In the UK health services research has most commonly been associated with a public health model of research looking at the impact of health care services on populations. This is often endorsed by the positioning of health services research departments alongside public health or population sciences departments. Indeed, the MRC assigns health services research to its "People and population studies" directorate.

Many see health services research as an all encompassing term for multidisciplinary research – for example the BMA reports: '*Health services research is concerned with the problems of assessing needs and delivering medical care. It studies the social, psychological, cultural, economic, informational, administrative and organisational factors which affect the delivery of health care to individuals and communities'*[9]

Black similarly takes a broad view and defines the aim of health service research as to: '*provide unbiased, scientific evidence to influence health service policy at all levels so as to improve the health of the public…it is not a scientific discipline but uses a range of methods from several disciplines including sociology, statistics, economics, epidemiology, psychology and history…it also requires input from biology, medicine, nursing and other clinical areas…it usually adopts a population perspective, by contrast to the clinical view focusing on individual patients'* [10]

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[9] www.bma.organisation.uk

[10] Black NA. Health services research: saviour or chimera. Lancet 1997; 349:1834-1836.

Perhaps the broadest definition is contained in the 1988 report from the House of Lords Select Committee[11] which defines health services research as '*all strategic and applied research concerned with the health needs of the community as a whole, including the provision of services to meet those needs*'.

The US tends to have taken a more organisational perspective rather than a medical approach. In 1979 the Institute of Medicine defined health services research as "enquiry to produce knowledge about the structure, processes or effects of personal health services'.

Later, in 1995, the Institute broadened its definition to: 'a multidisciplinary field of inquiry, both basic and applied, that examines the use, costs, quality, accessibility, and delivery, organisation, financing, and outcomes of health care services to increase knowledge and understanding of the structure, processes and effects of health services for individuals and populations[12].

Lomas draws out the differences that exist between European and North American definitions of health services research[13]. He argues that HSR serves the scientific needs of those who finance, organise, manage and deliver health services. It is therefore concerned with the three E's of healthcare: Effectiveness, Efficiency, Equity.

He proposes that

- HSR is a field of enquiry and not a discipline
- HSR is interdisciplinary between health and social scientists
- HSR is driven by the management and policy questions of those running the health service
- HSR is about both producing new knowledge and encouraging its use by decision makers
- applied health services research involves decision makers in the research process and researchers in the decision process
- future trends in HSR will move it into increased consideration of values and equity, broader use of methods and integration into trans-disciplinary teams.

Our respondents debated what work is considered "research". Particularly within the area of operational research there are strong opinions as to what is and what is not considered credible "research".

Some argued that the term "research" can only be applied to "methodologically pure" work. For example work conducted in academic departments, reviewed by academic peers, published in academic peer reviewed journals.

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[11] House of Lords Select Committee on Science and Technology (1988) Priorities in medical research. HMSO. London.

[12] 'Health service research: workforce and educational issues. Washington DC: National Academy of Sciences, 1995.

[13] Lomas. J. Health Services Research: A domain where disciplines and decision makers meet in Sibbald. W.J. Bion. J.F. Eds. Evaluating critical care. Using Health Service Research to improve quality. 2001.

'Think Tanks are at the soft policy end -generally very poor, not subject to peer review (design or dissemination). Highly superficial but can be highly influential – causing waste / distress for the NHS. Consultancy firms are equally bad! Amateurs should not dabble!' (academic)

'I see the type of research I was exposed to as a Medical Director (for example on A&E services) as audit or clinical research and not HSR. It was done by clinicians – HSR is done by academics in a rarefied environment' (other)

Others argue that more pragmatic "research" is equally valid and equally (if not more) useful for policy makers and managers.

'Academics are not the right type of people to do this type of research-they are too concerned about basic /new knowledge generation. But there is a role for academics to help others who want to get involved with research, helping them to refine the questions / methodology' (other)

Warbuton and Black[14] point to the NHS Service Delivery and Organisation (SDO) programme as an example of the changes in thinking that have taken place within the Department of Health and among researchers and clinicians concerned with service delivery and organisation. The SDO programme, they argue, is calling for greater recognition that the type of evidence useful to change management may differ significantly from the scientific evidence that underpins pharmaceutical and technological advances in medicine and that therefore a broader range of research methodologies is needed.

Savage notes that funding bodies are often not as receptive to "process evaluation" and its methods, on the basis that it often uses case studies and qualitative methods, so does not lend itself so easily to traditional generalisability[15].

One of the barriers to the increased use of "process evaluation" is that the findings are often published as reports and not in peer reviewed journals. This may be due to the distinction that St Leger and Walsworth-Bell[16] make between 'theory-enhancing' research, which is the focus of most academic work and 'change-promoting' research, which is more closely aligned to the real world issues faced by policy makers and clinicians.

Lomas believes that the eventual incorporation of qualitative methods will draw in social scientists and business schools, law schools, and public administration. Health services research's roots in the analysis of medical care will be

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[14] Warbuton, B. Black, M. Evaluating processes for evidence-based health care in the National Health Service. British Journal of Clinical Governance 2002; 7 (3) 158-164.

[15] Savage. J. 2000. Ethnography and health care. British Medical Journal, 321, 1400-2.

[16] St Leger, A.S. Walsworth-Bell, J.P. 1999, Change-promoting research for health services, Open University Press, Buckingham

increasingly left behind and supplanted by a broader remit around overall health-related services, including, for example, social services. Issues of access and equity will come to the fore with the unmet needs of specific populations beginning to receive more attention.

Underlying these different perspectives on health services research are different understandings about the aims of HSR. The academic, scientific and medical roots of research tend to see impact at a health outcomes and population level – for example looking at how different health care structures or approaches will impact on the health of the population.

Often this is at odds with other objectives of health care services – for example a service which is more "customer responsive" achieving higher levels of customer or user satisfaction, or a more efficiently run service. So, the NHS Plan[17], aimed at ensuring a National Health Service delivering "patient centred care", may have struggled to draw on health services research to identify how to develop a "patient centred" service, as this had not previously been a stated objective of health services research.

