Research utilisation and knowledge mobilisation in the commissioning and joint planning of public health interventions to reduce alcohol-related harms: a qualitative case design using a cocreation approach

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Scientific summary

Public health interventions to reduce alcohol-related harms

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Scientific summary

Background

Despite considerable time and resources spent creating the evidence base on effective public health interventions and multiple policy documents calling for its use, research suggests that it takes, on average, 17 years to get evidence to embed in practice (if at all). In public health, the use of evidence is particularly difficult. The evidence is often patchy or created in very different settings, or does not give the exact answers that are needed in a timely way, giving rise to concerns about the local 'fit'. The evidence base may be seen as driven by powerful groups with vested interests, and may not be trusted. Finally, public health issues go across sectors and are often intertwined with political, economic and sociocultural factors, making it difficult to know where to start addressing them and requiring joined-up solutions across sectors.

Research suggests that evidence use is a social and dynamic process, subject to and shaped by, multiple contextual factors and differing stakeholder influences rather than any simple adoption of research findings. It is unclear whether it is easier to secure the use of research evidence via a legal contracting process or within unified organisational arrangements with shared responsibilities. In particular, we know little about what conditions might make the use of evidence more likely. This project has investigated these issues.

Objective

To work collaboratively with research partners to investigate how research evidence is utilised and wider knowledge mobilised by managers (and others) in the commissioning and planning of public health services to reduce alcohol-related harms.

Design

Two mainly qualitative, in-depth, multimethod, cross-comparison process case studies (in two sites) were undertaken. Our research questions were (1) how, when, where and by whom is research utilised and other forms of knowledge mobilised in the commissioning and planning of public health services; (2) what is the perceived impact; (3) what is involved in working collaboratively with research participants to cocreate knowledge; and (4) what are the individual and organisational factors that support or hinder research use? A realist framework was used to identify the dominant programme theory and to ask the overarching theoretical questions of 'what works where and under what conditions?' by examining the mechanism, context and outcomes combinations.

Sampling

In real time we examined research utilisation across two different managerial mechanisms for achieving change: commissioning over a purchaser–provider split and joint planning across unified organisational arrangements to address alcohol-related harms.

Methods and data collection

Fieldwork took place January 2012 to November 2013 against the backdrop of the global financial downturn and significant NHS reforms in England. We worked in cocreation with our case study partners in three ways: our partners picked the case study process, and they could take part in both the research process and the data analysis of emergent findings through joint interpretation forums, if they so wished. Our English partners picked 'reducing maternal alcohol consumption' and our Scottish partners picked 'alcohol licensing' as the case study process. Through purposive sampling we interviewed key stakeholders ($n = 69$), carried out two focus groups, observed 14 decision-making meetings and examined accompanying documentation. To share our findings and to explore how the findings applied elsewhere (transferability), one national and two local workshops were held and a questionnaire with a modified Behaviourally Anchored Rating Scale (BARS) was issued and used to prompt discussion in the national workshop. A small amount of quantitative work was undertaken to contextualise the case study findings, but routine data to assess organisational quality and performance were not routinely available, had changed over the period in question and/or were not recorded reliably.

Findings

In the Scottish site, the process of granting licences is legally regulated. Within the legislation there is a rebuttable presumption that a licence will be granted unless evidence proves that this is inadvisable. Being in an 'overprovided area' does not count. Evidence can be requested (pulled) only from the five statutory objectors (of which Health is one). At the time of data collection, Health no longer routinely responded to each request (lack of capacity; mismatch of population data when applied to individual licences; and previous unsuccessful attempts torn down by legal agents). A story of competing local tensions emerges between focusing on health outcomes, the night-time economy and, more widely, economic vibrancy and regeneration. It is a complex situation in which focusing on solely reducing alcohol-related harms may remove the possibility of wider health gains.

