Evaluation of the NHS R & D Implementation Methods Programme

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ACKNOWLEDGEMENTS AND CONFLICT OF INTEREST

We are grateful to the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) not only for funding this evaluation, but also for the assistance provided in various ways. These included the efficient distribution of personalised questionnaires to lead researchers of projects funded by the Implementation Methods Programme. The evaluation was submitted to the SDO in November 2002 and we are grateful to the SDO Programme Director and the Director of the National Co-ordinating Centre for their agreement that the report should be published as a HERG report. (A very small number of points have been further clarified in this version).

This evaluation would not have been possible without the considerable and willing co-operation that the evaluation team received from those involved with the programme. The interviews with those who had served on the Advisory Group and/or the Commissioning Group provided a wealth of insights and we are also grateful to lead researchers, and potential users, who completed questionnaires. Furthermore, we gratefully acknowledge the help we received from the National Perinatal Epidemiology Unit with the distribution of the questionnaires related to perinatal care, and to C.H.A.I.N (the Contacts, Help, Advice and Information Network) for distribution of questionnaires to two of its groups of members. Several researchers from IMP projects also helpfully commented on drafts of the questionnaires.

Finally, we would like to thank our colleagues Teri Jones, for conducting some of the database searches, and Avril Cook, for the efficient way she entered information onto various databases and also undertook some of the data analysis.

Responsibility for the content of the evaluation lies solely with the authors, and it should be noted that one of the research team (SH) was a member of a team that submitted a proposal for topic 20. The group was invited to re-submit the proposal, but eventually nothing was funded in this topic area.

EXECUTIVE SUMMARY

Chapter 1: Background and introduction

- Concern with research implementation was a major factor behind the creation of the NHS R&D Programme in 1991. In 1994 an Advisory Group was established to identify research priorities in this field. The Implementation Methods Programme (IMP) flowed from this and its Commissioning Group funded 36 projects. Funding for the IMP was capped before the second round of commissioning. The Commissioning Group was disbanded and eventually responsibility for the programme passed to the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) which, when most projects had finished, asked the Health Economics Research Group (HERG) to conduct an evaluation. This was intended to cover: the quality of outputs; lessons to be learnt about the communication strategy and the commissioning process; and the benefits or payback from the projects. As agreed, the evaluation also addresses the questions of whether there should be a synthesis of the findings from the IMP and any further assessment of payback.

Chapter 2: Methods

- We adopted a wide range of quantitative and qualitative methods in the evaluation. They included: documentary analysis; interviews with key actors; questionnaires to the funded lead researchers; questionnaires to potential users; and desk analysis.

Chapter 3: The outputs from the programme

- As in previous assessments of research programmes, we first examined the outputs in terms of knowledge production and various items related to capacity to conduct further research. Although there was a high response rate to the questionnaire to lead researchers (30/36), missing responses mean that the data given below are incomplete. In the case of publications, however, we also made some use of data previously gathered by the programme office.
- We attempted to identify publications that were in some way a specific product of IMP funding. About half (59) of the publications from the IMP projects are articles in peer reviewed journals. The journal used most frequently for publication, the *BMJ,* is also the one with the highest journal impact factor score of those publishing articles specifically from the programme. The recent publication

datesof many articles reduces the value of citation analysis. Nevertheless, one article, Coulter *et al*, 1999, has already been cited on 53 occasions. Important publications, including *No Magic Bullets* (Oxman *et al,* 1995), are also associated with preliminary work undertaken for the IMP to assist priority setting.

- Fifteen projects, with grants of over £1.3 million, have been awarded to IMP researchers by other funders for follow-on studies connected in some way to the IMP. We also collected details about some non-IMP researchers who are building on the IMP projects.
- Research training provided in at least nine of the funded IMP projects is associated with higher/research degrees**,** including three MDs and four PhDs, that have been awarded or are being completed**.**

Chapter 4: Disseminating and using the research findings

- Limited thought had been given by the Implementation Methods Programme to dissemination strategies, but many of the individual researchers were active here. In response to the questionnaires, lead researchers reported making 92 presentations to academic audiences and 104 to practitioner/service groups. Some lead researchers showed that their effective dissemination led to utilisation of the findings.
- The Commissioning Group gave some thought to the likely use that could be made of individual research projects, but there was limited systematic analysis of how the findings as a whole would be taken forward. Achieving impact is difficult in this complex field and less than a third of lead researchers claimed to have done so, but about half thought impact could be expected. Based mainly on reports from lead researchers, we give a brief account of how the findings from six projects are being utilised.
- We sent electronic questionnaires to groups of potential users of selected projects but this produced a very low response rate. Our postal survey to Heads of Midwifery/researchers in perinatal care produced a higher response of 44%. Amongst those who did respond, there is quite a high level of knowledge about some of the programme's projects and some level of existing and potential utilisation. We suggest, however, that in some cases there are difficulties in identifying how far the respondent's focus is on the findings from the original research projects, and it how far it is on the impact of the IMP study that is about ways of influencing the uptake of such findings. Comments from several respondents showed strong support for the cutting edge nature of some of the

research. Others, however, also indicated why findings might not be utilised by some practitioners. Several respondents advocated greater dissemination of the IMP.

Chapter 5: Comparing applications with outputs

- We attempted to compare the scores given to project applications with those given to projects based on their outputs. This exercise faced various problems. The final reports from all completed projects had in theory already been reviewed and given scores for their quality and relevance. In practice, not all final reports received scores. We added a refinement by giving further scores that incorporated the additional information we gathered about both publications and any uptake of the research findings.
- Various limitations meant that we conducted this analysis on just 19 of the 36 projects. Nevertheless, the wide range of scores given to the outputs from projects indicates that some were much more successful than others. Our rather limited evidence suggests that there is some correlation between the scores for applications and those for outputs but it is small, which could be related to the difficulties encountered during commissioning.

Chapter 6: Lessons learnt about the commissioning process

- Those who established the IMP were aware that it was a different type of research field from those previously addressed within the NHS R&D Programme, but one regarded nonetheless as important. Within the NHS R&D Programme at that time a standard clinical RCT approach was strongly favoured. There was also, as ever, a need for quick results.
- In developing an understanding of implementation the Advisory Group (AG) conducted cutting edge analysis, consulted widely and drew on a wide range of disciplines. Our interviewees generally took the view that the AG worked well in setting priorities and went as far as it could at the time, especially given the time constraints.
- Based on our field work and analysis we identified a series of lessons that might inform future exercises. More attention was required to ensure that all relevant background disciplines were adequately taken into account in setting priorities and commissioning research. Some of these processes needed to be given more time than was available. Consultation needed to be organised in a sufficiently

selective way to be of maximum benefit in such a complex area. A time-limited programme was not the most appropriate way to cover a field such as this.

- In relation to the commissioning of the projects, we identified issues about the composition of commissioning groups and how people from different backgrounds (researchers, practitioners, managers and patient representatives) should best be involved.
- In this new field the Commissioning Group (CG) had to work closely with applicants to develop some of the research applications. This raised issues about how, and when, this process should be handled.
- Despite its own rationale, and for a variety of reasons, including the disbanding of the CG, the Implementation Methods Programme never developed an implementation or communication strategy for its own findings.
- The general conclusion of those who had been involved with the IMP was that it worked as well as it could at the time, and that various important projects were commissioned. But it was only a start.

Chapter 7: Should a synthesis of the findings from the programme and further payback analysis be undertaken?

- From interviews and questionnaires we identified widespread, but not total, agreement that there should be some type of synthesis of the findings from the IMP. There is more debate about the form such a synthesis should take. There is some support for a more limited type of stock taking, but also wider backing for the inclusion of many different elements. These could include: a conceptual map of the field of research implementation; an exploration of how the findings from the IMP fit into the context of research implementation today; and an assessment of how far work is still needed in those areas where no projects were funded. One possible suggestion that might incorporate much of this thinking is for the establishment of a group or commission of leading researchers in the field. Their investigation could incorporate all these elements and attempt to show how the issues could be advanced.
- We suggest that further work on assessing the payback from the IMP is probably not worthwhile unless it is undertaken as part of a wide-ranging synthesis.

Chapter 8: Conclusions, lessons and recommendations

- We conclude that the IMP was seen by many of those involved as a new and exciting field. Looking back, they were generally positive about what was started through the IMP. It commissioned a series of projects that produced some important, rigorous, and cutting edge research, at least some of which is making an impact. But this is a complex area in which traditional clinical research, health services research and the social sciences all have a role to play. A unique set of difficulties, as well as opportunities, was faced by those responsible for taking the programme forward. The intellectual challenges of constructing a programme to cover such a vast area with diverse and sometimes conflicting conceptual and methodological perspectives, were compounded by practical problems. These included the capping of the programme's funding and the premature winding up of the Commissioning Group. As a result, this complex programme, which arguably needed better support than its more clinically orientated predecessors, did not receive it at some stages. Those involved in the programme had a considerable task – the difficulties of which were not completely appreciated at the time. They are clearer in retrospect and feed into the lessons and recommendations presented here, but it is recognised that a programme such as the SDO is already adopting some of the steps.
- In relation to research commissioning and communication strategies for research programmes in general, we suggest it could be helpful if protocols were drawn up to cover certain potential difficulties. These include the remit and role of the various stakeholders represented on commissioning groups and the extent to which commissioning groups should be expected to support applicants with their proposals. Perhaps the key general lesson from this evaluation is the need for research programmes to have a proper communication strategy. This should target dissemination at relevant audiences and stress the desirability for contact to be made with potential users as early as possible in the process of devising a project.
- Our other recommendations are more specifically relevant when the SDO Programme is considering an area such as implementation methods research. It would be desirable for more time to be made available for preparatory work than was allowed for the IMP and also scope provided for the programme to be able to re-visit issues and learn from early results. It is difficult to incorporate all the analysis that is required if a programme is operating in a time-limited way.

- Our conclusion that research implementation is a crucial area for the NHS R&D Programme leads to the recommendation that more R&D activity is needed in this field in order to assist delivery of some key NHS agenda items. As a preliminary step, there is certainly scope for a type of stock taking of the findings from the IMP. On balance there seems also to be an argument for conducting a synthesis of work in the implementation field that goes beyond a mere collation of findings from the specific projects funded. If undertaken, it should fundamentally examine the current NHS needs for research on implementation and how they could be addressed in the light of the findings from the IMP and elsewhere.
- Finally, we recommend that more attention should be given to the timing of evaluations such as this and that a phased approach should be adopted. Furthermore, researchers should be informed at the outset of their project about the likely requirements that might be placed upon them in terms of responding to requests for information by those conducting an evaluation.

CHAPTER 1: BACKGROUND AND INTRODUCTION

1.1 The establishment of the Implementation Methods Programme

The NHS R&D Programme was established in 1991 partly as a result of concern that insufficient benefits were flowing into the NHS from biomedical and health research. Various strategies were adopted by the NHS R&D Programme to address this issue. In 1993 in North East Thames (and later in North Thames) the regional director of R&D, Andy Haines, initiated an Implementation Group to commission R&D implementation projects (Evans and Haines, 2000). This activity helped encourage the NHS Central Research and Development Committee (CRDC) to establish a review of research into methods to implement research findings. This review, commencing in 1994, was seen as important, underpinning the 'whole activity' of the NHS R&D Programme (Department of Health, 1995, para.18), and as highly innovative.

The review was conducted by an Advisory Group (AG) chaired by Andy Haines and the Implementation Methods Programme (IMP) flowed from this. In April 1995 the Advisory Group identified 20 priority topics for research funding. These included issues such as: 'why some clinicians but not others change their practice in response to research findings'; and 'effectiveness and cost effectiveness of reminder and decision support systems to implement research findings' (Department of Health, 1995, p. 20). No distinction was made between top and further priorities as had been done by some other time-limited NHS R&D programmes (Wisely and Haines, 1995). Following the work of the Advisory Group, the IMP, like other national time-limited NHS R&D programmes, was administered through an NHS regional R&D office, in this case North Thames.

Later in 1995 a Commissioning Group (CG) was established with Jeremy Grimshaw as chair. Following calls for proposals, in July 1995 and April 1997, a total of 35 projects was funded and in addition a contribution of £100K was made to the *Informed Choice Leaflets* project. Unlike in previous national programmes, two approaches to commissioning were adopted in the first round of funding. In addition to the usual two stage process, there was a one stage process for applications under £50K. This short application approach 'was adopted in order to get small studies, particularly systematic reviews, underway as soon as possible' (NHS Executive, 1996).

The invitation resulted in 235 short applications being received; more than had been expected. Processing them involved considerable additional work because, even after an initial triage, 199 short applications were externally peer reviewed and assessed by the CG. In discussing the process, it was argued that although the number of applications perhaps demonstrated that the one stage process was welcome by applicants, the workload created was large and yet many applications had been inappropriately resourced to stay within the £50K limit. Therefore, it was recommended in the programme report that: 'defining the types of studies permitted (e.g. only systematic reviews) as well as giving a funding limit would reduce the number of inappropriate applications. In this way studies may be commissioned more quickly without the burden on reviewers and the administrative process becoming unmanageable' (NHS Executive, 2000, p.23).

The more traditional two-stage process resulted in 149 outline applications. Eventually 69 full applications were peer reviewed and assessed by the CG, but their success rate 'was low and particularly disappointing' (NHS Executive, 1996) and Commissioning Group members were reported to be disappointed that the ideas from the outline stage were often not sufficiently developed in the full applications. There were concerns about many of the quantitative and qualitative proposals, and the concerns about the latter are listed here with the points being further discussed in section 6.8:

- 'a lack of theoretical underpinning to studies;
- a lack of detail on how the analysis would be undertaken;
- that the resources required for undertaking studies were underestimated;
- that methods inappropriate to the research questions posed were identified' (NHS Executive, 1996).

The IMP had been established with a budget of about £8 million. Half was allocated in the first round, although £534K of that was not spent after one study was terminated following the feasibility stage. Prior to the second round a funding cap on national R&D programmes was announced and in that round just £800K was allocated to three projects. The Commissioning Group was disbanded.

A progress report on the IMP was produced (NHS Executive, 2000) just before responsibility for it passed, in 2000, to the National Co-ordinating Centre for NHS

Service Delivery and Organisation R&D (NCCSDO). By then, both rounds of commissioning, and various projects, had been completed.

1.2 The evaluation of the programme

The Health Economics Research Group (HERG), Brunel University, had conducted evaluations of the benefits from various health R&D programmes, including assessing the payback from the North Thames regional R&D programme (Buxton *et al*, 1999 and 2000). This had not, however, included the time-limited national programmes administered by North Thames. When most of the projects from the IMP had been completed, HERG was invited to make a proposal to undertake an evaluation of the IMP that would specifically include the quality of the outputs and the commissioning process. The aim of the evaluation included seeing what lessons could be learnt for future commissioning and communication strategies of the Service Delivery and Organisation (SDO) Programme.

Various ways of analysing the publications were identified for the proposed evaluation, but in discussions it was agreed that the recent nature of many of the publications from the projects would limit the relevance of the citation analysis that would be conducted. On the other hand, it was agreed that a small-scale assessment should be included of the impact of the IMP on policy and practice in the health service. This would not be as extensive as previous payback assessments from HERG. Neither would it fully fulfil the original brief of the IMP's Commissioning Group which included advising on 'the quality *and value* to the NHS of the programme three and five years after its commencement' (NHS Executive, 2000, p.41—emphasis added).

Our report starts by describing the range of methods used to achieve the various objectives. Then Chapters 3 and 4 contain the largely quantitative account of the outputs, dissemination and impacts from the projects funded by the programme. These chapters reveal how the IMP identified and commissioned projects that have successfully produced a quite substantial body of literature, have provided the basis for further research and research training, have been widely disseminated, and have produced some impact. In Chapter 5, a comparison is made between the scores given to applications and those given to the projects for their final reports and subsequent outputs.

Many of those involved in the Advisory and Commissioning Groups felt that much had been achieved by the various activities. Inevitably, given the newness and evolving

nature of the area, and the subsequent capping of the programme funds and truncation of its work, there is much to be learnt from the experiences and difficulties encountered. The interviews with the members of both groups are drawn together in Chapter 6 which details a series of specific lessons related particularly to commissioning processes.

Chapter 7 addresses two further issues that were identified in the initial discussions between the NCCSDO and the evaluation team. These are whether there should be a synthesis of the findings from the programme and how far it would be appropriate and feasible to undertake a more substantial assessment of paybacks from the programme.

Finally, in Chapter 8 some conclusions are made and lessons drawn, including ones about the conduct of evaluations such as this.

The report's appendices include a list of the 20 topics identified by the Advisory Group and the 36 projects funded. Executive summaries of each project, including those not yet complete, are available on the programme's web site:
http://www.doh.gov.uk/research/rd3/nhsrandd/timeltdprogs/imp/index.htm

CHAPTER 2: METHODS

2.1 A range of methods

In undertaking this evaluation a mixture of both quantitative and qualitative methods was seen as being appropriate. Numerical data about items such as the number of articles produced are supplemented by methods that allow the context to be explored and the different perspectives of the key actors understood. An early draft of the report was submitted to the Director of the NCCSDO for comment.