Buxton[18] lays out five main categories of potential impact from HSR:
- knowledge;
- research benefits;
- political and administrative benefits;
- health sector benefits;
- and broader economic benefits

Black concludes that:
- health services research improves understanding of new technology
- health services research has helped shift the balance from practitioners to patients concerns
- health services research had helped identify ways of improving the organisation and management of services [19]

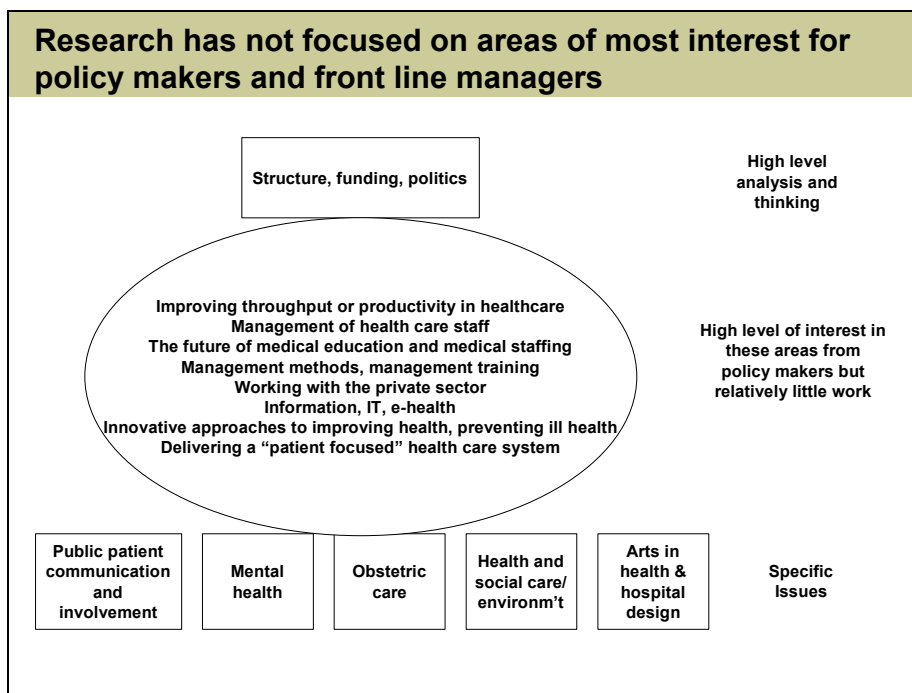[17] The NHS Plan. A Plan for investment. A plan for reform. Department of Health. July 2000.

[18] Buxton M, Hanney S. How can payback from health service research be assessed? J Health Serv Res Policy 1996 Jan;1 (1): 35-43.

[19] Black NA, Langham S, Petticrew M, Coronary revascularization: why do rates vary geographically in the UK. J Epidemiol Comm Health 1995; 49: 408-412.

5.2. Research not conducted into areas of prime importance for health service policy makers and managers

Much health services research tends to be focused on issues considered to be important by academics and funders. This has led to a gap in the areas being examined. For example there has been more work done on effectiveness of health care and on public health related studies than on management and policy research. That said, a considerable amount of research into areas cited as being of prime importance to policy makers and managers does exist with the management community, often in business schools and within management consultancy. But there appears to be a reluctance to use this work in studies looking at health care services. For example the management community has a wealth of research into the impact of mergers and acquisitions but little of this was referred to in a study of mergers conducted by the SDO programme.[20]

Even within management and policy research, work has tended to focus on either big picture questions as to how health care services should be structured, or on specific services. There has been relatively little research conducted into areas of prime importance to policy makers or health services managers. These are shown in the diagram below:

Research has not focused on areas of most interest for policy makers and front line managers

Structure, funding, politics

High level analysis and thinking

Improving throughput or productivity in healthcare
Management of health care staff
The future of medical education and medical staffing
Management methods, management training
Working with the private sector
Information, IT, e-health
Innovative approaches to improving health, preventing ill health
Delivering a "patient focused" health care system

High level of interest in these areas from policy makers but relatively little work

| Public patient communication and involvement | Mental health | Obstetric care | Health and social care/ environm't | Arts in health & hospital design | Specific Issues |

Some point to the difficulty of getting research aligned to the needs of the service:

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[20] NCCSDO: Size does matter. Do mergers improve performance? Second SDO conference March 2003.

'It has been very hard to get any dialogue going between what NHS mangers need and what the researchers can deliver. At times we have fallen into the trap of defaulting to the questions that researchers want to answer!' (NHS /DH)

Increasingly people are proposing that work be commissioned by front line managers, policy makers and potentially users of services.

'Service providers /patients should play a role in setting the agenda - how you involve users is a key issue. The intellectual agenda has to be sorted upfront to create the necessary environment for good research. Once a list of good research has been created it can be filtered for user applicability.' (academic)

Others believe the system falls down due to a lack of co-ordination

'No –one sets the agenda in a coherent /planned way and it is a mess within the DH . We have been approached by 4-5 separate departments within the DH, who have clearly not talked to each other, to do a piece of work on waiting lists' (Think Tank)

Though not all agree!

