Research use and knowledge mobilisation in the commissioning and planning of public health services - what helps and hinders - a study in the co-creation of knowledge

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Abstract
Where evidence informs effective practice, clinical outcomes improve. In public health, however, this is challenging; the evidence base is not always proven and stakeholders may believe local conditions are counter indicative. Public health agendas span health, local government and voluntary organisations, each with distinct research cultures and governance arrangements. Getting research to flow over field boundaries and gaining agreement on actions and outcomes is challenging, making it difficult to know what services to support for best outcomes. However, boundaries are crossed, actions agreed and services developed – although we do not know if research utilisation is embraced or supported to create public health services. This research will follow a public health commissioning process in North West England and a joint planning process in Scotland, as each develops one public health service or intervention to reduce alcohol-related harm, from planning to delivery, in order to explore the ways in which research evidence (and other types of information) is used. With a strong focus on collaborative working and knowledge co-creation, the project will draw primarily upon qualitative methods, although a small amount of basic quantitative work will be undertaken in order to help contextualise the qualitative data. An interactive national workshop will take emergent findings and explore their transferability to other contexts. Findings will be shared in regular joint data interpretation meetings, briefing papers, via practitioner networks and in conference presentations and publications.

Introduction
Services which are based on research evidence of what works frequently lead to better patient outcomes. In Public Health (PH), evidence of what works well may not be available, or may not apply in all settings, making it difficult to know precisely what services to support for the best outcomes. Furthermore, we do not know if research evidence is utilised effectively to create PH services and if NHS managers support this. What services are put in place are likely to depend on many things such as the evidence which is available and brought into play, what stakeholders want, and whether the manager can commission specified services or jointly plan and agree services collaboratively with other partners.

The Research
Research Aims and Questions

The aim of the project is to work collaboratively with research participants to explore and understand how research is utilised and knowledge mobilised by NHS managers in the commissioning and planning of public health services with a focus on interventions to reduce alcohol-related harm.

The following research questions will be addressed:
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? What is their perceived impact?
2) What is involved in working collaboratively with research participants to co-create knowledge?
3) What are the individual and organisational factors that support or hinder research use in the planning and commissioning of services?

Design and Theoretical / Conceptual Framework

This project will carry out two case studies. Each case study will follow a live process of the commissioning (or Joint Planning) cycle from start-to-finish as PH services are put in place (or removed). The overarching analytical framework will be provided by Pawson and Tilley’s notion of realistic evaluation (that mechanism plus context informs outcomes) in order to ask the fundamental question: ‘what works, where, and under what conditions’.

A Study Designed to Co-Create Knowledge

Our aim is to work collaboratively with our research participants on the case study sites as an exercise in the co-creation of knowledge. To promote and prompt collaborative working we will require two things from our participating sites:

i) That the specific topic and process to follow will be selected by our case studies sites as their choice (within the study parameters). This devolved decision-making should allow the research to address issues that are timely, useful and relevant to services needs and show our commitment to work together on areas of mutual interest.

ii) That members of our case study sites take part in regular feedback and data review sessions to encourage joint interpretation of the data, its importance and explore possible iterative responses to the emergent findings.

Case Study Site Selection

NHS structures and the places in which public health commissioning takes place will be changing as this project unfolds. We will need to take a flexible approach to what we mean by ‘case study sites’. We will follow the commissioning (and joint planning) of a service or intervention to reduce alcohol-related harms, and ‘follow-the-action’ across whichever organisations are involved in securing these services or interventions. We will begin in 1 Primary Care Trust in England (commissioning) and 1 Health Board in Scotland (joint planning) as they put one alcohol-related development in place from start-to-finish, from planning to delivery. The final choice of which service or intervention to reduce alcohol-related harm will be decided in agreement with our case study sites.

Data Collection

Five strands of work will address the research questions using multi-methods:

i) Qualitative work with those carrying out the commissioning and joint-planning (JP) to explore how research is used: rationale; opportunities; challenges; and perceived impact of the process at operational, tactical and strategic levels. This will involve semi-structured interviews, observation of commissioning (JP) meetings and documentary analysis of written documents such as minutes, commissioning (JP) agreements, strategies.

ii) In-depth qualitative interviews with those holding a knowledge management role within the two case study sites. Interviews will explore the role holders’ perceptions of their
role within the organisation, what they consider works well, the challenges they face, their views on how they are supported by their employing organisation and if, and how, these have changed over time.

iii) Impact Analysis. Once the services for evaluation have been established, we will conduct a scoping exercise in order to establish what impact measures are available. This will facilitate the identification of relevant quantitative data to support the interpretation of qualitative data collected in each case study site. The actual measures will depend on the specific topic that we agree to focus on (in agreement with our case study sites). In each case study site we will attempt to populate a minimum dataset so that comparisons can be made with neighbouring localities and between the case study sites. Where possible, data will be used to establish a baseline for future research and trend analysis.

iv) A modified 2-stage Delphi process: approximately 10 of the main findings emerging from the case studies (that tease out similarities as well as differences across the cases) will be selected for inclusion in the Delphi questionnaire.

v) An interactive UK national dissemination workshop: this will both disseminate and road-test substantive findings and to explore transferability of the emergent findings across the UK.

**Data Analysis**

**Case Studies Analysis and Knowledge Management Roles Analysis:**
Analysis of interview data will follow the method of constant comparison whereby analysis of early interviews in one site will be used to inform later data collection not only within that site but also across the other case study site. All qualitative data will be anonymised at the point of transcription and will then be entered into the analysis tool NVivo. Regular data-interpretation meetings will be held with staff from each case study in order to check our understanding of the data and allow them to adjust practice if they so wish.

**Impact Analysis:**
The quantitative data will be managed within Excel and SPSS where appropriate. The data will be cleaned prior to analysis and identifiable by case study site.

**Delphi Process and at the National workshop (discussion, feedback and comment):**
A Delphi questionnaire will ask attendees their views of the main findings emerging from the case studies in advance of the national workshop. These results will be fed back to the attendees and a second round Delphi process take part at the workshop. Field notes will be taken during the discussion and a thematic and narrative analysis (in line with case study analysis) will be undertaken to relate the data to the themes emerging from the case studies.

**Research Outputs**
It additional to the standard academic research reports, journal papers and conference papers we will also offer participants support, if they so wish, with developing practice-related publications and presentations for workshop/conference/networking events. Participants (and others with an interest in the topic area) will be invited to attend the national workshop (and take part in the Delphi process as part of this). Participants, policy-makers and other stakeholders will also be offered a one page briefing note summarising the main findings and given links to the main report as it will appear on the NIHR website. Results will be circulated via practitioner networks.