2.2 Documentary analysis

In addition to the published documents from the IMP, some review of the IMP's files was also undertaken to help inform analysis of the key issues facing the development and work of the IMP. Information was recorded from the project files about: the scores given to proposals; potential users of the project identified on the application forms; and scores given to end of project reports.

2.3 Interviews

Throughout the evaluation a phased programme of interviews was conducted, starting with the chairs of the Advisory and Commissioning Groups, Andy Haines and Jeremy Grimshaw respectively, and with Trevor Sheldon, who acted as Deputy Chair of the Commissioning Group on occasions. Then other members of both groups were interviewed. All but one of those approached for an interview agreed to participate, and the positive attitude displayed by many interviewees reflected the enthusiasm that generally seemed to characterise the work of these groups. In total 25 interviews were conducted with 24 subjects, mostly face-to-face, but some by phone. A semi-structured interview schedule was devised based on the initial reading of the documents and the early interviews.

The prime focus of the interviews was on the commissioning process and therefore an attempt was made to talk to all those who had been members of this group. Fifteen Commissioning Group members were interviewed out of the 20 who served at one time or another. Of the remaining five, two had died, two were abroad and one could not be located. Some of these 20 were also on the Advisory Group and in total 12 of the 19 people who served on that group were interviewed, as were two members of the IMP's secretariat. Trevor Sheldon was interviewed again towards the end of the process to comment on the emerging findings. The interviews were all recorded, transcribed and entered into a database in which the interview schedule provided the coding frame. As

is discussed later, quite a few members of the two groups successfully applied for funding from the IMP and in some of the interviews specific points about their project were also discussed.

2.4 Questionnaires to lead researchers

A questionnaire was sent to the lead applicants of all 36 projects funded. The questionnaire was based on one developed by HERG for the evaluation of the North Thames Programme (Buxton *et al*, 1999; Hanney *et al*, 1999). The questionnaire had been adapted and applied in the evaluation of other NHS time-limited national R&D programmes (Wisely, 2001a and b) and was further amended following discussions with members of the SDO and piloting by lead researchers from two projects. Some helpful amendments were made but the questionnaire retained its basic structure which was informed by the HERG payback framework (Buxton and Hanney, 1996). Therefore, it started by asking about knowledge production, then examined each project's contribution to research training and further research, and next considered the possible impact on health policy (as broadly defined) and practice. Given the limited time and resources for the evaluation, and the technical difficulties, no attempt was made to move towards assessing final outcomes. Instead the questionnaire finished by attempting to analyse features of the way in which the dissemination of the IMP's projects might have contributed to their impact, and the role of the programme as a whole.

Shortly after their completion, the commissioning processes of the time-limited national NHS R&D programme on the interface between primary and secondary care were subject to evaluation by a questionnaire sent to applicants, both successful and unsuccessful, and reviewers (Wisely and Haines, 1995). This was not done for IMP, and it seemed too late during this evaluation to ask detailed questions on these issues. A general question on these issues, however, was included in our wider questionnaire to lead researchers. (A full copy of the questionnaire is given as Appendix 3).

The questionnaire was sent out under a covering letter from the Director of the NCCSDO and this was repeated to those who had not responded. Following at least two further emails or follow-up phone calls to those who still had not replied, the eventual response rate was 30/36 (83%). Several of these, however, were completed very briefly. Though incomplete, this was higher than the response rate of around 67% achieved in the previous evaluations noted above (Buxton *et al*, 1999; Wisely, 2001a and b).

2.5 Questionnaires to potential users

Without an in-depth assessment of benefits from individual projects, along the lines previously attempted by HERG, it was always going to be difficult to assess the impact of the programme. The problems were compounded by the disparate nature of the projects. Efforts were made, nevertheless, both to select projects that could be grouped together because of their subject matter, and to identify suitable recipients of a brief questionnaire that would contain information about the group of projects. There were a series of questions which included asking about whether the recipient had: heard of the projects described; read the articles described in the attached abstracts; already been influenced by the findings etc. The questionnaires were aimed at gaining information about both dissemination and potential use of the findings. Comments about the proposed questionnaires were obtained from: three of the researchers whose projects were included; the NCCSDO; and a member of the Commissioning Group.

Electronic questionnaires were sent out using C.H.A.I.N. (the Contacts, Help, Advice and Information Network). This is a network designed to facilitate links between professionals interested in research or evidence based health care. Two groups within C.H.A.I.N. were identified to receive specific questionnaires: people with an interest in Women's Health and those with an interest in the management of heart disease. A questionnaire with a similar format was sent using a message board for researchers interested in shared decision making. (Abbreviated copies of the questionnaires, from which the abstracts - and in one case a letter extract - have been removed, are provided as Appendices 4-6). The response rate was very low - only 22 replies to 535 questionnaires distributed - but nevertheless some useful material was obtained from these questionnaires.

An attempt to elicit a larger response was made using a postal version of a similar questionnaire to 227 practitioners and researchers in the maternity care field, primarily Heads of Maternity units in England and Wales. (See Appendix 7 for the abbreviated version). This produced a better response of over 44% from one mailing and, in addition to the data about numbers who had read and been influenced by various projects, many interesting comments were made.

2.6 Desk analysis

Various databases were used to make assessments of the quality of the research outputs. Citation analysis was undertaken for journal articles using the Science, and Social Science, Citation Indices from the Institute for Scientific Information (ISI). For

those journals included in the ISI databases, the journal impact factor score was recorded. The journal impact factor score for a journal in any given year is the average number of citations received that year by papers published in the journal in the two proceeding years. The NHS section of the Research Outputs Database (ROD), which is now maintained by HERG, contains details about articles that have been funded by the NHS/Department of Health in some way, ie through project grants or institutional support (NHS Executive/Wellcome Trust, 2001). Where relevant, it was searched to see if the publications from the IMP were recorded there.

As far as possible in the analysis attempts were made to draw together material from the various methods.

CHAPTER 3: THE OUTPUTS FROM THE PROGRAMME

3.1 Publications

One of the problems facing exercises aimed at identifying the outputs from a research programme is that knowledge advances rarely come in neatly contained packages. Therefore, it can sometimes seem artificial to attempt to link outputs precisely to specific programmes. On the other hand, if the contribution made by a specific programme is to be assessed then inclusion criteria should be used to determine the boundaries of what is to be analysed.

Previous exercises (Buxton et al, 1999; Wisely, 2001a and b) had revealed problems with efforts to get researchers to be accurate about the publications coming from specific projects. There had been both over and under counting. The programme report compiled in late 1999 listed the projects that lead researchers claimed by then had come from the programme (NHS Executive, 2000). An initial review was conducted of some of those publications and this indicated that several such articles did not carry acknowledgements to funding from the IMP. Therefore, our questionnaire to lead researchers contained the publications previously notified. It asked respondents to delete any that were not funded, at least in part, by the programme and to state whether the programme funding was acknowledged for the publications listed and for any subsequent ones. As far as possible, therefore, the analysis here focuses on publications that did carry acknowledgements to the IMP, or were ones where comments by researchers, on the questionnaire or through subsequent iterations, had clarified the position. For those projects where no questionnaire was returned, the articles from the 2000 programme report were included only if they contained an appropriate acknowledgement. This is likely to have led to a conservative bias underestimating the number of publications.

As of autumn 2002 about 120 publications could be associated with the IMP, of which 59 are articles in peer reviewed journals. More have been submitted. Details about the numbers of publications in the various categories are given on Table 3.1.

Table 3.1: Publications from the IMP's 36 projects

Type of publication	Number
Peer reviewed journal article	59
Journal editorial	3
Journal letter	2
Published abstract	15
Book	2
Chapter	11
Non-peer reviewed article	2
Published conference proceedings	6
Publicly available full report	6
Other	14
TOTAL	120

The most frequently used journal is the *BMJ* which published 11 of the articles. It has quite a high journal impact factor score—currently 6.6. [This means that on average papers published in the *BMJ* in 1999 and 2000 received 6.6 citations in 2001]. Such a high proportion of papers appearing in this journal ~~probably~~ reflects the quality of much of the work undertaken, its relevance to clinicians and the interest shown in research implementation issues by the *BMJ*. Different publication dates make citation comparisons particularly difficult over a short time period, but six papers have already received 10 or more citations. The most highly cited paper that explicitly comes from IMP funding is Coulter *et al*, 1999, which appeared in the *BMJ* and had been cited 53 times by October 2002. [In itself this provides an illustration of the dangers of undertaking citation analysis when the period since publication is short: this article had received just 37 citations when it was examined, along with a small number of others, at the start of the evaluation in March 2002].

Forty one of the 59 articles appear in journals that are included on the ISI databases, ie the Science Citation Index and Social Science Citation Index. Inclusion in the ISI databases can be taken as a sign of the quality of a journal, but other factors should also be considered. For example, as shown below, *The British Journal of Midwifery* was the most frequently used non-ISI publication vehicle for the IMP's researchers. All seven of the publications in that journal come from the one project, *Informed Choice Leaflets,* which also contributed two of the 11 articles in the *BMJ*. Some of the

respondents to the questionnaire to midwives noted that the articles in *The British Journal of Midwifery* were a reason they knew about the project. And, as we shall see, knowledge about the project was quite widespread among Heads of Midwifery.

No separate category was included in the questionnaire for reviews in the Cochrane Library and, therefore, the five reviews or protocols identified have been included as articles, but they do not have a journal impact factor score. Table 3.2 shows the full list of journals in which articles have appeared, the numbers in each, and their journal impact factor scores.

Table 3.2: The peer reviewed journals containing articles from the IMP—number of articles and journal impact factor scores

Journal title	Number of articles	Impact factor score
BMJ	11	6.6
Brit J of Midwifery	7	
J of Advanced Nursing	6	0.8
Cochrane Library	5	
Brit J of General Practice	4	1.4
Family Practice	3	1.2
Int J of Pharmacy Practice	2	
Med Ed	2	1.4
Qual Saf Health Care	2	1.2
Soc of Health & Illness	2	1.2
Evidence Based Nursing	1	
Health Bulletin	1	
Health Expectations	1	
Int J of Nursing Studies	1	0.8
Int J of Tech Assess in Health Care	1	0.8
Int J Qual in Health Care	1	1.4
J of Clinical Nursing	1	0.5
J of Eval Clin Prac	1	0.8
J of Nursing Education	1	0.5
J of Nursing Scholarship	1	
Medical Decision Making	1	2.1
Postgrad Med J	1	0.4
Qual Health Research	1	0.8
Soc Sci Med	1	1.8
Statist Med	1	1.4

TOTAL	**59**	

According to the lead researchers, and selective confirmatory checking, 49 of the 59 articles acknowledge programme funding. As one respondent noted, however, some of the publications were being submitted at about the time when responsibility for the programme was being transferred and it was not entirely clear to researchers what acknowledgement it was appropriate to give. The NHS ROD database was also used to help identify where IMP, or at least NHS, funding had been acknowledged.[1]

A range of other publications has resulted from the programme. The book, *Informing Patients* (Coulter *et al*, 1998), was at one time the King's Fund's best selling title: the sales figures of over 1300 are seen as excellent for a book in this category.

Analysis was also conducted of a somewhat wider range of publications that could be associated with the IMP. These came both from the preliminary work conducted by or for the Advisory Group, and from subsequent and concurrent research activity related to some of the projects.

To inform the work of the Advisory Group, Andy Oxman was commissioned to update an earlier review and this resulted in a publication, *No Magic Bullets* (Oxman *et al*, 1995), that has received 284 citations. It is seen as a major contribution to the international literature on research implementation. Important publications have also come from other preliminary work. A major book on research implementation, *Getting Research Findings into Practice* (Haines and Donald, 1998), contained some chapters related to the IMP, including one based on one of the workshops run for the Advisory Group (Oliver *et al*, 1998). A further example illustrates how attributing credit for the work is complex, particularly in the systematic reviews field. A report for the Advisory Group was prepared by the editors of the relevant Cochrane Review Group - *Effective Practice and Organisation of Care*. A paper (Bero *et al*, 1998) by the same team in the *BMJ* series edited by Haines and Donald states that, 'This paper is based on a briefing paper prepared by the authors for the Advisory Group on the NHS research and development programme on evaluating methods to promote the implementation of research and development'. The paper in the BMJ has been cited 158 times and is therefore another major contribution to the field. However, similar papers produced concurrently and subsequently by the same team do not refer to the IMP.

As noted, it can similarly be difficult to draw precise boundaries around the work that should be attributed to the IMP projects. For example, project IMP 11-29 resulted in a Cochrane Protocol on educational meetings, workshops and preceptorships to improve the practice of health professionals and health care outcomes (Thompson *et al*, 1998). A subsequent systematic review (Davis *et al*, 1999) refers to this as being one of the two previous studies on which the review is based. This subsequent review was published in *JAMA*, which has one of the highest impact factor scores of any journal on the ISI databases, and it has been cited 114 times. No specific funding acknowledgement to the IMP is given in the *JAMA* article, and, as a result, it is not included in our tables.

Other projects funded by the IMP went to researchers who also were concurrently and subsequently conducting various similar pieces of work. While the above analysis of publications has attempted to identify those most specifically associated with the IMP, it is clearly the case that their IMP project should not be entirely divorced from the wider body of work of such researchers. Examples of such projects include IMP 15-9 conducted by Martin Eccles and IMP 3-16 by Adrian Edwards. In the latter case, the overall body of work included an editorial in *JAMA* (Edwards and Elwyn, 1999).

3.2 Further research

A total of 15 further projects conducted by researchers who had previously been funded by the IMP were seen as in some way following-on from their IMP project. The grants for the 10 where figures were given in the questionnaire total over £1.3 million and some are substantial follow up pieces of research to that funded by IMP. One example is the £339,000 MRC funded study for Nicky Cullum and colleagues to build on the work conducted in project IMP 2-11 on nurses' use of research.

Table 3.3 shows the number of follow-on grants, and their value, broken down into 3 categories describing the contribution of the IMP project to securing the subsequent grant--considerable, moderate, small.

Table 3.3: The importance of the IMP project to securing further research funding

	Considerable	Moderate	Small	Contribution not recorded	Combined totals
Number of projects where funding known	3	4	3		10
Total amount awarded in each category	£678K	£576K	£60K		£1,314K
Number of projects where amount of further grant not stated	2	2		1	5
Total number of projects	5	6	3	1	15

Other IMP researchers are waiting to hear the results of applications. At least six other significant projects being conducted by researchers not funded by the IMP were also seen as drawing to some extent on projects from the IMP. The contribution of the IMP project to this work was assessed as being considerable in one case, moderate in two and small in the remaining three.

3.3 Research training

One of the difficulties facing the IMP was reported to be the lack of research capacity in this area. It is, therefore, particularly important to note that at least nine projects involved research training. An accepted indicator of such research training is whether it has led, or will lead, to higher/research degrees (Buxton and Hanney, 1996). The degrees from these nine projects include four PhDs and three MDs—see Table 3.4 below which also shows the level of contribution to the research degree that came from the IMP project.

Table 3.4: Qualifications gained or expected from involvement in the projects

Qualification	Obtained	Expected	Contribution from IMP project		
			Considerable	Moderate	Small
MSc	1			1	
MPhil	1		1		
MD	3		2	1	

PhD		4	2	2	

CHAPTER 4: DISSEMINATING AND USING THE RESEARCH FINDINGS

4.1 Dissemination

This evaluation was asked to comment on the lessons that could be learnt about communication strategies for research programmes. As discussed in Chapter 6, the rush to identify topics and commission studies meant that only limited thought was given to a dissemination strategy for the IMP and the subsequent history of the programme meant there was no co-ordinated approach to dissemination. Nevertheless, many of the researchers have been active at an individual project level in disseminating their findings. Indeed, much of the publication activity described above is part of the dissemination process. Table 4.1 below shows the figures supplied by the lead researchers about the presentation of findings. More attention was given by research teams to disseminate findings to practitioners/service users than to academic audiences. The figures for presentations to practitioners/service users include 40 given by Angela Coulter and team about project IMP 4-13, and 20 by the researchers on the *Informed Choice Leaflets* project.

Table 4.1: Conference/workshop presentations based on the research findings

Audience	Number
Primarily academic audiences	92
Primarily practitioner/service user audiences	104

Examples of the quality of some of the presentations were reported by lead researchers. These include the presentation, *An expert at your fingertips,* given by project IMP R2-34 which was rated as the highest quality abstract at the Society for Social Medicine Conference 2002.

Dissemination and its analysis, however, is a complex matter. Previous evaluations have shown that it is possible to gather much data about dissemination and then be uncertain what to do with it (Buxton *et al,* 1999). As the classic article by Knott and Wildavsky (1980) asked, 'if dissemination is the answer, what is the problem?' They and others (see Lavis, 2002) show that a large amount of dissemination does not necessarily lead to uptake. Therefore in this evaluation, in addition to collecting information about total dissemination efforts, we ~~made a specific focus~~ focussed specifically on dissemination that seemed to assist with impact. Ten projects suggested that liaison with potential users before starting the project was a factor in

actual or potential utilisation of the findings, and nine of these also thought that liaison during the project was relevant. Similar views were also expressed by interviewees. Further examples are described below in the discussion on impact.