'There is rightly no process for setting the agenda –diversity of agenda setting is crucial – no one group can get it right. It's works well because individual academics get interested in something, look at it, publish something which, if it is interesting, ignites a chain of events and more work gets done' (academic)
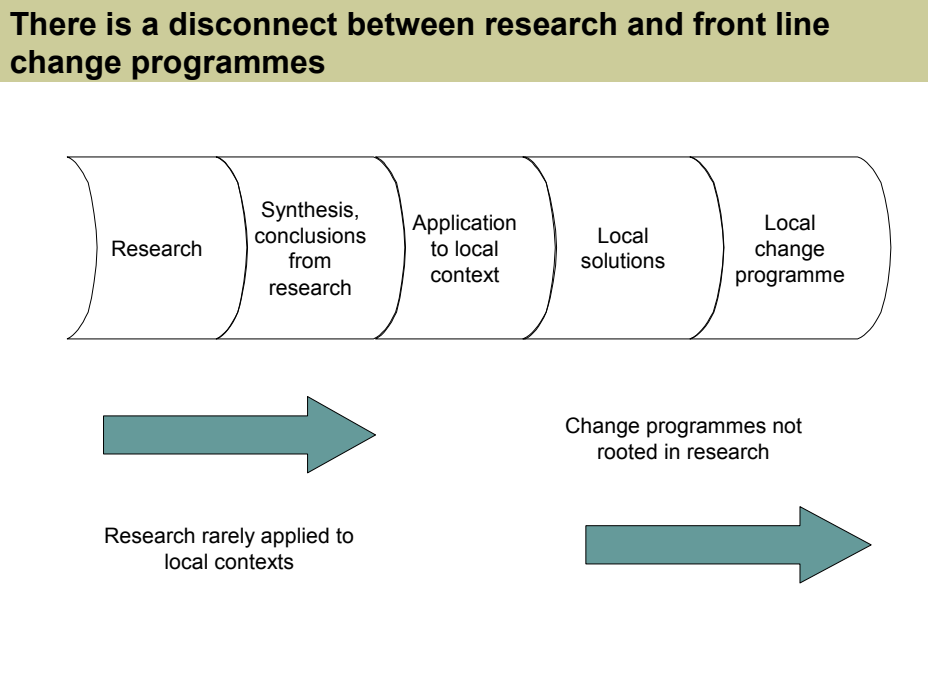
5.3. *Research* not accessible to policy makers and front line managers

Much health services research is published in academic journals rather than in journals targeted at the management/policy making community.

Further, research tends to be presented in ways which make it difficult to implement findings.   This can be partly because researchers may not discuss local application.

Research can often take 2-3 years or more to complete by which time the agenda has often moved on and managers and policy makers are focusing on a new set of issues or problems.

Many of these issues are outlined in the diagram below:

There is a disconnect between research and front line change programmes

Many of the interviewees pointed to the substantial divide between research and implementation

> *'Most examples of effective implementation are serendipity' (academic)*

Others point to the lack of involvement throughout of front line staff

> *'It is vital to engage medics / service deliverers - if people (i.e. medics /service deliverers in this case) own the research they are more likely to change than if it is coming from a manager. The involvement of medics in HSR is crucial - the NHS management structure is not sufficiently empowered to drive HSR implementation' (academic)*

In particular, a lack of "synthesis" of results to make them more useable for policy makers and front line staff seems to be a problem:

> *'Research needs to be made understandable, real and relevant to clients. There are analogies with accountancy where accountants "translate" financial laws and accounting principles into real applications for individuals or for companies. Academics don't want to and often can't provide that kind of a service. The people who need it don't have the skills or the time to access the original research' (other).*

Ham et al[21] discuss the need for an effective mechanism for transferring the results of research into policy. They suggest the establishment of an independent foundation based on a 'hub and spoke' model – analysts in the middle – working

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[21] Ham C, Hunter DJ, Robinson R. Evidence based policymaking. BMJ 1995; 310: 71-72

with network of researchers around the UK and a closer alignment of evidence based policy making with evidence based medicine

Many point out that there is little incentive for researchers to ensure that their work is widely disseminated and incorporated into practice

> *'We ought to be able to exert some leverage over researchers but when they all refuse to play, it becomes very difficult. When asked in the commissioning process about dissemination, all the academics do is cut /paste a paragraph at the bottom of their application, focussing on scientific journals.' (NHS /DH)*

> *'If the funding was dependent upon dissemination, it would force the culture to change.' (NHS /DH)*

Finally, many point to a culture clash between the users of health services research and the providers/funders.

> *'There are two completely different value systems – the academic value system that measures the intellectual rigour of the work – and the health care system that is looking for research to drive change, drive improvements.' (academic)*

The views that the care delivery and academic communities held of each other can be summarised in the table below:

Academic community	Management/policy makers
Working to long timescales – up to 3 years	Working to short timescales – up to 3 months
Focus on methodological purity Dependent on funders, and on RAE	Focus on a high level steer – this way or that way – pragmatic conclusions Dependent on central government
Publication is key – and publication in peer reviewed journals	Obtain information from peers, superiors and HSJ
Driver is respect amongst academic community	Driver is performance ratings
"Theory enhancing"	"Change promoting"

5.4. There is a lack of "intelligent commissioning", funding decisions not aligned to improving health care services

Some point to the structure of funding and commissioning of research as being a major problem:

> 'The pressure to tender (within SDO) comes from academics (who are obsessed with fairness) not government ' (NHS /DH)

> 'It is a constant hassle to raise funding. There is a constant temptation to inflate all grant applications to keep researchers working. It is difficult to rapidly deploy people to do a piece of work and so we tend not to respond to quick pieces.' (academic)

Some point specifically to the high levels of influence by academics on funding decisions. Many funders have academics as trustees or board members. Most project proposals are put out to peer review – a process whereby the academic community judges a project on it's methodological worth. Many funders expect work to be published in peer review journals.

> 'Commissioning is still too researcher driven rather than service driven. The process is long winded – a brief is sent out, academics send back their view as to what the work should be about. Funding decisions are based more on the methodology rather than on the output – more about whether the research is done in a robust way rather than whether or not it answers the question.' (other)

The research assessment exercise (RAE) is seen as particularly unhelpful. Academic institutions are dependent on central funding which is in turn dependent on the RAE. The RAE uses as its measure of success the profile of a department with the academic community. Hence researchers need to be publishing in high profile academic journals, and presenting at academic conferences for a department to be well funded.

There is little emphasis on impact, for example the impact on the quality of health care services.