In the English site, the (then) primary care trust commissioned data collection by a market research company to ask local women of childbearing age and midwives their views on the acceptability of interventions to reduce maternal alcohol consumption. This data collection temporarily stalled when midwives and pregnant women could not be recruited to take part. This revealed a much wider divide between the commissioners and the provider organisation. We were not able to engage with the provider organisation in our efforts to work in cocreation.

The evidence base on the effects of alcohol consumption in pregnancy is not conclusive and the guidance issued by various UK bodies is different. Data on the prevalence of the problem (maternal alcohol consumption) are not easily available, either locally or nationally. Many participants discussed the challenges of commissioning where the evidence base is weak. The necessity to be persuasive, using research to tell a story, appealing to both 'evidence and passion', building relationships and having the support of local champions were felt to be important. Participants discussed the difficulty of building these relationships across the formal purchaser–provider split and resorting to informal (unsanctioned) means to build these alliances.

Across both sites, several issues emerged in common. Research evidence, local data and statistics are pulled into organisational decision-making at particular evidence entry points, but these points were few. Strategic policy and planning documents (including the Joint Strategic Needs Assessment) are regularly updated and at this time pull in the latest research evidence. Problematic issues, their prevalence and trends over time are highlighted in order to set local priorities. In this important way, all actions within the organisations that fall out of these is evidence informed. The evidence base provides a starting place and raises awareness, but rarely directly influences action in an instrumental way. To find actionable messages, both sites attempted to agree actions with partners and collect their own local data. In our case sites these data are more influential in shaping commissioning and planning activity than national research findings. In the Scottish

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site (licensing) these data were in the form of local statistics on crime and footfall in city centre outlets, collected in order to gauge how well licensing decisions were working. In the English site local data collection (via the market research company) asked pregnant women and midwives about their attitudes to various social media campaigns to guide local intervention development. Beyond this, evidence use is largely up to specific commissioners. Local knowledge, professional expertise, anecdotes and personal testimony are all taken into account to consider the feasibility and acceptability of proposed activity against often politically charged backdrops. Organisations have created roles whereby the incumbent gathers, collates and interprets external information sources, but there does not seem to be any specific requirement to use this provision.

It was difficult to see evidence in use. It was also difficult to see where commissioning and planning decisions were made; this was not in a single place at a particular time, but evolving, sometimes taking place outside the formal meetings we observed (as informal chats, ad hoc discussions and e-mail correspondence).

Road-testing the findings

To explore transferability, the 10 main findings on how evidence is identified, weighted and mobilised were used in a questionnaire using a 9-point BARS. With no right-or-wrong answers, or 'easy solutions', these 10 findings can be considered 'wicked problems'. We identified the ways that these issues are typically, if temporarily, resolved in our sites and used these to write behavioural anchors. The wicked issues were what type of evidence is most useful; what is 'valid knowledge'; is evidence ready for use; where is the most useful evidence found; how and where is evidence mobilised (and by whom); what are the contextual influences and other factors that compete to shape the decision; and why is evidence mobilised? We included an eleventh item to gather the views of respondents on cocreating research.

The BARS questionnaire and invitation to the national workshop were issued widely to stakeholders with an interest in alcohol, licensing and maternity issues, including the voluntary and community sector, by personal invitation to alcohol leads in local authorities and through practitioners' networks (73 replies). Respondents were mainly public health, local authority (LA) and NHS members. The sample is not representative of all parts of the UK, and the modest response rate suggests caution is required to avoid overstating the findings. However, in this small sample, NHS members show a strong preference for academic research, LA public health has a stronger preference for practical experience, and academics believe that national evidence is more useful in decision-making, illustrating different views on what counts. A chi-squared goodness-of-fit test confirmed that the spread of responses was unlikely to have happened by chance.

National workshop

Only 10 delegates attended the national workshop, making it difficult to draw conclusions, but following discussion participants gave their opinions and views on how to get evidence used: do not be a 'health purist' but aim to win people over; identify allies; tailor messages; and use actionable messages to tell a story.