4.2 Utilisation of the findings

The Advisory Group's report stated that, 'the overarching need was to identify research which was likely to provide the greatest payback to the NHS' (Department of Health, 1995, p.16). At one level these issues were addressed and the review of project files revealed extensive claims about both the potential users and the benefits that could flow from the projects. Similarly, when completing the questionnaire, the lead researchers were generally willing to answer the question about who, when the research was commissioned, were seen as potential users of the research. Interviews with CG members confirm that some consideration was given to these matters as applications were considered.

Things become more difficult when we move on to consider the actual value of the IMP, which, as already noted, was part of the brief originally given to the CG. At an overall level, many interviewees suggested that the IMP had raised awareness of the need to improve the implementation of research (in general) in the NHS, and indeed this was one of the reasons why so many participants were keen to be involved with this programme. Quantifying such awareness and in particular identifying actual use of the IMP findings themselves are more problematic. Partly this is a matter of the timing of the evaluation and this issue is addressed in the final section of the report. It also, however, reflects more fundamental difficulties related to the problems of actually achieving research utilisation, especially from individual projects. Furthermore, various interviewees felt that a systematic attempt at identification of potential users of the IMP was not something that had received a great deal of thought during the work of the Advisory and Commissioning Groups. Several interviewees could see the paradox of the whole exercise being so intense, in terms of identifying priority topics and commissioning projects, that they could not give sufficient thought, at the overall level, to the implementation of research on research implementation.

In general, as in other studies, more lead researchers claimed in the questionnaires that there was a possibility of future impact than were able to state that there had already been impact. This is shown in Table 4.2.

Table 4.2: Lead researchers' opinions about the existing and potential impact of their research (n = 30)

Type of impact	Answers from questionnaires			
	Yes	No	Don't know	Blank
Already impacted on policy	9	15	2	4
Expect to impact on policy	16	11	0	3
Already impacted on practice	8	12	5	5
Expect to impact on practice	17	5	1	7

The proportion of projects where the lead researcher is claiming that the project has already made some impact, or is likely so to do, is compared on Table 4.3 with the figures reported in the evaluations of the North Thames research programme (Hanney *et al*, 1999) and other national R&D programmes (Wisely, 2001a and 2001b).

Table 4.3: Proportion of lead researchers claiming an impact on policy and practice in four R & D programmes

Type of impact	North Thames (Hanney *et al*, 1999)	Primary/ Secondary Interface (Wisely, 2001 a)	Mother and Child Health (Wisely 2001 b)	Implemen-tation Methods Programme
Already impacted on policy	41%	35%	27%	30%
Expected impact on policy	65%	54%	68%	53%
Already impacted on practice	43%	27%	31%	27%
Expected impact on practice	63%	48%	44%	57%

Any measure such as this is extremely crude and will be influenced by the time elapsed since completion of the projects. While there are problems in relying on self completion questionnaires, in the example of the North Thames regional R&D programme the figures reported by researchers in questionnaires were consistent, at an overall level, with the picture revealed by case studies of a selection of the same projects (Hanney *et al*, 1999). Despite the somewhat unusual nature of many of the IMP projects, and the relative newness of the whole field, the figures for perceived impact are very much in line with those reported by the other national programmes. It seems reasonable to assume that the researchers in the IMP are more likely than most to focus on implementation, but are also more cautious in their expectations.

In some cases the impact from the projects in the IMP is as yet rather tentative, as illustrated by the details given below. The first three examples describe impact in the services provided by the respective research teams, or during the research project, but where the expectation is that impact will be wider. The next three all describe more widespread impact, but in each case there is an important point to note in relation to the dissemination of the findings:

- IMP R2-25, on improving nursing practice and outcomes, gave quite explicit examples of change that had occurred in the trial sites and further impact is expected.
- IMP 2-11, on nurses' use of research information in clinical decision making, has influenced various courses or educational programmes provided by the researchers at the University of York.
- IMP 3-5, on communicating risk reduction to patients and clinicians in the secondary prevention of ischaemic heart disease, produced findings that have directly informed the strategy of the clinical effectiveness group based in the department from which the research was conducted and perhaps have had a wider impact.
- Researchers from the *Informed Choice Leaflets* project have had communications from Heads of Midwifery units about their use of the research to improve dissemination of information to clients. Furthermore, in discussions midwives have told them that the research has influenced their practice. The claims about impact from this project are supported by evidence from the questionnaires described in the next chapter.
- IMP 19-15, on the injecting drug taker and the community pharmacist, is claimed to have made an impact on Department of Health recommendations of involvement of pharmacists in supervising consumption of methadone by opiate addicts in treatment, and on practice in this area. Two members of the project team were members of the Department of Health Working Group that produced new guidelines.
- IMP 4-13, which analysed a range of information leaflets given to patients, has already been described as the project with the most highly cited publication and with the largest attempt to present findings to potential users. It is claimed that this project was used by the British Heart Foundation to re-write their leaflets. In interview, a member of the Commissioning Group referred to the project's findings also being used by another organisation.

It is worth stressing that in each of the last three examples above, the utilisation is facilitated, at least in part, by an important aspect of dissemination. As noted, these aspects include: talking to those most likely to be directly implementing the findings and publishing extensively in the journal most relevant to the profession (*Informed Choice Leaflets*); serving on the relevant departmental working group (IMP 19-15); and talking to many professional groups and publishing a reader-friendly book (IMP 4-13).

Furthermore, the lead researcher of project IMP5-40, on uptake of effective practices in maternity units, describes how although the project has only recently had its main article published, there are reason for expecting utilisation of the project's findings. A very blunt editorial accompanied the article in the *International Journal of Quality in Health Care* and called for action based on the findings. There has also been considerable press coverage of the project. The lead author suggests that interest from the public is also likely to put pressure on mangers and professionals, and claims press interest is an indicator of public interest. There have been articles/items about the project in: *The Observer; BBC Radio 4's Today Programme; ITV's News at Ten; BBC World Service;* and *Radio Vancouver.* This project was included in our questionnaire to Heads of Midwifery and researchers in perinatal care. Despite its recent publication in a journal that might not necessarily have an enormous readership amongst midwives, it was still known by 26 of the 100 respondents - though some of these were sites where the project was conducted.

Several lead researchers claimed that their findings, sometimes negative, should be taken into account in current policies and practice to a greater extent than was probably happening. It was further claimed that several projects came up with negative findings because of the greater rigour in these IMP projects than in some previous assessments of the various implementation approaches analysed. But it is widely recognised that the uptake of negative research findings is particularly problematic. These points strengthen the case made later for suggesting further work, such as a synthesis, is required to enable this programme to achieve its full potential impact. This line of argument is further strengthened by the figures on Tables 4.4 and 4.5. These show that as individuals the researchers had some awareness of the work of other projects, but that, as yet, being part of a programme has not been seen as being particularly important by most lead researchers.

Table 4.4: Response to questions about giving attention to any other projects from the programme (n = 30)

	Yes	No	Blank	Total number of projects read or presentations attended
Read results of other IMP projects?	14	11	5	29
Attended presentation about other IMP projects?	5	20	5	10

Table 4.5: Response to question about how far the fact that the project was part of a programme had any impact on the project (n = 30)

Degree of impact	Number
Not at all	10
A little	8
Moderate	2
Considerable	5
Extensive	0
Left blank	5

4.3 Impact on potential users

As described in Chapter 2, four questionnaires were devised and sent to potential users. Each was in an area where several projects could be combined to provide material to form a questionnaire. (See Appendices 4-7 for details).

There were three different electronic versions of the questionnaire and these were sent to 535 email addresses. Just 22 responses were received overall, and some of the replies from the shared decision making bulletin board were from overseas. The combined figures are shown in Table 4.6 below:

Table 4.6: Total figures from three electronic questionnaires to groups of potential users

	Number	% of those returned
Questionnaires distributed	535	
Questionnaires returned	22	
Knew about IMP	9	41%
Heard of at least one project	19	86%
Read an article from at least one project	18	82%
Findings from at least one already influenced:		
a) clinical practice	3	14%
b) research	10	45%
c) teaching	11	50%
Findings from at least one project will influence:		
a) clinical practice	9	41%
b) research	14	64%
c) teaching	14	64%
Findings from at least one project have/will have influenced others	15	68%

While clearly the response rate is too low to make any generalisations, and may itself partly be a reflection of lack of knowledge about the IMP, the replies do provide illustrations of instances where there is already some knowledge about the projects and some use being made. Furthermore, various interesting observations were made. Scepticism was expressed in some questionnaire responses, as indeed it had been in some interviews, about the practical use of some of the research projects, including some of the RCTs. Nevertheless, several of the shared decision making researchers who responded were positive about the contribution of the projects to their field. Four projects were included on that questionnaire: IMP 4-21; IMP R2-34; IMP 4-13; and IMP 3-16 (see Appendix 6 for details). One of the respondents from the USA wrote: *"These are very important studies that lead the field. Number 2 [IMP R2-34] deserves a special comment. Among the studies included it pushes the envelope the most...it will be important to have it widely discussed."*

This response is compatible with our emerging conclusion that the programme is making a positive contribution to a field that is now more clearly recognised as requiring further and wider work.

In an attempt to obtain a better response rate, a postal survey was sent to 207 Heads of Midwifery and 20 university researchers in perinatal care. A summary of the figures from the 100 out of 227 questionnaires returned (44%) is shown in Table 4.7 below.

Table 4.7: Total figures from postal questionnaire to Heads of Midwifery and university researchers in perinatal care

	Number	% of those returned
Questionnaires distributed	227	
Questionnaires returned	100	
Knew about IMP	35	35%
Heard of at least one project	80	80%
Read an article from at least one project	68	68%
Findings from at least one already influenced:		
b) clinical practice	54	54%
b) research	8	8%
c) teaching	20	20%
Findings from at least one project will influence:		
a) clinical practice	73	73%
b) research	14	14%
c) teaching	24	24%
Findings from at least one project have/will have influenced others	73	73%

The response rate is clearly not sufficiently high to provide figures that can be viewed as properly representative. Nevertheless, they do suggest that there is a reasonably high level of knowledge about the projects. In particular, the project on *Informed Choice Leaflets* was known by more than half of the Heads of Midwifery who replied, and most of them had read at least one of the articles about it.[2] A few respondents pointed out that the questionnaires themselves had provided a good means of disseminating information about these projects. In reply to question 9 that invited comments on the IMP, the following points were made:

"Needs to be more widely communicated to ensure readership and awareness. Quality newsletter circulated. NB. I have retained the articles to discuss with midwives."

"I am very impressed with this questionnaire approach, since it has raised my awareness – and I considered myself to be quite aware of R&D etc."

"I think it needs more publicity."

"I was unaware there was such a programme. This is unfortunate as the research quoted is very interesting and could positively inform practice."

Given the widespread knowledge about some of the projects, and comments such as those above, it seems reasonable to suggest there is quite a considerable interest within the midwifery profession in the implementation of research findings. This interest would also appear to follow through into practice. About half the respondents claimed that their clinical practice was already being influenced by the findings of some projects, and about two-thirds thought this would be so in future.

One of the problems when interpreting the level of existing and potential impact is the question of what exactly is being referred to when discussing impact in relation to projects from the IMP. It is possible that replies to the questionnaire from some respondents related to whether they had been directly influenced by the existing research on the substantive topic, rather than whether they had been influenced by the conclusions of the IMP project, which examined ways to encourage the implementation of this existing research. Nevertheless, 44 midwives thought that the findings from, for example, project IMP 5-40, on the uptake of effective practices in maternity care, might in future be used in their unit to influence clinical practice. There is also an issue of generalisabilty here (and discussed further in section 6.8). This concerns whether the IMP projects will have an impact in terms of showing how the uptake of research in general can be enhanced, or whether the impact is limited to the implementation of findings from specific research applied in specific contexts.

Other midwives explained why the findings of the IMP studies would not impact on them. One, for example, expressed opinions also shared by others and stated in relation to the three projects respectively (see Appendix 7 for details): *"no IT system available"* for touchscreen information; *"policies in line with recommendations already"* about project IMP 5-40; [informed choice] *"leaflets too expensive-no budget".* It is worth noting that the leaflets are now available on the web, which illustrates the almost constantly changing situation in which this type of analysis of implementation is conducted. Furthermore, the full complexity of the issues is revealed by one respondent who took a rather different view and commented that the *Informed Choice Leaflets* project *"has possibly reduced evidence based practice – it discouraged managers from buying the leaflets".*

Drawing together the discussion in this chapter suggests that there has been effective communication of the findings from various projects. In some cases dissemination to key potential users, and previous liaison with them, seems to be linked to a degree of utilisation of the findings. The evidence from the user

questionnaires is consistent with that of most interviewees that the programme is less well known than individual projects. As we have seen several respondents to the questionnaire argued that it was a pity that the IMP had not received more publicity. At one level, of course, it might not really matter that people are not aware of the programme so long as the projects are making an impact. There is some evidence, however, from previous evaluations of national NHS R&D programmes that researchers felt their project gained more credibility and attention from being seen as part of a national programme (Wisely, 2001a and b). It seems feasible to argue that such benefits could be extended through a communication strategy. Indeed, Wisely noted the comment from one researcher in the Mother and Child Health Programme that a concurrent Department of Health programme was adopting a useful model of having all the researchers meet annually and there were plans to draw together messages from all 12 funded projects (Wisely, 2001 b).

Furthermore, there could be an argument for claiming that the IMP would have benefited even more than other programmes from a communication strategy. In other programmes, many of the projects are often in a specific medical field and their findings could be appropriately presented at the same routine conferences and meetings. This might give such programmes a high profile within the relevant research/practitioner networks and communities. No such avenues were available for collective presentation of the disparate projects in the IMP.

As far as we are aware, our questionnaires to potential users mark the largest aggregation of work from the programme, apart from the programme report in 2000 and the web site. The comments quoted above from some midwives suggest there would be support from potential users for greater dissemination of information about the programme. In later chapters of this evaluation, comments from interviewees and lead researchers are brought together to demonstrate that the IMP could have benefited from a proper communication strategy and would still benefit from some collective work.

CHAPTER 5: COMPARING APPLICATIONS WITH OUTPUTS

5.1 Undertaking the comparisons and the difficulty of doing so

An attempt was made to compare the grades given to applications at the commissioning stage with the outputs from the projects. The purpose of this exercise was to see whether it threw any more light on the commissioning process. The performance of peer review 'has seldom been evaluated systematically', but one major study of 2,744 projects funded by the Spanish Health Research Fund concluded that, 'peer review scores of grant applications were significant predictors of performance of funded projects' (Claveria *et al*, 2000, p.11). Previous evaluations of NHS R&D programmes had attempted to undertake a comparison between applications and outputs (Wisely, 2001 a and b).

For the exercise described here, as part of the evaluation of the IMP, the scores originally given to applications by reviewers were put onto a common scale of 0-10. Inevitably, given that these were the funded projects, the scores are generally quite high. In the review process for the short applications each project had been scored only at an overall level. The full applications had been given a score for quality and another for relevance.

The original reviewers of the final project reports had been asked to score the report according to quality and relevance. These scores were used as the primary source of the scores for outputs given in the evaluation described below. For several reasons, however, other information was also used. First, the passage of time and the response to our questionnaires to lead authors meant that for many of the projects more information was available than had been to the reviewers. Therefore, we sometimes made adjustments, based on the criteria set out below, to the scores the reviewers had originally given to the final reports. Second, not all the project reports had been given scores—in some cases there were only comments. If possible, where there were no existing scores for project reports, we gave scores solely on the evidence that became available during the evaluation, again using the criteria set out below. In these cases, the score was not based on reading the end of project report.

Additional factors taken into account in deciding on the scores to be given here for the quality of the outputs include: the number and type of publications; the impact factor score of the journals in which articles appear; and the citations achieved. In relation to relevance, attention was given to the comments in the questionnaire from lead

authors about the impact, or potential impact, of the projects. Negative findings present a complication because it is often more difficult for such findings to be published and make an impact. This in no way reflects on their quality or their potential relevance. Therefore, in this assessment, where projects had resulted in negative findings that were not necessarily being implemented, credit was still given if the issue seemed to have relevance. Although the procedures described above involved an inevitably subjective process, in some ways it perhaps allowed greater consistency of comparison to be achieved between the projects.

Various difficulties confronted our attempt to compare the portfolio of projects in an overall way that would allow analysis of how far the scores at commissioning stage predicted eventual success. In the new field covered by the IMP, various interviewees mentioned the difficulty of finding experienced peer reviewers.[3] One interviewee commented that of all the commissioning groups of which he had been a member, this was the one in which the scores given by reviewers varied the most. Several interviewees reported strong differences of opinion between members of the Commissioning Group about the quality of the applications, as well as their relevance to the NHS. In addition to the difficulties referred to above, other difficulties included:

a) The scales used for grading applications differed from those used for scoring the final reports.
b) Some lead researchers did not return our questionnaire, and others only partially completed it—and some projects are not yet complete.
c) One project—*Informed Choice Leaflets*—was given a score for its report, but not for the application, which was handled by the joint funder.
d) The time since the projects were completed varies enormously, thus giving different amounts of time for impact to have occurred.
e) There is great diversity within the field and between the types of projects funded.