> 'HSR is unfairly judged - the only criteria are getting papers in Nature and new scientific knowledge. Research should be judged as to whether it is fundamentally important not whether it is new or important. My criteria would be whether the problem is worthy of being answered and whether the researcher has got a sensible / best way to answer it.' (other)

5.5. Lack of "pull" from front line managers & clinicians and policy makers

Many interviewees point to front line managers and policy makers as being a part of the problem.

For example there is very little pull for research to inform policy making and service improvement. This seems to be more related to underlying drivers and incentives for change than due to research per se.

> 'Whilst I agree NHS managers have a huge workload/lots of pressure, it is not an excuse for not taking an interest in research /learning. The issue is that NHS mangers do not want to learn because if they did they would have do something about it – managing clinical change is very difficult and most mangers want to avoid it.' (NHS /DH)

Some point to a lack of skills within policy makers and managers – a lack of analytical capability, a lack of research understanding

> 'The audience for research is naïve – unschooled in research - increasing capacity of consumers to understand research is a key issue' (academic)

Others refer again to cultural differences between the research, medical and managerial worlds

> 'It's not just that NHS mangers do not have a research background it's that they do not even have a culture of reading journals /keeping up to date with latest evidence. The medical profession are driven to keep professionally up to date for fear of being laughed at by their colleagues. NHS mangers read journals to keep up with who has got what job and they are more likely to be laughed at for being an 'anorak' if they look at the MA website. There is no culture that they are in a technically leading edge profession that they have to keep up to date with.' (NHS /DH)

5.5. Little/no dialogue between different groups

Underlying many of the issues outlined above is a sense that the different communities have little interaction. This compares with other countries and possibly other industry sectors where there is a greater degree of movement. Some point to US and Canadian organisations which could act as a model for how to encourage greater communication and links between different groups

> 'You could argue that the most important role the Canadian HSR Foundation has taken on is that of brokerage between managers, policy makers and researchers' (academic)

> 'The disconnect between policy and research is greater in the UK than elsewhere - in the US people move around a lot more between academia and policy departments and the Academy of Health is a great forum for bringing together policy makers and researchers.' (academic)

This is partly due to career structures. In general most academics working in health services research are career academics with few experiences outside the academic world. External experiences are not rewarded and often not recognised. This contrasts with academics in business and management studies where there is a greater fluidity of roles – for example academics spending part of their time acting as management consultants/advisors to companies, and academics often recruited from a management consulting background and vice versa.

Similarly there are few opportunities for policy makers (often career civil servants) or front line managers to spend time working in academia. For both these groups the norm is to rise up through the ranks with little or no exposure to any other organisation.

Differing pay scales inhibit movement – in general, academic salaries are below those in policy-making positions or for health service managers. However, in the business world, some of this differential is compensated for by allowing, and encouraging, academics to work as consultants to organisations – a practice more difficult in HSR academia.

Another reason may be the relatively low standing of HSR within the academic, medical and managerial communities.

> *'In academic terms HSR does not score highly within the university system. It is also seen as an NHS driven agenda which is not accepted by medics.' (academic)*

Some argue that the lack of clear definition and purpose for HSR makes it less attractive to both academics and managers

> *'A lack of any professional identity for HSR linked to the lack of any university structure, is a major problem in terms of its profile – this is in marked contrast to the US where every medical school has a department of HSR and there are lots of professional groups /foundations' (other)*

6. EXAMPLES FROM OTHER ORGANISATIONS

Different approaches to HSR

6.1. Our respondents often referred to two overseas organisations undertaking health services research. These are The Academy in the US and The Canadian Health Services Research Foundation.

6.2. **AcademyHealth** aims to bring together health services researchers, policy analysts, and practitioners to promote interaction across the health research and policy arenas. By bringing people together the organisation aims to encourage different players to share their perspectives, learn from each other, and strengthen their working relationships.

Established in 2000, the Academy is now seen as the professional society for more than 3,600 individuals and 120 affiliated organisations throughout the U.S. and abroad.

6.3. The organisation facilitates the use of health services research and health policy information by:

- Translating research findings and the lessons of experience into useful information for clinical, management, and policy decisions;

- Enhancing communication and interaction between health service researchers and health policymakers; and

- Identifying areas in which additional research is needed to better inform decisions.

6.4. The **Canadian Health Services Research Foundation** is an independent, not-for-profit corporation, established with endowed funds from the federal government and its agencies.

6.5. It was formed in 1997 with a one-time endowment of $66.5 million. The aim was to strengthen the scientific bases for decisions made by people running health services and to promote and facilitate evidence-based decision-making in Canada's health sector. In 1999, the foundation received a further $60 million, which included the addition of a 10-year, $25-million Nursing Research Fund to increase research on Canadian nursing issues.

6.6. The Foundation was the product of two players with converging intentions: the Medical Research Council which wanted more applied research funding for research into the delivery of health services, and the federal government which was interested in more use of health services research evidence to inform health system decisions.

6.7.   The Foundation promotes and funds management and policy research in health services and nursing to increase the quality, relevance and usefulness of this research for health-system policy makers and managers.

6.8.   The Foundation also works with health-system decision makers to support and enhance their use of research evidence when addressing health management and policy challenges. Any foundation project, process or activity always involves researchers, managers, and policy makers.

Different approaches to improving services used in commercial organisations

6.9. An attempt has been made to make comparisons with how change and improvements are brought about in organisations outside of health care. Case studies are described looking at change in both commercial and health care organisations.

6.10. The case studies have been taken from commercial organisations and the NHS. While they draw generalised observations and are deliberately stark to show differences, there are some high level comparisons which can be made. These are summarised following the case studies.

Case Studies One and Two

6.11. The first set of case studies compare approaches to reconfiguring services, in the NHS example reviewing the number of, and services provided at, hospitals; in the commercial example reviewing the number of, and products produced at, manufacturing plants. In both situations, there was a need for robust analysis to support any proposals, but the availability of information and analysis was far greater in the manufacturing plant example. This facilitated decision making, helped to communicate proposals to a wide group of stakeholders and allowed the impact of changes to be monitored over time.