Working in cocreation

Our research participants were volunteers. They identified stakeholders (for interview) and brokered access to the decision-making groups to be observed. They actively took part in the joint data interpretation forums (including local workshops) and helped to contextualise the data. They did not, however, choose to add any additional research questions or take part in data collection, which was viewed as the role of the research team. Each site picked a tricky issue for us to research, perhaps as a way of surfacing difficult local issues that everyone knew but could not resolve. In this way, the research team's efforts were deployed tactically by the research participants.

Partners expressed surprise at the length of time it takes for research to begin (applying for funding, contracting, gaining research and development approvals), what cocreation actually involves, and the time commitment needed to work in cocreation. In the Scottish site, where we were able to engage all key stakeholders in the cocreation process (under unified organisational arrangements) and facilitate

(or accelerate) the development of closer working relationships between them, a new jointly funded post was developed to boost capacity to respond under the public health licensing objection. In the English site (under commissioning across a purchaser–provider split), we were not able to engage all of the key players.

Conclusions

Working in cocreation takes time at all stages of the process. Practitioners may not have the time, willingness, interest or skills to fully take part. All key stakeholders need to be engaged at the start to secure buy-in. Being on site for data collection was insufficient for researchers to become 'insiders' and build the necessary trusting relationships. Cocreation might work better if researchers were on site for significant periods of time, suiting ethnographic approaches. Cocreation did not guarantee full access to all research data – there were places we did not get to see (the Licensing Board meetings and informal meetings between commissioners and providers), suggesting limits to the extent to which research participants will subject themselves to the research gaze.

The dominant programme theory is *Research evidence will enable public health functions to be met more easily.* We explore under what condition this works and explain this in a mid-range theory, through two linked sociocultural mechanisms (mechanism): saliency and immediacy. If the evidence is salient (about 'here and now' as opposed to 'there and then') and if it has immediacy (presented verbally, visually and emotionally as opposed to in a passive written format) then it is more likely to be used (in both contexts). Where evidence use works depends on 'what will work' (outcome) and requires a consideration of multiple factors in the context: what has been tried before, local fit, traditions, geography, etc. The answer to one part of the puzzle is dependent on the answer to the others, indicative of a complex system. The pull of competing contextual demands (context) is explained in a second mid-range theory (a visual schema) to illustrate how this shapes the evidence use (outcome). Gaining this agreement across stakeholders was more difficult across the purchaser–provider split, because negotiated discussions were often curtailed.

Limitations of the study

Quantitative data were not available to support our analysis. In England there are no national sources that link 'alcohol consumption' with 'pregnancy', and local sources are self-reports. High-level performance indicators have changed over the past 5 years, as have the organisations that carried them out. NHS indicators that do exist cannot be accessed outside the NHS. In Scotland the numbers of licences granted (or amended) is neither reported consistently nor collated in one place. As part of our negotiated entry we agreed not to issue a FOI request for local data. Our study being qualitative (looking at in-depth issues in two sites on different topics) made it important to test and share the findings more widely – but these efforts were only partially successful.

Future work

Recommendations are made.

For practice: create more evidence entry points by co-opting information scientists, analysts or academics on commissioning groups, creating standing items on commissioning agendas, with an expectation that evidence will be used if possible. Ensure that routine quantitative data capture meets the needs of the new structures.

For researchers: evidence needs to useful as well as rigorous; consider the role of context in mitigating 'what works'; consider what can be learned from small research companies in identifying actionable messages.

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For educators: teach influencing and negotiating skills alongside clinical skills to help practitioners with difficult conversations in politically charged and messy practice environments.

For research funders: consider offering a national responsive research service to meet local pressing research need, and allow more funded research time needed in cocreation studies.

Future research needs to focus on assessing whether or not the demands of cocreation are 'worth it'; investigating the unseen places in which commissioning and planning take place (informal spaces) and investigating the demands for different evidence types in these forums; identifying how evidence is used across the new public health landscape; and investigating the rigour and transferability of the mid-range theories to other contexts.

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