As a result of these difficulties, at this stage we feel able to present the comparative scores for just 19 projects, as described below.

5.2 The scores for applications and outputs

Tables 5.1 and 5.2 show the scores for applications and outputs for the 19 projects on as comparable a basis as possible. The scores for the applications are based on the originals, but irrespective of how many scores were given to the applications all have been presented using a common scale of 0 -10. The scores for the outputs represent the judgement made in this evaluation, as described above and again presented on a

scale of 0 – 10. The scores from the original reviewers of the research reports are given in brackets where available and they strongly influenced the score given in our evaluation. Those with question marks indicate there was a score from one reviewer and a comment, but no score, from another.

Table 5.1: The scores given to applications and outputs from projects funded using the short application method

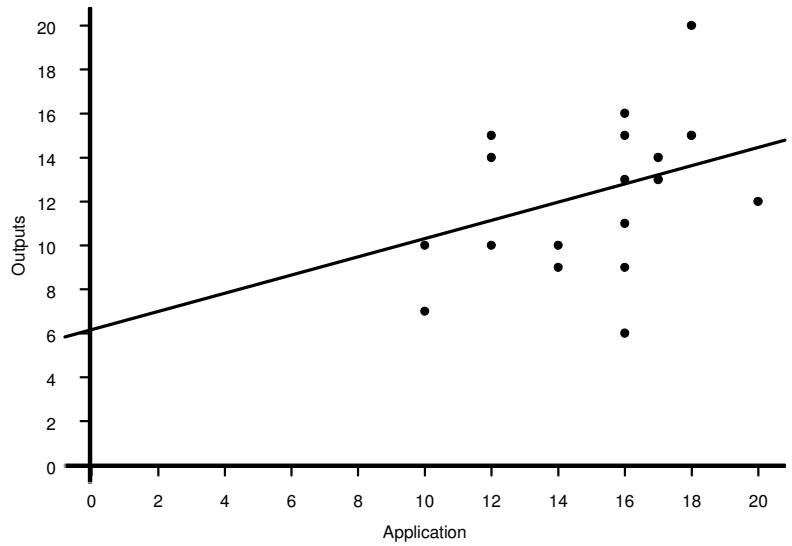
Score out of 10 for application	Scores out of 10 for outputs	
	Quality (original score from reviewers)	Relevance (original score from reviewers)
9	10	10
8	7 (8)	9 (9)
8	7 (6)	8 (7)
8	4 (5)	5 (5)
8	3 (3?)	3 (3?)
7	5 (4?)	5 (3)
7	4 (5)	5 (6)
6	8 (8)	7 (7)
6	8	7
6	3	7
5	6 (6)	4 (4)
5	4 (4.5)	3 (4?)

Table 5.2: The scores given to applications and outputs from projects funded using the full application method

Scores out of 10 for application		Scores out of 10 for outputs	
Quality	Relevance	Quality (original score from reviewers)	Relevance (original score from reviewers)
10	10	7 (7)	5 (5)
10	8	7 (7)	8 (8)
9	8	8 (8)	6 (6)
9	8	7 (8)	6 (8)
9	7	6	7
8	8	6 (5)	5 (5)
8	4	7 (8)	7 (8)

Figure 5.1 plots the correlation between the scores given for applications and those for outputs. The application scores taken from Table 5.1 have been doubled to allow the level of correlation to be presented for the two sets of figures combined. The degree of correlation is quite small at 0.34.

Figure 5.1: Correlation plot for applications and outputs combining both application methods



Correlation for figures from Tables 5.1 and 5.2 combined = 0.339 (Some evidence of correlation between scores). Simple (ordinary) correlation calculation was used. The line of best fit is shown. There are two projects with a score of 12 for the application and 15 for the outputs.

The difficulties facing this exercise place strong limitations on any conclusions that can be drawn. There are, however, some indications that, unlike in previous such exercises (Wisely, 2001a), it is not necessarily the projects getting poorer scores that are the ones where the lead researcher has not returned a questionnaire. In general, perhaps, it is reasonable to suggest that the results from the exercise are broadly consistent with two main themes emerging from our evaluation. First, some good projects were funded as part of the IMP, but others were much less successful. Second, enormous complexities confronted those tasked with determining the topics and projects most likely to lead to relevant and quality research in this field. This issue is examined in detail in the next chapter.

CHAPTER 6: LESSONS LEARNT ABOUT THE COMMISSIONING PROCESS

6.1 Introduction

The IMP was the last of a series of time-limited national programmes established by the NHS R&D Programme. Previous time-limited programmes had dealt largely with clinical subjects such as mental health and cardiovascular disease and the NHS R&D Programme as a whole was still, as one interviewee noted, *"very clinically dominated"*. The dominant research methodologies were randomised controlled trials (RCTs) and systematic reviews - widely perceived as the gold standard. Another interviewee noted, *"the notion of diversity of evidence was probably going through its lowest point at that time".* The model adopted in the NHS R&D Programme to set priorities and commission research reflected all this. The main emphasis was on providing good quality information on the effectiveness of clinical practice, seeking to identify interventions that could be assessed through RCTs.

Those who established the IMP were aware that it was a different type of field from those previously covered in the NHS R&D Programme. The group reported that, 'this is a complex field spanning a wide range of behavioural, social science, management, science policy and health service research interests' (Department of Health, 1995, p.6). This view was reinforced during consultation on the priorities. One key respondent warned of *"the need to think beyond the acute medical field with an emphasis not just on medical research but on health services research"*. The Advisory Group (AG) and the Commissioning Group (CG) were established with people from a broader range of disciplines than usual, and an set of wide-ranging background papers was commissioned for the AG. This was productive: *"It [IMP] opened up discussion about the relationship between clinical/other research and practice in a helpful way".*

However, many interviewees also mentioned their initial naiveté about the difficulties they faced, and stressed the amount they themselves learnt in the process:
"I think at the time we felt we knew a lot more than we now realise we did."
"For big new areas like this, one needs to have a good deal more humility about what the experts brought in know, and what the research community out there might have to offer."

And, despite extensive interdisciplinary discussion in both the AG and the CG, what one interviewee described as a *"clinical tendency"* remained within the IMP. This had

an impact on priority setting and on the research finally commissioned, although at least one interviewee suggested there had been insufficient clinically oriented work.

Those interviewees who were on both groups had difficulty separating what happened in connection with which group after all this time. A complicating factor was that there was another group as well, a Steering Group set up to oversee the large collaborative trials that it was initially expected that the IMP would commission, which met once in June 1995 and was disbanded later that year. There was cross membership between this group, the AG and the CG. The following analysis does not therefore seek to look at lessons that might be learnt from each group separately, but rather at what can be learnt from the IMP as whole.

6.2 Context – what influences were there on the Implementation Methods Programme and how important were they?

a) In the NHS

Influences identified by interviewees and in IMP background papers included:

- the internal market, the perceived need for an *informed* market, and the new element of competition that the market had introduced into the service;
- the newness of commissioning (services) and GP fund-holding, and the fact that 'at the time there was considerable emphasis on the role of health authorities in managing the healthcare resources for local populations through effective commissioning' (Evans and Haines, 2000, p. xiii).

Opposing views were expressed about the impact of these influences. Managers thought them important, saying that purchasing was what drove the IMP: *"...why are we buying more if we don't know that it works?"* Researchers played them down: the NHS context "*was a very, very background influence".* The actual outcome of the priority setting exercise supports the second of these views. There was some emphasis on commissioning (of services) among the priority areas selected (numbers 6, 7 and 8), but the many other topics selected indicate that the NHS context was only one of a number of general influences at the time.

A more important and more long-term influence identified by several interviewees was the chaos and change in the NHS. Optimistically, members of the Commissioning Group thought at the time that *"that was settling down".* This has not happened, and, as more than one interviewee pointed out, continuing change remains a key impediment to the successful implementation of research in the NHS -

"constant institutional change makes it difficult to get research about getting research into practice into practice".

b) In NHS R&D

Within the NHS R&D Programme the UK Cochrane Centre and the York Centre for Reviews and Dissemination had recently been set up. The existence of these centres had led to pressures to say what was happening to all the research they were collating and analysing. A related pressure was the evidence-based medicine movement, with its emphasis on individual clinical practice. As one interviewee noted, a key influence was *"the importance of implementing research <u>because</u> of the R&D Programme"*. Implementation was a hot topic. There were considerable pressures to get some implementation research commissioned quickly, with the AG noting that, 'The CRDC was anxious to take forward work in this important area without delay' (Department of Health, 1995, p.12).

As one of an ongoing series of NHS R&D time-limited national programmes, there was an expectation among AG and CG members that the IMP would follow the pattern of previous programmes, i.e. it would last for 4 to 5 years with more than one round of commissioning, there would be continuing involvement of the CG, and some time for reflection. The terms of reference of the CG (and of the short-lived Steering Group set up to oversee large scale collaborative trials) mention a five year programme. This expectation influenced priority setting and the first round of commissioning. In the event, as noted in our introduction, funding for the IMP was capped shortly after the first round of commissioning, and the CG was disbanded.

6.3 An innovative programme – understanding implementation

Many interviewees noted the challenge, and excitement, of getting to grips with such a key area for the NHS and for NHS R&D: *"It was cutting edge stuff, nowhere else in the world was doing much, let alone commissioning a programme of research on implementation"*. But there was a price to pay for this frontier approach - "*we hadn't really felt our way into doing this sort of research"*. Some AG members interviewed said that they thought at the time that the IMP would provide clearer, more definitive, answers than proved to be the case. But not all AG members were, even then, so sanguine. One had appreciated from the start the difficulties faced: "*perhaps we needed to do a bit more thought on the complexity that we had unravelled before necessarily commissioning all the work"*.

To support the priority setting exercise there was a consultation exercise, several commissioned papers, and four workshops run by AG members. A mapping exercise was undertaken to provide a conceptual framework for the AG. There was an awareness that in reviewing research need the AG should not be:
'too mechanistic, focussing on particular techniques and methods of implementation in isolation. R&D was needed to understand the process of implementation within the working environment of the NHS as well as to evaluate particular interventions. Study design would need to allow for these complex interactions, within and between organisations, professional coalitions and individuals' (Department of Health, 1995, p.23).

In addition the AG incorporated members from a wide range of disciplines, albeit with a heavy concentration on people from the health service. In all this the intention to be wide-ranging and innovative is clear. But did the IMP go far enough?

The research framework described in the AG's report makes it clear that the research approach of choice within the programme was the RCT, although the importance of descriptive and observational studies 'in identifying how and why individuals and organisations behave' (Department of Health, 1995, p.17) is also acknowledged. The conceptual map of the field in the same document draws on an understanding of implementation, provided by one of the background papers, as 'processes which aim to improve targeted clinicians' compliance with research based recommendations' (Bero *et al*, 1995). The focus of this was on interventions to change individual clinical practice. Several interviewees pointed out that this now seems rather reductionist.

The key question here - one raised by more than one interviewee - is whether *all* the relevant background disciplines available to the AG were adequately taken into account in setting the priorities: *"given what was known in other areas at that time, does this* [set of priorities] *reflect what was going on in those other areas"*. A related question is whether all the relevant background disciplines were adequately taken into account in commissioning the research: did the research approaches commissioned reflect the full range of methods then available in all those other areas?

Some interviewees from social science backgrounds were clear that this was not the case. One mentioned the lack of underlying theoretical orientation behind the topic areas, suggested that there should have been a reference to the broader theory that

was available at the time, and cited a paper contributed to the AG which had little apparent impact at the time. And with regard to acceptable research approaches the interviewee noted that for the CG *"The template was the double blind control trial….that restricted the kinds of studies that could be conducted and the kinds of answers that could be developed from the research"*. This interviewee was clear that key messages from social science disciplines were not fully assimilated, and the research approaches of these disciplines were not fully appreciated.

Could it have been different then? It takes time for research and knowledge to advance and to understand the challenges of new areas: *"These things take years often, before they settle in your mind"*. And since then understandings *have* changed. Looking back many interviewees now feel that neither group fully got to grips with the complexities of the field. Two comments illustrate this:

"…there was too much 'does this work?', 'does doing guidelines work?' rather than 'what are the processes by which these things happen?' and so on. So I think that we went too fast on those things and I think it was rather dominated by the rather clinical agenda – 'here are a set of interventions/approaches, let us evaluate them' type of thing."

"It is unlikely that these type of questions will in general be answered with 'if you do this then you'll get that' answers. It is more about, 'if you have the following understanding you're more likely to be able to put together things that'll work'…..in some ways the idea of producing results and implementing them is just not the right model. A more evolutionary approach saying 'we scrape away at the questions and we develop better understanding and that moves through into better implementation of evidence in the system' is probably a better model of the world to be holding than this rather more 'find out the facts, do the implementation, the implementation happens, happy healthy people'."

But the general view is also that in setting the priorities the AG worked well, and maybe went as far as it could *at that time*, especially given the time constraints under which it operated. One interviewee commented:

"…it could be that given our knowledge of the time, let's consult and find a whole series of areas, a scattergun approach, and some of the areas do seem sensible but others less so, and let's just see who comes up with good projects and go for it and try and get some flowers to bloom".

And certainly at the time there was a view among the AG that more might be learnt from the next stage, the commissioning process. One member noted that the AG had discussed the methodological implications of many topics but "*we didn't necessarily decide how we wanted to resolve them….maybe we were expecting the researchers to do more of that developmental work"*.

And at the time there was, also, awareness that this first priority setting exercise was only a start. It represented 'the beginning, rather than the end, of discussion on the best ways of evaluating methods to promote the implementation of research findings in the NHS' (Department of Health, 1995, p.23).

In summary, the IMP was a new programme in a new field, raising new and difficult challenges for the NHS R&D Programme and for the associated research community. In retrospect perhaps too much was expected too fast. Complex areas such as this, involving a wide range of disciplines, would benefit from more preparatory work, lower initial expectations - especially as regards the pace of the programme, and an ability to re-visit and learn from early results.

6.4 Consultation

The AG followed the standard NHS R&D practice of sending an open letter to about a hundred organisations, and also approaching purchasers and providers in the service. Responses were collated by the secretariat and presented to the AG. The intention was to identify NHS research needs. Many interviewees made criticisms of this process, others failed to remember it at all. One problem identified was that some of those consulted failed to understand the nature of this new field of research, and responded with suggestions for more research on clinical interventions. Another was that such exercises failed to reach grass roots workers in the service: *"swathes of the NHS…are disenfranchised from it"*. And those at the receiving end felt that such exercises were *"almost a waste of time…it disappears into a black hole".*

With hindsight the AG secretariat suggested in a briefing note that 'in a difficult area like this' a more selective consultation is needed, possibly using focus groups to which the nature of the area could be explained in advance. This approach was in fact used in the AG workshop to discuss consumers as a lever for change, and was thought to have worked well and led to the publication described above (Oliver *et al*, 1998).

More fundamental criticisms of such consultation exercises were also expressed. It was felt that they compound what is researchable and where research need lies, with where need lies in the NHS. The tension between the perceived need for general participation and openness in setting the research agenda, and the equal need for informed opinion about the nature of big questions in a complex area was also mentioned. One remedy now suggested by the former chair of the AG, Andy Haines, was to link the setting of a research agenda for implementation studies to a descriptive qualitative research project to identify the important decisions that people in the service are making at local level in terms of practice or organisation and why they fail or succeed, and whether there is any research evidence for those decisions.

In summary, therefore, the approach adopted to consultation in the IMP was generally thought not to have been entirely successful. A tension between getting good informed opinion about research need and also ensuring full participation of all stakeholders was identified. One remedy would be to link research topic priority setting to an examination of actual NHS decision-making about how to implement change.

6.5 Setting and developing the priority areas – did the IMP attempt to be too broad, too ambitious?

Following the pattern adopted by other NHS R&D Programmes, the AG set 20 priority areas. Many interviewees, including some who had been involved in earlier programmes, thought this was too many. One talked about *"the enormous canvas on which we painted"* and matching that to the research capacity available. Others noted that *"we cast our net too wide"*, and that *"ideally what you'd do is do a few and build it up… throwing so much money into an area where there is a relatively small community was not ideal although it was the way that R&D programmes had to work at the time".*

There was also considerable variation among the topic areas. Many interviewees noted that there were some areas in which it had been possible to be clear about what was needed and what research approaches might be used, other areas where more exploratory work should have been done, and some where it might have been too early to fund anything. As one said: *"Some clear priorities…there were lots of other areas where probably not enough was known to know what the priorities were…".* This interviewee expressed concern that this had led to a bias: *"…so I felt as a consequence the agenda was dominated by what a small number of people who*

were immersed in the area thought was the primary research agenda", and suggested an alternative approach: *"...if we had the time again I would like to see a mix of very specified funding where there was broad agreement that these were major objectives and then some much more open and phased funding to allow more exploration of what the major issues were"*.