	Strategic Health Authority (SHA) reconfiguration	Pharmaco manufacturing plants
Issue	Decide on future location of hospital services	Decide on future number and location of manufacturing plants post merger of two pharmaceutical companies
Research need	Quality and financial impact of different service models	Quality and financial impact of different plant layouts
Availability of research	Limited	Good
Approach/ process	•Team of people working across the SHA - mix of clinicians, managers, project managers	•Team of people working with the organisation - mix of front line operational staff, management consultants, senior managers
	•Strong desire from public/MPs etc to know the evidence behind proposals, and the expected impact of change on quality and finance	•Strong desire from board to know the logic behind proposals, and the expected impact of change on quality and finance
	•Report drew on research base to make the case, but a lack of research or benchmarks to predict likely impact of changes	•Report drew on benchmark studies to make the case - benchmarks and experience from other organisations (pharmaceutical and other industry sectors)
	•Lack of clear starting point data made analysis difficult	•Clear starting point data made comparison with now relatively straightforward
Outcome	Still unclear	Completed within one year

Case Studies Three and Four

6.12. The second set of case studies compare approaches to improving customer service, in the NHS example setting a high level strategy to introduce a "patient centred service"; in the commercial example redesigning the structure and ways of working of a bank to improve customer satisfaction and so increase customer recruitment and retention.

6.13. In both situations there was a need for robust analysis to support any proposals. The bank drew on examples from other organisations – both in the financial services industry but also in other industries, supported by external advisors who had supported similar efforts in other organisations. The bank had a clear drive to increase customer recruitment and retention in order to ensure long-term viability as a business. The NHS proposals were largely driven by political imperative with little analysis or research to substantiate plans.

	NHS customer service	Improving customer service in a bank
Issue	How best to implement a "patient centred service"	How best to structure organisation to meet customer needs and deliver good quality customer care to increase customer recruitment and retention
Research need	Definition of a "patient centred service", examples of good practice; analysis of impact, future models, implications for organisation	Analysis showing current status, examples of good practice; analysis of impact, future models, implications for organisation
Availability of research	Good benchmark studies, moderate research but not used	Good benchmark studies, moderate research
Approach/ process	•Unclear aim •Small team of people working at central level - mix of front line operational staff, senior managers, politicians •Little desire from politicians to know the logic behind proposals, and the expected impact of change on quality/finance; staff largely sceptical •Report drew on benchmarks from other organisations, other experiences but not used •Lack of starting point data makes comparison difficult	•Clear aim extensively communicated to ensure widespread buy-in amongst staff •Team of people working at central and local level - mix of front line operational staff, senior managers, customer service advisors •Strong desire from staff/board to know the logic behind proposals, and the expected impact of change on quality/finance •Report drew strongly on benchmarks from other organisations, other experiences •Clear starting point data made comparison with now relatively straightforward
Outcome	Little change	Change measured and monitored

Case Studies Five and Six

6.18 The final set of case studies compare approaches to the development of a human resources policy. The NHS was under pressure to respond to increasing problems with recruitment and retention of staff, the commercial organisation was concerned about possible fall out following a merger of two companies and was keen to ensure that staff were retained.

6.19 Both organisations needed to understand drivers of recruitment and retention so that they could respond to them. The commercial company knew where it was starting from – the number of employees within each organisation coming into the merger was available and the company had conducted extensive research into employees' concerns. It also drew on the experience of other organisations going through mergers supported by external advisors working with the company. The NHS, in contrast, had little understanding of the starting position with no robust data on current employees, attrition rates or reasons for attrition. Hence it was more difficult to propose solutions. Further the NHS was less willing to draw on the experience of other organisations or to use external advisors.

	NHS HR strategy	Industrial company HR strategy
Issue	Decide on future pay, benefits package, training and development for NHS front line staff	Decide on future pay, benefits package, training and development for staff following a merger of two organisations
Research need	Key drivers of recruitment and retention; examples of good practice; analysis of impact; models of future demand and supply	Key drivers of recruitment and retention; examples of good practice; analysis of impact; models of future demand and supply
Availability of research	Good benchmark studies, moderate research (but not used)	Good benchmark studies, moderate research
Approach/ process	•Team of people working at central level - mix of front line operational staff, senior managers, politicians •Little desire from various stakeholders to know the logic behind proposals, high level of interest in the expected impact of change on quality/finance •Report drew on a few case studies from around the NHS. Few benchmarks nor experiences from other organisations were used •Lack of clear starting point data made comparison with now difficult	•Team of people working at central and local level - mix of front line operational staff, senior managers, external advisors •Strong desire from staff to know the logic behind proposals, and the expected impact of change on quality/finance •Report drew strongly on benchmarks from other organisations, other merger experiences •Clear starting point data made comparison with now relatively straightforward
Outcome	Still unclear	Good retention

6.20 These case studies show that commercial organisations often face similar challenges to health care organisations – where to provide what sorts of services to what sorts of people; how to recruit and retain a good quality workforce; how to continually improve services to improve user satisfaction with those services.

6.21 Commercial organisations require research to understand how best to approach these challenges and develop future strategies based on analysis and research. Bringing about change in commercial organisations requires Board commitment to the change, and the buy-in of employees, customers and other stakeholders. Commitment and buy-in is easier to obtain if there is a clear logic and evidence base as to the rationale for change and the changes being proposed.

6.22   The way in which this research is accessed and used tends to be different in commercial organisations and the NHS. In particular:

▪ **There is more of a middle ground between no research and rigorous academic research**. While the commercial world is equally demanding of analysis and research, the sorts of knowledge which are acceptable are different. For example a piece of customer research (understanding customer needs, building a picture of different customer segments, trying out new concepts on a cross section of all customers) would be an appropriate input to designing a customer-focused organisation. A cost benchmarking study comparing competitor organisations would be seen as a valid study to set objectives for cost reduction and process improvement. An analysis of what impact previous changes had (both in that organisation but also in other organisations) would be used to assess the likely impact of change in this organisation.