But in this new field, it is not clear that it would have been possible to identify exactly which priority areas needed this additional initial work *before* the first round of commissioning. As noted above, one interviewee pointed out: *"maybe a scattergun approach was the only way forward at the time"*. The first round of commissioning revealed a huge amount of information about the available research capacity and about the general difficulties of the field. Much of this was distilled in the 1996 CG paper that was intended to inform later commissioning in exactly the way suggested above. This was published in the 2000 programme report (Eccles, 2000).

Other constraints on a more deliberative approach were the pressures to get some research in place quickly, mentioned above, and the fact that IMP was a time-limited programme. There was a general view at the time that, having got a budget for research in this field, it was important to get something in place, to make a start. And, as more than one interviewee pointed out, the fact that the funding for the programme was capped and there were only two rounds of commissioning, justifies this approach in retrospect.

It also raises another question: if the AG had known that the programme was to be capped would it have set the priorities it did? The interviewee who raised this issue thought that this *might* have made a difference, but neither he nor any of the others interviewed speculated further on the nature of that difference. What we do know is that, as reported above, several interviewees thought that too many priority areas had been chosen. It is, perhaps, not unreasonable to assume that, had it been known at the time that the budget was to be restricted, a more restricted set of priorities might have been chosen. Our only other clue as to the possible impact of prior knowledge of budgetary restrictions is what actually happened after those restrictions had been imposed i.e. the way in which the CG adjusted its plans regarding the second round of commissioning (see section 6.8).

In conclusion, therefore, there was a tension in the IMP, as in other time-limited NHS R&D programmes, between getting on and getting something done versus a more

considered approach. However, in a new area such as the IMP, a careful combination of the two approaches is required. It is not clear this is achievable in a time-limited programme. This suggests the need for a longer initiative in such an important field, possibly as a continuing theme running through the NHS R&D Programme.

6.6 Commissioning Research – composition of the Commissioning Group

The CG took over and advertised the priorities set by the AG, commissioning a first round of research within 6 months. As noted above, the task was considerable. Despite the pressures most interviewees felt that the process was well handled, although they all remember piles of paper.

One issue frequently raised in interviews was the composition of the CG. There was general agreement on the need to involve NHS managers, clinicians and users in setting priorities for the IMP, and therefore on the AG. But some interviewees expressed doubts about the value of some people with these backgrounds on the CG—although in fact others of them did, also, have research experience. Insofar as the task of that body was to assess the quality of the research there was a general view among researchers that this specialised function was best left to the experts, the researchers themselves. Insofar as the task of the CG was also to assess the relevance of the research there was less unanimity about how that should be handled. It was clear that tensions had arisen on the CG when research quality (as assessed by researchers) and perceived relevance to the NHS (as assessed by managers, for example) pulled in opposite directions.

In general the importance of establishing relevance at the commissioning stage was accepted, although one interviewee wondered why, if relevance had already been established at the priority setting stage, it needed to be re-visited. But the more prevalent concern was about doing so in one meeting as one group. One suggestion was to have a separate group of non-researchers acting in some sense as advisors to the researchers on the CG, possibly before the assessment for research quality, possibly afterwards.

A related issue was the mix of the CG. Having one consumer or one clinician among a large group of researchers left that person unsupported, a lone voice who could be ignored, especially if that person was, also, relatively junior. In relation to the IMP, some interviewees thought that a similar problem had arisen for researchers from

disciplines outside clinical research. If their viewpoint was new and strange to the rest of the group, they risked being seen as *"members of the awkward squad".*

We conclude, therefore, that commissioning groups are required to assess the quality of proposed research and its relevance to the NHS, yet those best able to undertake the first task are not necessarily those best able to undertake the second. Their views may clash, creating tensions on the group. We suggest a solution might be to develop protocols with commissioning groups, to be agreed with the group at their first meeting, to cover the role and remit of members, taking into account their differing backgrounds, skills and experience, and defining the group's relations with others brought in to advise the group in any capacity.

6.7 Commissioning research – interaction with applicants

The quality of many of the applications received by the CG was poor. In consequence the CG felt that it was necessary to put a lot of effort into developing applications, helping to build research teams and providing methodological support. Several workshops were held with applicants, and both the CG chairman and several members spent considerable amounts of time brokering these arrangements.

There was general, but not complete, agreement about the need for this work. Those who queried its value pointed to the (sometimes unfulfilled) expectations raised by repeated iterations between applicants and funders, and to the difficulties research teams might experience working to briefs that had been developed for them by the CG. Other interviewees also differed about the nature of this process. Some thought that you should not work with teams who had not already developed a strong methodological understanding; others thought that this was just where you needed to help researchers relatively new to a field. The CG aimed to fund high quality research, and was much concerned about methodological rigour. Much thought went into the development of RCTs, statistical advice was provided, as was advice on economic evaluation. This was regarded by those involved as useful and productive: *"in terms of behaviour change trials and systematic reviewing, it was important in improving understanding of why previous studies were bad, poorly designed, which then limited their interpretation and usefulness".*

However, the tension was, as always, establishing the balance between funding only work of the highest quality and developing the research capacity. Should you, in the

words of one interviewee, *"be prepared to let the excellent be the enemy of the good"* and, if not, in what circumstances?

Concerns were also raised about the timing of CG/researcher interaction. Despite the acknowledged quality of the inputs, workshops for applicants tended to be awkward affairs, with competing teams reluctant to talk in each other's presence. But, equally, several interviewees thought that exploratory workshops earlier in the process might not have attracted the full range of relevant disciplines or all potential applicants.

In summary, therefore, commissioning groups may find it necessary to provide support for research applicants during the commissioning process, especially in areas which are relatively new and/or where the existing research capacity is weak. There are different views about what form this interaction should take. We suggest that, should the need for such support be anticipated by a group, it should be fully discussed by them before commissioning work, and, if necessary, a protocol drawn up. If this approach is adopted, it too should be subject to evaluation.

6.8 Commissioning research – were there any unacceptable biases?

The NHS R&D Programme was young and, as mentioned above, clinically dominated. The IMP was the first programme to look at change and management. Interviewees confirm that there was agreement on both the AG and the CG that a wide range of research approaches was needed in this field. They differed on what this meant. One view was that there was a need to make sure that people with, for instance, sociological skills were there to help those doing trials on guidelines. Another was that there was a need to draw on existing bodies of knowledge in various social science disciplines and integrate them with NHS issues. There was a perceived need to develop qualitative methodologies. Others identified a raft of issues about the development of RCTs: this led to considerable methodological gains, and also to attempts to stretch this approach (too far some thought) to cover the many complex questions raised by the IMP. The IMP did not resolve these debates. But in posing them it did begin to challenge the previous supremacy of quantitative approaches, and in particular the RCT, within the NHS R&D Programme.

In the event, however, many of the first round research projects were systematic reviews or RCTs, or pilot studies for the latter. Interviewees are agreed however that this did not reflect any undue bias towards those approaches. Several reasons were

suggested for the tendency to fund this sort of work. These include the context discussed above - Cochrane/CRD, EBM, and the general clinical orientation of the NHS R&D Programme - and also:

- the poor quality of many of the qualitative applications. These were often submitted by interested clinicians with little or no research training in qualitative research. The opinions expressed in interviews were often consistent with the points made, as we noted in our introduction, in the First Annual Report (NHS Executive, 1996) about the lack, in many applications, of a theoretical underpinning and/or sufficient detail about the proposed analytical approach;
- concerns about generalisability. Research results in the social sciences can have a general theoretical applicability. Interviewees confirm that both groups discussed generalisability, but, as one interviewee noted: *"generalisability of different kinds of qualitative research methods looks at different notions of generalisability: it's the complex view. Rather than saying 'here's a result, use it there', it's 'here is some understanding, understand the problem' kind of generalisability. There was probably a bit of naiveté of what we were looking for in terms of generalisability and that probably pushed towards trying to commission more quantitative, clinical trials type things…because we all as a group knew how you would generalise from those kinds of results."*
- a related *"failure to embrace complexity",* a tendency to go for the known and more mechanistic approaches and not pursue complex questions in unfamiliar territory;
- the need for research teams working in this field to have good links with the NHS. Existing teams of clinical trialists tended to have these links already;
- the fact that, as one interviewee put it, *"medics tend to favour RCTs".*

The three projects funded under the special circumstances of the second round of commissioning were all large trials. At this point the CG was working under considerable pressure to get the remainder of the capped budget allocated, and funded large studies that they thought might make an impact. Interviewees involved in those decisions justified those allocations on those grounds. Whatever the reasons, and whatever their justification, the second round of commissioned research clearly accentuated the clinical orientation of the IMP.

It might be reasonable to conclude, therefore, that the tendency to clinical research that marked the IMP, despite the perceived need at the start to use a full range of

appropriate methodologies, had a number of causes. One that was inherent in the programme itself was the newness of the field; an important external pressure was the time constraint under which the IMP worked. Taken together these reinforce the need for a more measured approach to new fields of work, as already suggested above.

The other bias apparent to an outside observer is the large number of CG members who were themselves funded through the programme. The success rate of their applications was considerably higher than that of other applicants. Concerns about this, both *ante* and *post facto*, were raised by various AG and CG members with the commissioning body. The response was robust: we need good researchers to help us develop this new field, there are very few good researchers available, inevitably therefore some will be on one or both these groups; this does not concern us as long as due process is followed. All interviewees assured us that due process had always been followed, and that such conflicts of interest are common on other commissioning groups. In parenthesis it is worth noting that these experienced researchers were funded in the first round because they were able to develop a good proposal which could be funded in the confidence that it would deliver in a timely manner. Many of the other applications were, as noted above, of poor quality; many required several iterations with the CG. Had the programme not been capped, and had the CG been able to develop the research capacity as they hoped, that additional research capacity would have been available in future rounds of commissioning.

We conclude that due process was followed, and fully recorded, in dealing with the conflicts of interest that arose because CG members also submitted applications to the programme. Where conflicts of interest exist within commissioning groups this should continue to be the case.

6.9 Identifying users and other concerns

The need to identify the potential users of IMP research was clear from the outset. In this field it was seen as particularly important. An AG briefing paper put the position clearly: 'As the AG is concerned with implementation presumably it should set something of an exemplar role in the active communication of its own work'. Yet when we asked interviewees, many of whom are active researchers in this field and therefore potential users of IMP-funded research, if they were aware of the outputs of the programme, the majority were not. And, although individual applicants were

asked to identify potential users for their own work, interviewees had no recollection of discussions on either the AG or the CG about how the findings of the IMP as a whole might be disseminated and implemented.

One interviewee expressed this paradox neatly and speculated on a reason for the lack of discussion:
"As a CG we didn't really embrace the complexity of seeing how difficult it would be to get our findings into practice given that we were in the business of findings into practice." This he put down to: *"the bounded rationality problem that it is difficult enough thinking about the generation of evidence, and then thinking about the application of evidence into complex service settings was something we didn't have intellectual capacity to worry about".*

Then the funding for the IMP was capped, the CG was disbanded and was no longer available to support the programme as anticipated in its terms of reference and eventually the programme was moved from North Thames. Even those who had been most enthusiastic at the outset lost touch with the programme and its outputs. As one interviewee noted: *"…the organisational continuity has gone….there is no memory there*". He continued*: "…the disengagement thing was bad. In retrospect something should have happened around that".*

One result was that the IMP was never able to develop an implementation or communication strategy for its own findings. This is despite the points noted in Chapter 4 about the need for it possibly being greater than for some other programmes.

This disengagement had other consequences as well. One of the lessons from the first round of commissioning was that the research capacity in this field was weak and needed to be developed if further work was to be funded in this field. At that time regional R&D Directorates were developing programmes to enhance research capacity locally through funded fellowships and other schemes. The possibility of engaging with these programmes to develop capacity in this field was recognised. But, following the capping of the programme and the disbanding of the CG, no strategic links could be developed, although some of the funded research projects did support young researchers and provide training on a one off basis.

Similarly the CG was no longer around to continue any work on methodological development - the work that one interviewee had hoped would emerge from the commissioning exercise but which, largely, did not. Nor, collectively, could it contribute to the theory building that many thought was necessary in this complex field. Nor could it assess the value of the IMP, or build on the initial start made by the AG and develop the research agenda in the way envisaged in its terms of reference. Nor could it make strategic links with other NHS R&D programmes to ensure that their approach to implementation reflected its own findings. Nor, most importantly, could it easily maintain what had been a developing role of providing support to the research teams already commissioned. Some CG members did continue on steering groups for individual projects, but there was no overarching oversight. This gap is still apparent today in the time it takes to undertake reviews of some completed IMP project reports.

Finally there was a concern that lessons had not been learnt from IMP. There was a danger of re-inventing the wheel because, as one interviewee put it: *"this* [the IMP] *was a very good bit of SDO* [-type] *work".*

In summary, many difficulties arose once the funding for the IMP had been capped and the CG disbanded. Continuity was lost and there was no-one to establish a general dissemination strategy, liaise with other relevant NHS R&D programmes, or develop the programme itself further. These deleterious consequences might have been avoided had there been no disengagement, but these were not unique occurrences, and point to the need for more continuity in the development of R&D strategies.

6.10 The views of lead researchers

Supplementing the interviews with AG and CG members, the questionnaires to lead researchers also asked for opinions about the commissioning process. Perhaps unsurprisingly, given these were the successful applicants, those who commented generally did so favourably as illustrated by three examples:

"There was a day workshop—the methodological content was excellent and entirely valuable and helpful."

"Jeremy Grimshaw helped refine research questions and suggest an appropriate plan for research."

"We received useful advice from the commissioning group about aspects of study design, and were able to make changes to our proposal to ensure the study fitted in

with the broader needs of the programme, and served to complement the other commissioned studies."

These comments are consistent with the claim in the programme report that the commissioning processes were 'more interactive than those previously employed by national programmes' (NHS Executive, 2000).

Critical comments about the programme were mostly about the later stages. A couple of researchers commented on the lack of support with dissemination, and a few on the slowness of obtaining feedback from reviewers to whom the NCCSDO submitted the final reports. These comments reflect the views of the interviewees and enhance the feeling that there had been some loss of ownership or interest in the programme. Indeed, one researcher explicitly contrasted what had happened with this programme with the supportive role played generally by SDO in relation to the work it commissions.

6.11 Was Implementation Methods Programme successful?– views of Advisory and Commissioning Group members

On the whole, interviewees were positive about their engagement with the IMP. Several spontaneously praised the way the activities had been chaired and suggested that the way the various events were conducted contributed to their success. Looking back, they were generally positive too about what was started through the IMP. Typical comments were:

"It was exciting in that it was the first programme that started to take a hard look at how we change practice in a big concerted way and tried to pick off some of the main issues."

"I thought the process we went through came quite close to giving us the programme we were looking for even though with hindsight it wasn't quite the programme we should have been looking for."

"…it did seem to me at the time that we had funded research that promised to be usable."

But, as discussed above, there were concerns about the lack of real engagement with the social sciences and a feeling among some that this had led to missed opportunities, particularly in exploring some of the big questions (including ones exemplified in the priority areas that remained unfunded). One illustration of this concerns the nature of evaluation, and what the health service and health policy makers expect from evaluation. There was much discussion, at the time and in the interviews, about the merits and practicalities of evaluating interventions designed to

encourage implementation of research in the service – interventions such as GRiPP (Getting Research into Practice and Purchasing). What emerged from these discussions is that what *could* be done depends on the methodological approach people are prepared to endorse and, of course, the resource available (including the active engagement of the service).

More generally, the debate about what *should* be done depends on the value attached to studying a set of specific interventions, as opposed to a wider, systems-based approach that looks at the drivers of change, *in general*, in organisations affecting those who work in them. The IMP favoured the first of these alternative ways of addressing the question of what should be done. Some interviewees argued that that was too limited an approach at the time, and is certainly so now. *That* is the key debate.

As regards the final outcome of the projects themselves most interviewees were, as described above, unable to comment except where they had some personal involvement. The final word is best left to one of the interviewees:
"One thing I feel uncomfortable about is the feeling that somehow 'we've done implementation research'. Even if we had had the full £8 million, we wouldn't have done all this, we'd have started….this was the start of it. There are good lessons to learn from it, there are a whole range of areas that need further work…. we should continue to see this as an important component of R&D."

The general conclusion of those engaged at the time with the IMP is that the processes through which it was established were, on the whole, as good as they could have been then. There is general agreement about the *"clinical tendency"* of the programme, and some concerns about the lack of real engagement with the social sciences. This debate continues. The final lesson reflects what was known by those developing the programme at the beginning: the IMP is a start, this is a crucial area for the NHS R&D Programme, more work is needed.

CHAPTER 7: SHOULD A SYNTHESIS OF THE FINDINGS FROM THE PROGRAMME BE UNDERTAKEN AND FURTHER PAYBACK ANALYSIS CONDUCTED?

7.1 Should there be a synthesis of the findings?

There was widespread, but not total, agreement from the interviewees that some type of synthesis of the findings would be desirable; as one noted: *"I would be enthusiastic for trying to get more mileage out of the effort that's been put into this".* In the questionnaire to lead researchers, support for a synthesis was not quite so strong. Of those who answered this question, two respondents were definitely against and another four not sure it would be a good idea—mostly because of the disparate nature of the projects. Seven out of the 18 respondents, however, were strongly in favour and another five were broadly supportive. The comments included the following*:*

"Absolutely, a book (possibly with accompanying web-site) would be fantastic."

"There should be some attempt to summarise what was learned and to look at the implications for policy and practice, which may not yet have been picked up."

'There were parallels, overlaps and generalisable issues from the projects—not to synthesise these would be a wasted opportunity."

Furthermore, as we have seen, the articles describing the overall preliminary analysis behind the original programme received many citations. This might suggest that syntheses in this area are regarded as particularly useful.

There was considerable support for a synthesis of some sort but interviewees also emphasised the importance of clarifying the potential audience or customer. In addition, they offered many suggestions about the form a synthesis might take. Some described the benefits of drawing together the findings from the projects; some also warned of the difficulties of doing this and given the very different nature of the projects they wondered whether the task was feasible. This led one interviewee to suggest that rather than a synthesis what was required was more of a 'stock taking' exercise. There was certainly a widespread view that the IMP had not in the end been a comprehensive programme, and that, in terms of the projects commissioned, *"it would not provide a coherent world view".* This reinforced the general thought that any synthesis therefore should involve more than a mere collation of key findings.

Suggestions made included:

- an overview of the systematic reviews and other data produced by the IMP projects;
- an assessment of what the findings meant and what lessons could be drawn from them collectively, lessons that might not be as obvious or evident from a collation of individual studies;
- a synthesis of what came from the programme with what else is known now, drawing lessons about how things should be taken forward. This could draw on but not replicate relevant work done by the Cochrane Collaboration and others;
- an analysis of the areas not commissioned with a discussion of whether work should now be done in these areas;
- an assessment of what might be the appropriate methodologies to use in further work in the field;
- the production of a conceptual map of the whole field of behaviour change.

Many of these comments reflect a growing understanding of the complexity of this field and the interviewees' view that the IMP itself had not, inevitably, been able to explore all the relevant conceptual and methodological difficulties in a one-off time-limited exercise.

One suggestion that might provide a framework to encompass many other comments was that a group exercise might be undertaken, and indeed was necessary if all the relevant issues were to be adequately addressed. Six or so leading researchers from a range of disciplines could be commissioned to review the field and, with a strong secretariat, report on recent advances, on what research it would now be feasible to do, and on the best methodological approaches. Within such an exercise:

- one researcher, or group, could produce a collation of the findings from the projects in the context of what was known at the time. This could possibly take the format of an extended version of the type of summary that appears in articles, such as those in the *BMJ*, that state what was known and what is added (or not) by each study. A slight extension of this would incorporate assessment of key findings emerging from some of the major follow-on studies such as that being conducted by the researchers responsible for project IMP 2-11.
- another person could look at the priority topics in which no projects were commissioned, exploring how far work is still required in those areas.

- others could examine the current situation with regard to research implementation, and how far the projects helped bring us to this position and how the knowledge fits in with SDO's wider responsibilities and approaches. This also links with the questions about the nature of research implementation, the need for an organisational approach, and the issue of who now has prime responsibility for implementing research findings in the UK. The various positive *and* negative findings produced through the IMP have contributed to a greater understanding of the complexity of this field – *"our knowledge base now is far more sophisticated than it was then".* There is now more realisation that we are at an early stage of working through many of the relevant issues and that moving forward requires many different and detailed pieces of work to be used and a range of methodologies adopted to build up an overall picture. This analysis could also build on the existing calls for further research on implementation, for example Foy *et al*, 2001.

A related suggestion was that an US National Institutes of Health style consensus conference might be set up with a multidisciplinary panel, including some people from the service, which invited written and oral evidence from researchers commissioned through the IMP and from others known in the field. The key here is, in the words of another interviewee, to *"learn from the experiences of people who try to do this research".*

In summary, a synthesis that clarifies where we are now, rather than just collates the findings, is generally thought to be a useful idea. One interviewee also said that she thought the timing was right too*: "Actually some of those big projects will only just have finished anyway. So it wouldn't be out-of-date. Probably the right time".*

Clearly it would be necessary to ensure that any proposal was not incompatible with SDO procedures. For example, the various interview and questionnaire exercises that led to this current report could, in this context, perhaps be viewed as at least part of the 'Listening Exercise' usually conducted by the SDO.

7.2 Should further payback analysis be conducted?

The HERG evaluation of the IMP was also asked to consider the feasibility and desirability of conducting a more detailed assessment of the payback from the programme. The evaluation has shown it is even more difficult to undertake this type of activity on a *programme* of disparate projects than it is for individual *projects*. More

intensive techniques would be required if the aim was to get much detail beyond the type of general response gathered in the questionnaires used here. If this was to be done, one approach would be to concentrate on a small number of 'tracer' projects (Hanney *et al*, 2000) chosen from among those projects already identified as having something interesting to show. Examples could include the six projects listed in Chapter 4 as examples of where the lead researchers had described the impact that their project was making. It would probably be important to attempt to explore the issue of how far any impact is seen as being from the IMP project as opposed to just being linked to the original research findings.

Given, therefore, the nature of the programme plus the fact that the sources of funding available to the IMP are no longer in place, it probably is not worth considering more payback analysis in its own. It might, nevertheless, be worthwhile undertaking payback analysis as part of a more complex synthesis of both where the IMP projects had led, and what further work is still achievable.

CHAPTER 8: CONCLUSIONS, LESSONS AND RECOMMENDATIONS

8.1 Conclusions

Various conclusions can be drawn from our evaluation. The remit for the evaluation included the request that it provide lessons for the SDO Programme's future commissioning processes and strategies for communicating findings, as well as make recommendations about a synthesis of the findings. Conclusions will be given first, followed by some lessons and recommendations - including about the conduct of evaluations such as this. The lessons and recommendations are presented under several headings. It is recognised that a body such as NCCSDO is already adopting some of these steps; to that extent these recommendations endorse the existing approach of the SDO Programme.

1. Research implementation was seen as being of key importance by leading figures within the health research community, but its comparative newness created difficulties as well as generating great interest. The general conclusion of those engaged at the time with the IMP is that the processes through which it was established were, on the whole, as good as they could have been then. There is general agreement about the *"clinical tendency"* of the programme, and some concerns about the lack of real engagement with the social sciences. Overall, most of those involved were generally positive about what was started through the IMP.
2. The IMP identified a series of priority topics and commissioned a portfolio of projects that led to a range of important outputs. Various publications, including at least 59 articles in peer reviewed journals, came from the projects in addition to the several important publications that resulted from the preliminary activity. The projects have also provided research training that contributed to at least nine higher/research degrees, and contributed in various ways to further research grants totalling over £1.3 million.
3. That almost 20% of the articles have been published in the *BMJ* can be taken as an indication of work of considerable quality. Comments from respondents to our questionnaires also indicate how some studies are viewed as producing high quality, rigorous and cutting edge research. The quality of the studies, and the resulting publications, varies greatly, however, and this variation reflects not only the differing skills of the research teams but also suggests that some topics are more amenable to research than others. Furthermore, several well-conducted

studies produced negative findings that probably deserve more attention than they might have received given the publication bias against negative studies.

4. Certain researchers made considerable efforts to disseminate their findings. Not surprisingly, the projects that had most impact were associated with some of the researchers who used effective dissemination routes. At the programme level, however, there were very limited efforts, despite the subject matter, to disseminate the research findings. Furthermore, the whole concept of the utilisation of research findings in this area is particularly complex. Nevertheless, there is some evidence, from the questionnaires to potential users of the IMP projects related to perinatal care, of a reasonable level of awareness of the research among potential users, and some degree of existing or potential use of the findings. There is also evidence from those questionnaires, however, that greater attention to disseminating the existence of the IMP would have been welcomed by potential users of the findings.
5. A unique set of difficulties, as well as opportunities, was faced by those responsible for taking the programme forward. The intellectual challenges of constructing a programme to cover such a vast area with diverse and sometimes conflicting conceptual and methodological perspectives were compounded by practical problems. These included the capping of the programme's funding and the premature winding up of the Commissioning Group. As a result, this complex programme, which arguably needed better support than its more clinically orientated predecessors, did not receive it at some stages. This, perhaps, only strengthens the case for saying there would probably also be value in undertaking a review/synthesis of the field now in the light of the outputs of the programme.

8.2 Lessons and recommendations about research commissioning and communication strategies in general:

- Commissioning groups are required to assess the quality of research applications and their relevance to the NHS. Those best able to undertake the first task are not necessarily those best able to undertake the second. Their views may clash, creating tensions on the group. When a commissioning group for a programme is faced with this situation it might help if protocols were developed, to be agreed with the group at their first meeting, to cover the role and remit of members. These would take into account the members' differing backgrounds, skills and experience, and define the group's relations with others brought in to advise the group in any capacity. (section 6.6)

- Commissioning groups may find it necessary to provide support for research applicants during the commissioning process, especially in areas which are relatively new and/or where the existing research capacity is weak. There are different views about what form this interaction should take. This should be fully discussed in the CG before commissioning work, and, if necessary, a protocol drawn up. (6.7)
- Due process was followed, and fully recorded, in dealing with the conflicts of interest that arose because CG members also submitted applications to the programme. Where conflicts of interest exist within commissioning groups this should continue to be the case. (6.8)
- Despite the effective dissemination of some projects within the IMP, various interviewees, lead researchers, and potential users suggested that it would have been beneficial to have had a communication strategy at programme level. We endorse this view, and conclude - more strongly still - that effective dissemination of complex research findings from programmes such as the IMP is more achievable if research programmes, and their funding bodies, have communication strategies. Such strategies should operate at an overall programme level as well as encouraging activities by individual research teams, and, in all cases, should carefully target dissemination to those users most likely to be receptive to the research findings. Successful practices identified by individual projects should also be encouraged, such as the selection of appropriate journal outlets adopted by the *Informed Choice Leaflets* project. And researchers should be encouraged to work closely with potential users even as the research is being formulated. Bearing in mind that time-scales for research of this type can be lengthy, continuity in the organisation of such research programmes, *and* their associated communication strategies, is also important. (4; 6.9; 6.10)

8.3 Lessons and recommendations relevant for research activities in the implementation or similar fields:

- The IMP was a new programme in a new field, raising new and difficult challenges for the NHS R&D Programme and for the associated research community. In retrospect too much was expected too fast. Various lessons can be drawn for the SDO when it is faced with complex areas such as this, involving a wide range of disciplines. Compared with the situation faced by the IMP, a future programme in such a field would benefit from: more preparatory work;

lower initial expectations - especially as regards the pace of the programme; and an ability to re-visit and learn from early results. (6.3)

- The approach adopted to consultation in the IMP was generally thought to have had some weaknesses. A tension between getting good informed opinion about research need and ensuring full participation of all stakeholders was identified. A suggested, and perhaps additional, approach that might address some of the problems would be to link research topic priority setting for implementation methods research to an examination of actual NHS decision-making about how to implement change. (6.4)
- In the IMP, as in other time-limited NHS R&D programmes, there was a tension between getting on and getting something done versus a more considered approach. In a new area such as the IMP a careful combination of the two approaches is required. It is not clear this is achievable in a time-limited programme. This suggests the need for a longer initiative in such an important field, possibly as a continuing theme running through the NHS R&D Programme. (6.5)
- The final lesson reflects what was known at the beginning by those involved in developing the programme: the IMP is a start. This is a crucial area for the NHS R&D Programme and more R&D activity is needed in this field to assist delivery of some key NHS agenda items. As a preliminary step there is certainly scope for a type of stock taking of the findings from the IMP. On balance there is also an argument for conducting a synthesis of work on research implementation that goes beyond a mere collation of findings from the specific projects funded. If undertaken, it should identify current needs for research and explore how they could be addressed in the light of the findings from IMP and elsewhere. Further work on assessing the payback from the IMP is probably only worthwhile as part of such a wide-ranging synthesis. (7)

8.4 Lessons and recommendations about the conduct of evaluations of research programmes:

- This evaluation has underlined several points made previously to the NHS about the timing of such evaluations (Buxton *et al,* 1999). There has been difficulty in getting interviewees to remember details of events that occurred up to eight years ago. Similarly, some of the first projects, including some systematic reviews, were completed six years ago. Other projects are not yet complete and several are only just finishing. Lead researchers responding to the questionnaires we sent

them made it clear that more attention should be given to the timing of such evaluation activities (see also Wisely, 2001a). All this points to the need for phased approaches if maximum benefit is to be gained from evaluations (Croxson *et al,* 2001).

- At a more detailed level, several steps might assist future evaluations. It would be useful if more consistent approaches were used in the scales for scoring applications and final reports. It would also be desirable to inform researchers at the start of a project what might be expected of them in terms of acknowledging the programme funding and responding to requests from those evaluating research programmes.

ENDNOTES

1. A criticism sometimes made of the ISI database is that it underestimates the output in Health Services Research (HSR) (Black and Davies, 1999). The source journals used to construct the ROD were extended as a result of the analysis by Black and Davies to give greater coverage of HSR (NHS Executive/Wellcome Trust, 2001). In the case of the IMP, however, this did not increase the number of publications from the programme that were included on ROD.

2. It perhaps should be noted, however, that this was the one project out of the 36 that was not a specific IMP project, but rather the IMP made a contribution to it.

3. This was also seen to be a problem in the programme on the interface between primary and secondary care (Wisely and Haines, 1995).

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Appendix 1: Priority Topics Identified by the Advisory Group

1. Influence of source and presentation of evidence on its uptake by health care professionals and others

2. The principal sources of information on health care effectiveness used by clinicians

3. The management of uncertainty and communication of risk by clinicians

4. Roles for health service users in implementing research

4. Why some clinicians but not others change their practice in response to research findings

6. The role of commissioning in securing change in clinical practice

7. Professional, managerial, organisational and commercial factors associated with securing change in clinical practice, with a particular focus on trusts and primary care providers

8. Interventions directed at clinical and medical directors and directors of nursing in trusts to promote evidence-based care

9. Local research implementation and development projects (such as GRiPP)

10. Effectiveness and cost-effectiveness of audit and feedback to promote implementation of research findings

11. Educational strategies for continuing professional development to promote the implementation of research findings

12. Effectiveness and cost-effectiveness of teaching critical appraisal skills to clinicians, patients/users, purchasers and providers to promote uptake of research findings

13. The role of undergraduate (pre-qualification) training in promoting the uptake of research findings

14. The impact of clinical practice guidelines in disciplines other than Medicine

15. Effectiveness and cost-effectiveness of reminder and decision support systems to implement research findings

16. The role of the media in promoting uptake of research findings

17. Impact of professional and managerial change agents (including educational outreach visits and local opinion leaders) in implementing research findings

18. Effect on evidence - based practice of general health policy measures

19. The impact of national guidance to promote clinical effectiveness

20. The use of research-based evidence by policy makers

Appendix 2: Studies Commissioned by the Implementation Methods Programme

Imp M 1-11 ARMSTRONG

Project title: A qualitative study of GP's reasons for changing or not changing their prescribing behaviour in two areas

Lead researcher: Dr David Armstrong, United Medical and Dental School

Imp M 2-11 CULLUM

Project title: Nurses' use of research evidence in decision-making: a descriptive and analytical study

Lead researcher: Dr Nicky Cullum, University of York

Imp M 3-5 FEDER

Project title: Communicating risk reduction to patients & clinicians in the secondary prevention of ischaemic heart disease: perspectives of inner city patients, general practitioners and practice nurses

Lead researcher: Dr Gene Feder, St. Bartholomew's & the Royal London School of Medicine and Dentistry

Imp M 3-10 WYATT

Project title: Investigation of Doctors' ability to understand and use clinical prognostic models when different metrics are used to describe model performance

Lead researcher: Dr Jeremy Wyatt, University College London

Imp M 3-12 BISSELL

Project title: Self-medication and the communication of risk: the case of deregulated Medicines

Lead researcher: Mr Paul Bissell, University of Manchester

Imp M 3-16 EDWARDS

Project title: A systematic review of risk communication - improving effective clinical practice and research in primary care

Lead researcher: Dr Adrian Edwards, University of Wales College of Medicine

Imp M 4-13 COULTER

Project title:	Availability of information materials to promote evidence-based patient choice
Lead researcher:	Professor Angela Coulter, King's Fund

Imp M 4-16 GANN

Project title:	Increasingly effective? Evaluating improvements in the ability of health information services to provide information on clinical effectiveness
Lead researcher:	Dr Robert Gann, The Help for Health Trust

Imp M 4-21 SMITH

Project title:	Effective communication: an evaluation of touchscreen displays for providing information on prenatal diagnosis
Lead researcher:	Dr A Pat Smith, Aberdeen Royal Hospitals NHS Trust