• **There is a greater tendency to look outside the organisation for research or analysis which may be of use.** For example accessing information conducted in other industry sectors, other companies, or in other parts of the world.

• **There is greater differentiation of research** into R&D (new product development, testing, evaluation etc) and management development and service redesign. In most commercial organisations research is seen as separate to strategy development, service improvement or organisational change. Research tends to focus on an examination of what products work, what the benefits of products might be, how products should be applied in the market place, the cost effectiveness (or unique selling points) of different products. This work tends to be led by academics with a strong research background. In contrast strategy development (policy), planning, change programmes, organisational development work is led by senior managers often working with advisors with an expertise in these fields. These advisors will access academic research and other forms of knowledge (market research, benchmarking studies etc) and apply to the local context.

• **There is more local application in the commercial sector**. For example analysis will tend to start from the perspective of an individual organisation, looking at specific problems and examining what evidence could be applied in order to bring about change and improvements in that organisation.

• **There is a greater willingness to evaluate and refine en-route.** Partly as a result of greater time pressure, partly as a result of a greater willingness to take risks, and partly as a result of a more innovative culture, the commercial sector is more likely to start a change programme or develop a new strategy without having 100% of the answer. There is thus a lower threshold for research rigour.

- **There is a greater emphasis on the presentation of analysis and research**.   The commercial sector will often invest heavily in developing high quality presentation material to support the communication of proposals and the underpinning rationale (supported by research and analysis) in order to convince employees and stakeholders of the need for change and the way forward.

- **There is far greater use of specialist advisors or management consultants** who act as synthesisers or translators. These external consultants bring with them research sourced from a number of places (academia, benchmarking studies, other organisations) and work with their clients to identify areas for focus and develop strategies for change. These external organisations often act as repositories of knowledge – based on both the latest academic thinking but also experience from working with other organisations. Their experience allows them to make comparisons and capture examples of best practice.

6.23   Further, the use of research and analysis to underpin improvement efforts is conducted within a different organisational context. In particular

- **Commercial organisations tend to have a clearly stated "aim", communicated across the organisation and to their customers.**   This aim or "vision" is often translated into a specific objectives cascaded down the organisation – for example to reduce costs, improve customer satisfaction etc. In contrast the aim of the NHS is less clear-cut – some describe the aim as delivering a "patient centred service", others believe the aim to be improving the health of the population. Often all of these ambitions are taken on board resulting in a plethora of initiatives and targets making it difficult for individual organisations to know what improvements to focus on.

- **There is a greater focus on developing skills to access, analyse and use research.**   Often these skills are developed internally or through secondments to business schools or management consultancies and/or the recruitment of staff from management consultancies. Business schools conduct management research and many senior managers will have spent part of their career in an academic environment often studying for a MBA or an executive development programme.

- **There is a greater fluidity of roles between different groups**. There tends to be more movement of people between different roles – academia, advisors, policy makers (head office) and front line managers.   It is becoming increasingly common for academics in the business world to be recruited from a commercial background and/or to spend time working with commercial organisations as an expert advisor. This fluidity of roles encourages closer working between the academic and management worlds.

- **Project team working and process improvement are often part of the day job**. In many commercial organisations employees are expected and encouraged to be involved in change programmes – change often being seen as "part of the day job". This compares with the NHS where many employees see change or service redesign as something on top of the job.

- **Commercial organisations often have better performance data** to enable comparison in future. Most commercial organisations actively collect and use performance data. Usually performance measures can be collated into a few key metrics which are used to inform performance assessment at different levels within the organisation – for example at an individual level, a team level, an organisation level. There are usually IT systems which generate this data automatically. This enables organisations to understand their starting point, compare their performance with other organisations and so highlight areas for change and monitor the impact of change going forward.

7. PROPOSALS GOING FORWARD

Proposals for the future are focused on three key areas:

- **Developing health services research in order to improve the knowledge base** available to policy makers and managers to support improvements in health care services

- **Improving health care services** – what could be done to change the context in which knowledge is used to further the improvement of services?

- **Establishing a forum to bring researchers and users of knowledge together**

7.1. Developing health services research in order to improve the knowledge base

Improving the knowledge base requires:

- Funding and commissioning the development of knowledge which meets the needs of managers and policy makers - both in the shorter term and in the longer term

- Funding and commissioning non-traditional forms of research, for example benchmarking studies

- Consideration of the current configuration of the Research Assessment Exercise to ensure researchers are incentivised to conduct research which will be relevant, accessible and applicable to policy makers and managers in health care

- Ensuring knowledge is more accessible to front line managers and policy makers, adapted and tailored to local problems

7.1.1. *Funding and commissioning the development of knowledge which meets the needs of managers and policy makers - both in the shorter term and in the longer term*

Knowledge development needs to be more influenced by the people who will ultimately use research to improve services – managers, policy makers and consumers of health care services. Bringing the funding and commissioning of research closer to these users of research should improve the relevance of research to them.

For example money could be channelled to service delivery organisations to be used to respond to patient needs with evaluation closely linked to whether or not these needs had been met. Or funders could be encouraged to work more

closely with customers of health care services to understand the areas they consider important for research and improvement.

However, such an approach runs the risk of excluding research that might not have an immediate impact.

7.1.2. Funding and commissioning non-traditional forms of research, for example benchmarking studies

Different types of knowledge (from academic research to evaluation of services) need to be recognised and embraced – all play a part in improving health care services. Some forms of knowledge will be more able to meet the more immediate needs of managers and policy makers, while other forms may be more suitable to longer term issues, requiring larger, more complex studies to be performed.

Some research or knowledge development will not necessarily conform to traditional models of conducting research. But sometimes non-traditional methods, such as evaluation, benchmarking or audit, can be more effective at bringing about important change. For example data is increasingly becoming available to compare the performance of new Diagnostic and Treatment Centres (DTCs) with other NHS hospitals. The recognition that DTCs are managing more cases per operating theatre session is leading to substantial improvements in productivity in other NHS hospitals[22].