Imp M 5-23 YATES

Project title:	Understanding the reasons for change, or not, in clinical practice - the case of dilatation and curettage
Lead researcher:	Dr John Yates, University of Birmingham

Imp M 5-40 HEWISON

Project title:	Uptake of effective practices in Maternity Units
Lead researcher:	Dr Jenny Hewison, University of Leeds

Imp M 5-41 NEWTON

Project title:	Social networks and the use of research in clinical practice
Lead researcher:	Dr Elizabeth West, RCN Institute/University of Oxford

Imp M 10-11 SCHOFIELD

Project title:	Evidence based secondary prevention of heart disease in primary care: a randomised controlled trial of three methods of implementation (The ASSIST trial)
Lead researcher:	Dr Michael Moher, University of Oxford

Imp M 10-16 BAKER

Project title: The format of recommendations trial: a study of the effectiveness and costs of guidelines, prioritised audit criteria, and feedback in implementing change

Lead researcher: Professor Richard Baker, University of Leicester

Imp M 11-10 ROGERS

Project title: A randomised trial of the effectiveness of strategies directed towards education & implementation and the adoption of evidence based development in primary care

Lead researcher: Dr Stephen Rogers, University College London & Royal Free Hospital Schools of Medicine

Imp M 11-26 McINTOSH

Project title: Using informal learning in the implementation of research Findings

Lead researcher: Ms Aileen McIntosh, University of Hull

Imp M 11-29 FREEMANTLE

Project title: The effectiveness of continuing education conferences and workshops to improve the practice of health professionals

Lead researcher: Mr Nick Freemantle, University of York

Imp M 12-08 DEEKS

Project title: Systematic review of studies of effectiveness of teaching critical Appraisal

Lead researcher: Mr Jonathan Deeks, University of Oxford

Imp M 12-09 TAYLOR

Project title: A randomised controlled trial of the effectiveness of critical appraisal skill workshops on health service decision makers in the South & West region

Lead researcher: Dr Rod Taylor, London School of Hygiene & Tropical Medicine

Imp M 14-32 THOMAS

Project title:	Systematic review of the effectiveness of guidelines in professions allied to medicine
Lead researcher:	Dr Lois Thomas, University of Newcastle Upon Tyne

Imp M 15-4 LOGAN

Project title:	A randomised trial of a simple prompting system in promoting appropriate management of iron deficiency anaemia and its influence on clinical outcome
Lead researcher:	Dr Elizabeth C M Logan, The King's Mill Centre for Health Care Services

Imp M 15-8 WALTON

Project title:	The effectiveness of computerised advice on drug dosage in improving prescribing practice: Systematic review of comparative studies
Lead researcher:	Dr Robert Walton, Bury Knowle Health Centre (Imperial Cancer Research Fund General Practice Research Group, University of Oxford)

Imp M 15-9 ECCLES

Project title:	An evaluation of computerised guidelines for the management of two chronic conditions
Lead researcher:	Professor Martin Eccles, University of Newcastle Upon Tyne

Imp M 15-11 WYATT

Project title:	A Cochrane systematic review of the effects of paper and computer-based reminders and decision support on clinical practices and patient outcomes
Lead researcher:	Dr Jeremy Wyatt, University College London

Imp M 15-12 THAPAR

Project title:	Comparing a patient held prompt and reminder card to a doctor held prompt and reminder card to improve epilepsy care in the community: The PRIME (Prompts and Reminders In the Management of Epilepsy) Card Study
Lead researcher:	Dr. Ajay Thapar, University of Manchester

Imp M 15-19 BOWNS

Project title:	Maternity Guidelines Implemented on Computer - (MaGIC)
Lead researcher:	Dr Ian Bowns, University of Sheffield Medical School

Imp M 15-21 SZCZEPURA

Project title:	Systematic review of economic studies of reminders and decision support systems
Lead researcher:	Dr Ala Szczepura, University of Warwick

Imp M 16-18 FREEMANTLE

Project title:	Are mass media campaigns effective in influencing uptake of appropriate health care by health professionals & the general public? A systematic review of available evidence
Lead researcher:	Mr Nick Freemantle, University of York

Imp M 16-19 PHILO

Project title:	The role of the media in public and professional understanding of breast cancer
Lead researcher:	Dr Jenny Kitzinger, Brunel University

Imp 17-12 GRIMSHAW

Project Title:	Is the Involvement of Opinion Leaders in the Implementation of Research Findings a Feasible Strategy?
Lead researcher :	Professor Jeremy Grimshaw, University of Aberdeen

Imp M 17-13 GRIMSHAW

Project title:	Prevention of deep vein thrombosis: A feasibility study for a randomised trial of three different strategies to implement evidence based guidelines
Lead researcher:	Professor Jeremy Grimshaw, University of Aberdeen

Imp M 19-15 STRANG

Project title:	The injecting drug taker & the community pharmacist: impact of new DoH guideline, and obstacles to a broader service-providing base
Lead researcher:	Professor John Strang, National Addiction Centre (Institute of Psychiatry)

Informed Choice Leaflets

Project title:	Informed Choice in Maternity Care: An Evaluation of Evidence Based Leaflets
Lead researcher:	Professor Mavis Kirkham, University of Sheffield

Imp M R2-25 CHEATER

Project title:	An evaluation of the effectiveness and cost effectiveness of audit and feedback and educational outreach in improving nursing practice and health care outcomes
Lead researcher:	Dr Francine Cheater, University of Leicester

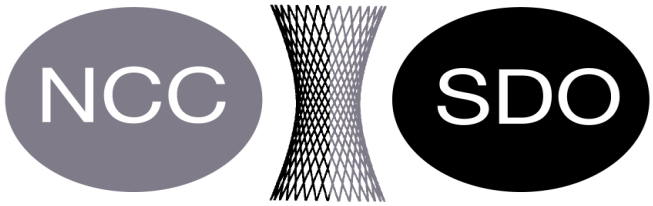
Imp M R2-34 CLARKE

Project title:	Development of evidence-based materials Clinical Guidance Tree, Decision Board & Leaflet for decision-making in Prophylactic Oophorectomy
Lead researcher:	Dr Aileen Clarke, London School of Hygiene & Tropical Medicine

Imp M R2-64 PITTS

Project title:	Effective practice: a randomised trial of dissemination and implementation strategies for guidelines for the appropriate extraction of third molar teeth
Lead researcher:	Professor Nigel Pitts, University of Dundee

Appendix 3: Questionnaire to Lead Researchers



NHS R&D IMPLEMENTATION METHODS PROGRAMME :

QUESTIONNAIRE FOR PROGRAMME EVALUATION

Project Title:

Project Reference No:

Lead Researcher:

Where relevant, please first check the pre-completed information in Section A about the publications from your project, which are mostly those taken from the ones listed in the Programme Report 2000. Please answer the questions about these publications and then complete the remaining sections using additional sheets if necessary.

Please return all sections (A-H) together with this sheet, and copies of all your peer-reviewed journal articles from the project, by 7 June 2002 to the Health Economics Research Group, Brunel University, Uxbridge, UB8 3PH, using the pre-paid envelope enclosed.

It is hoped that a version of the final evaluation report, and of the end of programme report, will be made available on the SDO web-site, and that a copy of either the evaluation, or a summary, will be sent to you. The focus of the evaluation, however, is the programme as a whole rather than the performance of individual research teams.

If you have any questions about completing the questionnaire please contact Dr Steve Hanney on 01895 203196 ext 3709, email: **stephen.hanney@brunel.ac.uk**

Thank you for your assistance.

A. PREVIOUSLY NOTIFIED PUBLICATIONS

A1. Please check the publications listed and:

1. delete any that were not, at least partially, a result of specific funding from this programme;
2. for each publication please tick the appropriate box about programme funding acknowledgement;
3. please use one of the following letters to categorise each publication, and add a 'w' after the letter if it was a publication available **ONLY** on the web:

a = peer-reviewed journal article b = journal editorial c = journal letter
d = published abstract e = book f = chapter
g = non-peer reviewed article h = published conference proceedings
i = publicly available full report j = other (please specify)

	Programme Funding Acknowledged		Category
	Yes	No	

B. PUBLICATIONS NOT PREVIOUSLY LISTED

B1. Please list any additional publications that have resulted directly or indirectly from the project. Include any accepted publications that are in press but not any that are only at the submitted stage. For each publication please:

1. tick the box on programme funding acknowledgement; and
2. use one of the following letters to categorise it, and add a 'w' after the letter if it was a publication available **ONLY** on the web:

a = peer-reviewed journal article b = journal editorial c = journal letter
d = published abstract e = book f = chapter
g = non-peer reviewed article h = published conference proceedings
i = publicly available full report j = other (please specify)

	Programme Funding Acknowledged		Category
	Yes	No	

C. POTENTIAL USERS OF THE RESEARCH

NB. In answering this question please DO NOT refer to actual use of the findings as this forms the basis of later questions.

C1. Please list any groups who at the start of the project, or during it, were viewed as potential users of the research findings. Please list the groups in approximate order of importance as potential users of your research. Examples of groups you may wish to list include: the research community, NHS managers, specific professional bodies, specific groups of clinicians, specific patient groups, the general public, and collaborations.

D. USE OF THE RESEARCH IN THE RESEARCH SYSTEM

D1. Has participation in the research led to additional formal qualifications for any members of the project team or is it likely to do so? Yes No

If so, please give details.

Qualification	Year		Contribution from specific project		
	Gained	Expected	Considerable	Moderate	Small

D2. Have the project findings or methodology or theoretical developments generated subsequent research **by members of the team**?
Yes No

If so, please give details of further grants, if any, and describe the contribution of your original project to securing these funds.

Funder	Amount	The importance of the project to securing later funding		
		Considerable	Moderate	Small

D3. If you are aware of any significant ways in which your project in the Implementation Methods Programme has contributed to further research conducted **by others**, please indicate.

Research Team	Project title/topic	The importance of your project to the further research		
		Considerable	Moderate	Small

D4. Please describe any contribution to further research that you have listed in D2 or D3 that is of particular importance.

E. USE OF RESEARCH FINDINGS IN HEALTH SYSTEM POLICY/DECISION MAKING

NB. Questions about applications of the findings by practitioners etc form the next section.

E1. Research findings can be used in policy making at any level (eg. national, regional, local trust or unit, professional, administrative or managerial) of the health service[1].

Have the findings from your project already been used in any such ways?
Yes No

E2. Are there any reasons for expecting the findings to be used for future policy/decision making. Yes
No

E3. If you have replied Yes to either **E1** or **E2** please give details of the use and/or expected use including: the level at which policies/decisions were influenced; the importance of the project's findings to the adoption of the policy(ies); and any supporting evidence[1] – please attach documents where relevant or give references to them.

[1] Evidence of the policy relevance could take many forms including: statements by policy makers; citing of the findings in a Health Service Circular, Chief Executive Bulletin or in a clinical guideline from a national or local professional group; inclusion of the findings in a contract or in a document from an audit, an inspectorial or an evaluative body; the establishment of a working group to examine the implications or implementation of the findings etc.

F. APPLICATION OF THE PROJECT FINDINGS THROUGH CHANGED BEHAVIOUR

F1. Have the findings from your project already led to changes, either directly or through the application of research-informed policies, in the behaviour of practitioners, managers etc, or in the involvement of health service users or the wider public?

Yes No

F2. Do you expect the findings to influence practitioner or managerial behaviour or involvement of health service users or the public in the future?

Yes No

F3. If you replied Yes to either **F1** or **F2** please specify: the level at which any change occurred (eg. local-institution, local-network, regional, national); how important the research findings were in changing behaviour; and any evidence (such as surveys of practitioners) to support claims that such changes in behaviour were caused by the research findings – please attach documents where relevant or give references to them.

G. FACTORS INFLUENCING THE UTILISATION OF RESEARCH : DISSEMINATION ETC

G1. Please state approximately how many conference/workshop presentations have been made based on the research findings to:

Primarily academic audiences:
.....

Primarily practitioner/service user audiences:
.....

G2. Describe any of these presentations, or any other dissemination activities, that were particularly important in achieving utilisation of the project's findings.

G3. Was liaison with potential users a factor in actual or future research utilisation?

Liaison before starting	Yes	No
Liaison during the project	Yes	No

G4. Please describe any aspects of such liaison and interaction that are particularly important.

G5. Describe any other factors (other than ones connected to the overall programme) that account for the research being utilised, or for the lack of utilisation. These could include the timeliness or quality of the research, the research findings being taken up by the key stakeholders etc.

H. THE ROLE OF THE PROGRAMME

NB. THIS SECTION OF THE QUESTIONNAIRE WILL NOT BE MADE AVAILABLE TO THE SDO

H1. Did the fact that your project was part of a programme have any impact on your project?

Not at all

A little

Moderately

Considerably

Extensively

H2. Did you request, and/or receive, any assistance from the programme commissioning group or office with:

	REQUEST HELP	RECEIVE HELP
Completing the application form	Yes	Yes
Development of your proposal	Yes	Yes
Technical issues during the research	Yes	Yes
Dissemination	Yes	Yes

If you said Yes to any item please explain and also explain whether there were any advantages in being part of a wider programme of projects.

H3. What are your views about the commissioning process used in the programme?

H4. How, if at all, could the commissioning process have been improved?

H5. Have you read of the results of any other projects from the programme?

Yes No

If so, how many: _____

Have you attended presentations about any other projects from the programme?

Yes No

If so, how many: _____

H6. Do you think an attempt should be made to synthesise the findings from the programme?

H7. Please use the space below if you wish to make any further comments about your project, the Implementation Methods Programme, or this questionnaire.

THANK YOU FOR YOUR ASSISTANCE.

Appendix 4: Electronic Questionnaire to CHAIN Members with an Interest in Women's Health

Dear CHAIN member,

Evaluation of the NHS R&D Implementation Methods Programme: Projects Related to Women's Health.

We are seeking your views as part of the assessment of a major R&D programme aimed at enhancing effective health care.

The SDO now have responsibility for the NHS's R&D Implementation Methods Programme. Most of the programme's projects are now finished, therefore the SDO have commissioned the Health Economics Research Group at Brunel University to conduct an evaluation. This is intended to inform thinking about issues such as research commissioning in this field.

One element of the evaluation is to gather the views of potential users of the programme about its value in their field. Attached is a one page questionnaire followed by brief details of five projects, out of the 36 commissioned by the programme, that could be classified as relating to Women's Health. (Projects were selected for funding on the basis of their approach to studying research implementation. It seems appropriate, however, for the evaluation to seek the views of reasonably coherent groups of potential users based on their medical field or professional grouping.)

We hope you would be willing to read the enclosed brief, one page, details of each of the five projects, and then complete the single questionnaire that covers all the projects using the ID number given to each project.

The answers will be treated in the strictest confidence and neither the project data-base, nor the final report, will identify any respondents. Information about this evaluation will be available in a few months time on the SDO web site.

Please return your answers to me by 20 September by:
fax (01895 203330);
post (HERG, Brunel University, Uxbridge, UB8 3PH);
or email: **stephen.hanney@brunel.ac.uk**

Please contact me if you have any queries about the questionnaire.

Best Wishes

Dr. Stephen Hanney.

QUESTIONNAIRE

PLEASE ANSWER THESE QUESTIONS USING THE I .D. NUMBER GIVEN TO THE ATTACHED PROJECTS.

1. Had you previously heard about the NHS R&D Implementation Methods Programme:

2. Regardless of whether your answer to the above question is yes or no, please give the ID numbers of any of the five projects from the Programme, listed overleaf, about which you had previously heard:

3. List the ID numbers of any of these six projects from which you had read either the article described in the abstract or a different article:

4. List the ID numbers of any projects whose findings have already influenced:
a) Your clinical practice:
b) Your research:
c) Your teaching:

5. List the ID numbers of any projects whose findings you expect to influence:
a) Your clinical practice:
b) Your research:
c) Your teaching:

6. If you have not used, or do not intend to use, the findings from any projects relevant to your area of work, please give your reasons:

7. List the ID numbers of any projects you think already have been, or will be, used by ***others*** to make a contribution to enhancing effective health care:

8. Please state your role(s) in relation to the health service (such as, midwife, nurse, consultant, university-based researcher, member of an advocacy group):

9. Please make any other comments you wish about the Implementation Methods Programme:

No. 1:

EFFECTIVE COMMUNICATION: AN EVALUATION OF TOUCHSCREEN DISPLAYS FOR PROVIDING INFORMATION ON PRENATAL DIAGNOSIS

Lead Researcher: Dr A Pat Smith Aberdeen Royal Hospitals NHS Trust

Project Summary:
Touchscreen information packages are already used in a variety of situations to facilitate public access to details on a huge variety of topics. One area of particular need is adequate, accessible and appropriate information for women and their partners on prenatal diagnostic tests. A touchscreen system to meet this need has recently been developed in Aberdeen.