Other research and analysis may come from "non-traditional" sources - research from business schools, management consultants, market researchers and individual companies.

7.1.3. Changing the Research Assessment Exercise

The current RAE incentivises, by means of funding, researchers to focus on specific types of work, rather than on work which meets a need in terms of improving health care services. It also encourages publication and dissemination targeted at the academic community rather than the broader health care community.
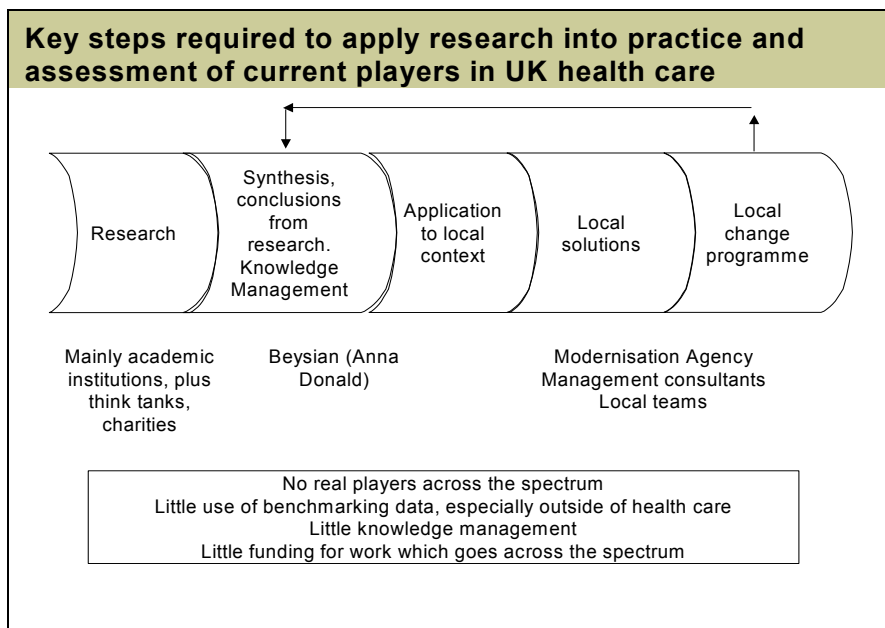
Consideration need to be given to the reward criteria of the RAE needs to be adapted to make it more relevant to health care service improvements.

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[22] "A Proving Ground for Patient Choice". Nicholas Timmins. The Financial Times. 19 August, 2003.

7.1.4. Ensuring knowledge is more accessible to front line managers and policy makers

One of the biggest areas of concern is the difficulty researchers and front line managers and policy makers have in "connecting".

The diagram below shows the spectrum of work that needs to be carried out to make research more accessible to policy makers and front line managers.

Key steps required to apply research into practice and assessment of current players in UK health care

| Research | Synthesis, conclusions from research. Knowledge Management | Application to local context | Local solutions | Local change programme |

Mainly academic institutions, plus think tanks, charities

Beysian (Anna Donald)

Modernisation Agency
Management consultants
Local teams

No real players across the spectrum
Little use of benchmarking data, especially outside of health care
Little knowledge management
Little funding for work which goes across the spectrum

Firstly research needs to be published in forms which will make it more accessible and which will support dissemination. Academic and practitioner health management journals could collaborate to present research findings in a format that managers find accessible and through journals that they actually read.

Secondly research needs to be synthesised into more relevant information or knowledge for users of that information. In the commercial sector, this space is sometimes filled by management consultants who act as "synthesisers" or "translators", drawing conclusions from research and presenting it in more user-friendly ways, for example articles in the McKinsey Quarterly[23] magazine, or the perspectives series from the Boston Consulting Group[24], both widely disseminated to front line managers.

This could also be referred to as "knowledge management" – the capture of knowledge from a range of sources (including examples of previous change programmes) which is then assimilated and stored in a user-friendly fashion.

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[23] www.McKinsey.com

[24] www.BCG.com

Some health care players are already recognising the opportunities within this space, including one health service researcher (Anna Donald) who has commercialised this opportunity and built a business (Bayesian) synthesising conclusions from research.

Thirdly, research needs to be applied to the local context, often supported by benchmarking data to identify areas to focus. Again, in the commercial sector, this tends to be a role adopted by management consultants and external advisors, drawing on different types of research and knowledge and applying it to the local context, to specific organisational problems. They act as repositories of knowledge, capturing and synthesising information accumulated in the course of their work. Thus they become "knowledge purveyors", combining academic research with benchmarking studies with best practice examples, to produce "evidence" or "knowledge" for their clients.

Finally, research and knowledge needs to be used to support specific proposals for change and developed into a change programme. Increasingly the Modernisation Agency is taking on this role in the NHS.

7.2.1. Lomas[25] suggests that organisations need at least four capacities for evidence based decision making:

- Capacity to **access** research evidence

- Capacity to **appraise** research evidence

- Capacity to **adapt** research evidence

- Capacity to **apply** research evidence

These attributes are often lacking in the NHS - few people enter NHS organisations with a background in research, analysis, strategy or change management and little is done to build these skills in house.

Managers and policy makers need to have a greater understanding of knowledge in order to use it more effectively[26]. For example Chief Executives need to be able to analyse data to diagnose how well their organisation is performing and highlight areas for improvement; they need to be able to review large amounts of research and knowledge to identify concepts which are likely to be useful to them; Directors of Strategy and policy makers need to be able to access knowledge to develop robust innovative strategies for the future; change management leaders need to be able to draw on knowledge to

[25] Jonathon Lomas, Canadian Health Services Research Foundation. "An International Perspective on Research on he Organisation and Delivery of Health Services". The second national SDO conference. March 19,2003.

[26] Walshe and Rundall. Evidence Based Management: From Theory to Practice in Health Care. Milbank Quarterly 2001. Vol 29, No. 3.

drive through high quality process management and an improvement culture; individual managers and clinicians need to be able to use knowledge in their day to day quest for better service delivery. All need strong analytical, presentational and communication skills to ensure they can communicate their proposals to staff, customers and stakeholders.

This could be brought about by

- encouraging more transition between different types of role and different organisations – managers, policy makers, management consultants, researchers

- providing training for managers in research methods, critical appraisal, and assessing the research literature

- providing resources and support to enable managers to undertake or participate in research within their own organisations

- offering more opportunities for managers to obtain postgraduate degrees and promoting such study through their human resources policies and career structures

- supporting business schools and other academic centres to provide more health management and policy programs

- providing more opportunities for managers and policy makers to have "space to think"

7.3. Establishing a forum to bring researchers and users of knowledge together

An "academy" or "centre" could be established to provide a forum for the users of health services research to meet and share ideas with researchers. The forum could develop a programme of research to meet the needs of policy makers and managers, and actively support the dissemination of research amongst users.

> *'The most useful role that PPP /Nuffield could play would be in facilitating / bringing together the right people to translate research into practice.' (other)*

> *'You should be looking towards the models of the academy and Canadian HSR Foundation – both are effective at bringing the research and policy making functions together. (academic)*

8. IMPLICATIONS FOR DIFFERENT ORGANISATIONS

Bringing about the changes outlined above requires action on the part of a wide range of players. This section of the report makes two sets of recommendations: one broad set for consideration by the different players involved; and one specific set largely for the Health Foundation and the Nuffield Trust, who are the funders of this project.

Broad recommendations

In particular, change requires:

- **Government and NHS top management** to ensure clear and meaningful incentives are in place across all health care organisations

- **Government and NHS top management** to develop, and ensure use of, a robust and useable performance measurement system. A system which will allow the use of meaningful measures of performance at an individual, a team and an organisation level. A system which identifies areas for improvement. A system supported by high quality IT to collect meaningful and accurate data as a by-product of day-to-day working.

- **Managers and policy makers throughout health care organisations** to ensure all staff are able to contribute to improving services. And key staff have the appropriate skills for their role. Building and constantly developing these skills is a potential role for the new NHS University.

- **Academics** to focus research on the needs (both current, medium and long term) of health care organisations. They need to work more closely with front line organisations to explore means of applying their work – starting at the conception of work and continuing through to dissemination.

- **Academic leaders** to support the development of roles which encourage and allow career academics to work more closely with policy makers, clinicians and front line organisations to support dissemination of research. Academics should consider secondment into front line or policy-making organisations to build their understanding of the knowledge needs of these organisations.

- **Academics** to acknowledge other forms of knowledge (for example audit, benchmarking, evaluation) as valid forms of input to developing policy or improving services. They need to be encouraged to work with staff focusing on these areas to improve quality of data capture and manipulation.

- **Knowledge captors** of all backgrounds to recognise the need for high quality communication skills

- **Policy makers, clinicians and managers** to be encouraged to use knowledge to ensure better quality decision making in order to better improve health care services. And encouraged to use knowledge from a wide range of sources – from outside as well as inside the health care community

- **Policy makers, clinicians and managers** to explore working alongside "synthesisors" or "translators" to better access knowledge and support to develop knowledge based strategies, policies and change programmes.

- **Organisations and/or individuals** to set up "translator" type businesses – these could work with local NHS organisations to identify areas for improvement, apply knowledge to identify potential solutions, and support implementation of new ways of working. These organisations or individuals will only evolve when there is a discernable market place for these skills.

- **Funders** to create a market place in health care improvement whereby some funds are allocated to front line organisations who can then use the funds to commission research to meet their needs, build a knowledge base to inform improvements, employ intermediaries to work with them to bring about informed change and/or ensure managers and policy makers have the appropriate skills to bring about improvements.

2   Specific recommendations

Recommendations to the Department of Health

1   Specifically, the Department of Health should also undertake a comprehensive review of its commissioning of HSR in the light of:

- issues concerning value for money
- issues concerning the negative impact of the RAE on existing HSR capacity and capability in English universities
- issues concerning the governance and administration of HSR funding

2   The Department of Health should consider the creation of a knowledge centre in the light of its future plans for review of the Modernisation Agency and the creation of CHAI.

Recommendations to the Health Foundation and the Nuffield Trust

3   The Nuffield Trust and The Health Foundation should take steps to stimulate the development of a UK Academy for HSR (this could be done in conjunction with the NHS Confederation who are actively considering the creation of an HSR scientific meeting as part of their annual conference).

4   The Nuffield Trust and The Health Foundation should support the development of "translator roles", exploring ways of stimulating such roles both within NHS organisations and networks of NHS organisations, as well as in commercial environments.

5   The Health Foundation should consider the creation of senior HSR fellowships and/or strategic partnerships between NHS organisations and academic institutions to kick start the growth in applied HSR capacity.

6   The Nuffield Trust should support further policy development work looking at the interface between epidemiological research public health and HSR.

9. CONCLUSIONS

Improving health services research (in whatever definition) has the capacity to substantially improve health care services, improvements which would be for the benefit of users, providers and governments.

The current system of research and its application in health care services is not working as well as it could be.

Reforms can and should be made to change the ways in which health care managers and policy makers access research and knowledge and use it to improve services. Funding and commissioning mechanisms need to be adapted and changed in order to bring about reform.

The Health Foundation and The Nuffield Trust could play lead roles in instigating reform.

Appendix

Project team and structure

The work was led by a steering committee with input from an international reference group. The team structure is shown in the diagram below:

Project structure

Steering Committee
•John Wyn Owen
•Stephen Thornton

International Reference Group
• Jonathon Lomas (Canada)
• Louise Gunning-Schepers (Netherlands)
• Mark Smith (California Healthcare Foundation)

External Team
•Penny Dash
•Anne Smith
•Helen Donohoe

Internal Team
•Deborah Rosanzky
•Gill Hastings
•Alan Ingram