The objectives of the proposed study are to evaluate the effectiveness of this touchscreen at providing information, to determine its acceptability to women, and to measure its impact on informed decision-making regarding prenatal diagnostic tests. A randomised controlled trial will be conducted, with one group of women exposed to the touchscreen and supporting information leaflet and the other receiving only the leaflet.

ARTICLE:
RANDOMISED CONTROLLED TRIAL COMPARING EFFECTIVENESS OF TOUCH SCREEN SYSTEM WITH LEAFLET FOR PROVIDING WOMEN WITH INFORMATION ON PRENATAL TESTS

Wendy Graham, Pat Smith, A Kamal, A Fitzmaurice, N Smith, N Hamilton
BMJ, **320:** 155-6 (15 January 2000)

Abstract:…….

No. 2:

UPTAKE OF EFFECTIVE PRACTICES IN MATERNITY UNITS

Lead Researcher: Dr Jenny Hewison University of Leeds

Project Summary:
This is a national study of changes in adherence to four obstetric care standards over time, conducted in 20 hospitals selected at random. It has two objectives, to estimate adherence to standards which are strongly supported by evidence from a well publicised database of systematic reviews (the Cochrane Database and its electronic and published precursors); and to relate this quality measurement to the knowledge and attitudes of clinicians, and to the rigour of the procedures established for implementing change. The standards are: use of 1) prophylactic antibiotics for Caesarian Section, 2) steroids when pre-term delivery can be anticipated, 3) the ventouse for instrumental delivery, 4) suture material used to repair episiotomy, and 5) the management of eclampsia. Current levels of adherence will be placed in the context of past performance. The results will determine the scope for further improvement and indicate topics for intervention studies.

ARTICLE:
THE LEEDS UNIVERSITY MATERNITY AUDIT PROJECT

B Wilson, J G Thornton, J Hewison, R J Lilford, I Watt, D Braunholtz, M Robinson
International Journal for Quality in Health Care, **14**: 175-181 (2002)

Abstract:……..

No. 3:

EVALUATION OF INFORMED CHOICE LEAFLETS IN MATERNITY CARE

Lead Researcher: Professor Mavis Kirkham University of Sheffield

Project Summary:
A study to evaluate the use of the informed choice leaflets in maternity care by means of:

- Mapping present use;
- An ethnographic study of 3 differing sites of current use;
- A 12 site RCT in Wales.

This will measure outcomes in terms of knowledge, attitudes, psychological, emotional and physical outcomes and relevant organisational and economic factors.
Qualitative work within the RCT will examine the process of leaflet prescription and use. Tools will be developed for local use – monitoring and assessing leaflets in use
The results will be likely to be useful in many areas concerned with informed choice and of wider significance in maternity care.

Funded jointly with the Central R & D programme.

ARTICLE:
QUALITATIVE STUDY OF EVIDENCE BASED LEAFLETS IN MATERNITY CARE

Helen Stapleton, Mavis Kirkham, Gwenan Thomas
BMJ, **324:** 639-643 (16 March 2002)

Abstract:……..

No. 4:

THE ROLE OF THE MEDIA IN PUBLIC AND PROFESSIONAL UNDERSTANDING OF BREAST CANCER

Lead researcher: Dr Jenny Kitzinger University of Glasgow

Project Summary:
This proposal is to examine the operation of the media and their influence on public and professional understanding of breast cancer. The research develops simultaneously on three levels.

1. Production processes involving interviews with journalists/health correspondents/sources.
2. A detailed examination of media content.
3. The use of focus groups to examine how new information is received and understood.

A key objective is to show why some messages on new research or related issues are taken up by the media and the impact of this on belief and understanding. This will provide relevant information on the potential success of different publicity strategies.

ARTICLE:

THE HUMAN DRAMA OF GENETICS: 'HARD' AND 'SOFT' MEDIA REPRESENTATIONS OF INHERITED BREAST CANCER

Lesley Henderson, Jenny Kitzinger
Sociology of Health and Illness, **21:** 560-578 (1999)

Abstract:……

No. 5:

DEVELOPMENT OF EVIDENCE-BASED MATERIALS; CLINICAL GUIDANCE TREE, DECISION BOARD, AND LEAFLET FOR DECISION MAKING IN PROPHYLACTIC OOPHORECTOMY – PO

Lead researcher: Dr Aileen Clarke London School of Hygiene and Tropical Medicine

Project Summary:
To develop a Clinical Guidance Tree – an evidence-based decision making aid which will allow patients and clinicians to take account both of available evidence and of patients' values using a computerised interactive decision tree with information presented and elicited in accessible formats. To develop a decision board and a patient information leaflet using the same information as for the Clinical Guidance Tree. To pilot and undertake preliminary feasibility and evaluation studies of the three forms of decision aid in PO. Outcomes investigated will include several measures of the overall quality of the decision made; including an in-depth qualitative assessment of patient and doctor satisfaction and measures of decisional conflict and anxiety, extent of information coverage and exchange, satisfaction with the decision and an assessment of the relationship of the decision made to predicted health gain. Results will be applicable to the process of implementation of best evidence and to practical decision-making in a number of common conditions besides PO, e.g. chronic diseases such as asthma, diabetes and hypertension and will also indicate the costs and benefits of the process of incorporating patients' values into evidence-based decision making.

ARTICLE:

WOMEN'S VIEWS OF TWO INTERVENTIONS DESIGNED TO ASSIST IN THE PROPHYLACTIC OOPHORECTOMY DECISION: A QUALITATIVE PILOT EVALUATION

Vanita Bhavani, Aileen Clarke, Jack Dowie, Andrew Kennedy,Ian Pell
Health Expectations, **5:** 156-171 (2001)

Abstract:……..

Appendix 5: Electronic Questionnaire to CHAIN Members with an Interest in the Management of Heart Disease

Dear CHAIN member,

Evaluation of the NHS R&D Implementation Methods Programme: Projects Related to the Management of Heart Disease.

We are seeking your views as part of the assessment of a major R&D programme aimed at enhancing effective health care.

The SDO now have responsibility for the NHS's R&D Implementation Methods Programme. Most of the programme's projects are now finished, therefore the SDO have commissioned the Health Economics Research Group at Brunel University to conduct an evaluation. This is intended to inform thinking about issues such as research commissioning in this field.

One element of the evaluation is to gather the views of potential users of the programme about its value in their field. Attached is a one page questionnaire followed by brief details of three projects, out of the 36 commissioned by the programme, that could be classified as relating to the management of heart disease—one is on the general theme of information for patients, but included heart disease as one of its areas of study. (Projects were selected for funding on the basis of their approach to studying research implementation. It seems appropriate, however, for the evaluation to seek the views of reasonably coherent groups of potential users based on their medical field or professional grouping.)

We hope you would be willing to read the enclosed brief, one page, details of each of the three projects, and then complete the single questionnaire that covers all the projects using the ID number given to each project.

The answers will be treated in the strictest confidence and neither the project data-base, nor the final report, will identify any respondents. Information about this evaluation will be available in a few months time on the SDO web site.

Please return your answers to me by 20 September:
by fax (01895 203330);
post (HERG, Brunel University, Uxbridge, UB8 3PH);
or email: **stephen.hanney@brunel.ac.uk**

Please contact me if you have any queries about the questionnaire.

Best Wishes

Dr. Stephen Hanney.

QUESTIONNAIRE

PLEASE ANSWER THESE QUESTIONS USING THE I .D. NUMBER GIVEN TO THE ATTACHED PROJECTS.

1. Had you previously heard about the NHS R&D Implementation Methods Programme:

2. Regardless of whether your answer to the above question is yes or no, please give the I D numbers of any of the three projects from the Programme, listed overleaf, about which you had previously heard:

3. List the I D numbers of any of these three projects from which you had read either the article or letter described in the abstract/summary/extract or a different publication:

4. List the I D numbers of any projects whose findings have already influenced:
a) Your clinical practice:
b) Your research:
c) Your teaching:

5. List the I D numbers of any projects whose findings you expect to influence:
a) Your clinical practice:
b) Your research:
c) Your teaching:

6. If you have not used, or do not intend to use, the findings from any projects relevant to your area of work, please give your reasons:

7. List the I D numbers of any projects you think already have been, or will be, used by ***others*** to make a contribution to enhancing effective health care:

8. Please state your role(s) in relation to the health service (such as, GP, nurse, consultant, university-based researcher, member of an advocacy group):

9. Please make any other comments you wish about the Implementation Methods Programme:

No. 1:

EVIDENCE BASED SECONDARY PREVENTION OF HEART DISEASE IN PRIMARY CARE: A RANDOMISED CONTROLLED TRIAL OF THREE METHODS OF IMPLEMENTATION

Lead Researcher: Dr Theo Schofield University of Oxford

Project Summary:
Aims: 1. To compare in a randomised controlled trial of 18 general practices three methods of promoting change in primary care; audit and feedback; the introduction of structured records, registers and recall; the introduction of nurse run clinics. 2. To evaluate within practice by randomised controlled trials the effectiveness of structured recall and nurse run clinics in changing the risk factor status and treatment of patients with known ischaemic heart disease.

ARTICLE:
CLUSTER RANDOMISED CONTROLLED TRIAL TO COMPARE THREE METHODS OF PROMOTING SECONDARY PREVENTIONOF CORONARY HEART DISEASE IN PRIMARY CARE

Michael Moher, Patricia Yudkin, Lucy Wright, Rebecca Turner, Alice Fuller, Theo Schofield, David Mant for the Assessment of Implementation Strategies (ASSIST) Trial Collaborative Group.
BM J, **322:** 1338-1342 (2 June 2001)

Abstract:…….

No. 2

COMMUNICATING RISK REDUCTION TO PATIENTS AND CLINICIANS IN THE SECONDARY PREVENTION OF ISCHAEMIC HEART DISEASE: PERSPECTIVES OF INNERCITY PATIENTS, GENERAL PRACTITIONERS AND PRACTICE NURSES

Lead Researcher: Professor Gene Feder
St Bartholomew's Royal London Hospital Medical and Dental School

Project Summary:
This multidisciplinary qualitative study builds on an ongoing prospective randomised controlled trial testing the ability of guideline-derived postal prompts to survivors of myocardial infarction and their GPs to increase uptake of secondary prevention in innercity primary care. Prompts to patients and their GPs used in this study contain detailed risk reduction information. Semi-structured interviews of patients, GPs and nurses will determine:

- Levels of understanding and acceptability of providing risk reduction information in different forms to a group of high risk patients and their GPs in an innercity environment.
- Perceived relevance of this information to innercity patients and clinicians and its potential to influence cooperative behaviour between the two, taking into account the patients' own context (eg. Health beliefs, ethnicity, age).
- Potential acceptability and preference for alternative forms of written presentation of risk reduction

LETTER:
MANAGING ESTABLISHED CORONARY HEART DISEASE: PRACTICE TEAMS NEED SUPPORT IN ORGANISING PHARMACOLOGICAL AND LIFESTYLE INTERVENTIONS.

Gene Feder, Chris Griffiths,
BMJ, **316:** 309 (24 January 1998)
Extract:……

No. 3

AVAILABILITY OF INFORMATION MATERIALS TO PROMOTE EVIDENCE-BASED PATIENT CHOICE

Lead Researcher: Professor Angela Coulter King's Fund

Project Summary:
A four-stage study to investigate the availability of patient information materials about treatment choices for ten conditions for which high quality systematic reviews exist; to assess the materials in terms of scientific validity and acceptability to patients; to develop guidance on the production of patient information; to provide practical help to health authorities and health care providers on evidence-based patients choice.

ARTICLE:

SHARING DECISIONS WITH PATIENTS: IS THE INFORMATION GOOD ENOUGH?

Angela Coulter, Vikki Entwistle, David Gilbert
BMJ, **318:** 318-322 (30 January 1999)

Summary points:……

Appendix 6: Electronic Questionnaire to Members of a Bulletin Board for Researchers into Shared Decision Making

Dear colleague,

Evaluation of the NHS R&D Implementation Methods Programme: Projects Related to Shared Decision Making.

We are seeking your views as part of the assessment of a major R&D programme aimed at studying the implementation of findings from health research. The UK's NHS R&D Implementation Methods Programme was one of the first major R&D programme systematically to address a range of issues related to this topic, including various aspects of decision making by clinicians and patients.

Most of the projects are now finished and the Health Economics Research Group at Brunel University has been commissioned to conduct an evaluation of the programme. This is intended to inform thinking about issues such as future research commissioning in this field.

One element of the evaluation is to gather the views of potential users of the programme about its value in their field. Various projects identified the research community as a target audience for their study. Attached is a one page questionnaire followed by brief details of four projects commissioned by the programme that might be of most interest to researchers in the field of decision making. We hope you would be willing to read the enclosed brief, one page, details of each of the projects, and then complete the single questionnaire that covers all the projects using the ID number given to each project.

The answers will be treated in the strictest confidence and neither the project data-base, nor the final report, will identify any respondents. Information about this evaluation would be made available from me on request in a few months.

Please return your answers to me by 11 October by:
fax (+44 [0]1895 203330);
post (HERG, Brunel University, Uxbridge, UB8 3PH);
or email: **stephen.hanney@brunel.ac.uk**

Please contact me if you have any queries about the questionnaire.

Best Wishes

Dr. Stephen Hanney.

QUESTIONNAIRE

PLEASE ANSWER THESE QUESTIONS USING THE I .D. NUMBER GIVEN TO THE ATTACHED PROJECTS.

1. Had you previously heard about the UK's NHS R&D Implementation Methods Programme:

2. Regardless of whether your answer to the above question is yes or no, please give the ID numbers of any of the four projects from the Programme, listed overleaf, about which you had previously heard through publications, conference presentations etc:

3. List the ID numbers of any of these projects from which you had read either the article described in the abstract or a different article:

4. List the ID numbers of any projects whose findings have already influenced:
a) Your research:
b) Your clinical practice:
c) Your teaching:

5. List the ID numbers of any projects whose findings you expect to influence:
a) Your research:
b) Your clinical practice:
c) Your teaching:

6. If you have not used, or do not intend to use, the findings from any projects relevant to your area of work, please give your reasons:

7. List the ID numbers of any projects you think already have been, or will be, used by ***others***:

8. Please make any other comments you wish about the potential contribution that could be made by the projects in this programme:

THANK YOU FOR YOUR ASSISTANCE

No. 1:

EFFECTIVE COMMUNICATION: AN EVALUATION OF TOUCHSCREEN DISPLAYS FOR PROVIDING INFORMATION ON PRENATAL DIAGNOSIS

Research team: Wendy Graham, Pat Smith, A Kamal, A Fitzmaurice, N Smith, N Hamilton
Aberdeen Royal Hospitals NHS Trust
Project Summary:
Touchscreen information packages are already used in a variety of situations to facilitate public access to details on a huge variety of topics. One area of particular need is adequate, accessible and appropriate information for women and their partners on prenatal diagnostic tests. A touchscreen system to meet this need has recently been developed in Aberdeen.
The objectives of the proposed study are to evaluate the effectiveness of this touchscreen at providing information, to determine its acceptability to women, and to measure its impact on informed decision-making regarding prenatal diagnostic tests. A randomised controlled trial will be conducted, with one group of women exposed to the touchscreen and supporting information leaflet and the other receiving only the leaflet.

ARTICLE:
RANDOMISED CONTROLLED TRIAL COMPARING EFFECTIVENESS OF TOUCH SCREEN SYSTEM WITH LEAFLET FOR PROVIDING WOMEN WITH INFORMATION ON PRENATAL TESTS

Wendy Graham, Pat Smith, A Kamal, A Fitzmaurice, N Smith, N Hamilton
BMJ, **320:** 155-6 (15 January 2000)

Abstract:……

No. 2:

DEVELOPMENT OF EVIDENCE-BASED MATERIALS; CLINICAL GUIDANCE TREE, DECISION BOARD, AND LEAFLET FOR DECISION MAKING IN PROPHYLACTIC OOPHORECTOMY – PO

Research team: Jack Dowie, Aileen Clarke, Andrew Kennedy, Ian Pell, Vanita Bhavnani
London School of Hygiene and Tropical Medicine

Project Summary:
To develop a Clinical Guidance Tree – an evidence-based decision making aid which will allow patients and clinicians to take account both of available evidence and of patients' values using a computerised interactive decision tree with information presented and elicited in accessible formats. To develop a decision board and a patient information leaflet using the same information as for the Clinical Guidance Tree. To pilot and undertake preliminary feasibility and evaluation studies of the three forms of decision aid in PO. Outcomes investigated will include several measures of the overall quality of the decision made; including an in-depth qualitative assessment of patient and doctor satisfaction and measures of decisional conflict and anxiety, extent of information coverage and exchange, satisfaction with the decision and an assessment of the relationship of the decision made to predicted health gain. Results will be applicable to the process of implementation of best evidence and to practical decision-making in a number of common conditions besides PO, e.g. chronic diseases such as asthma, diabetes and hypertension and will also indicate the costs and benefits of the process of incorporating patients' values into evidence-based decision making.

ARTICLE:
DEVELOPMENT AND PRELIMINARY EVALUATION OF A CLINICAL GUIDANCE PROGRAMME FOR THE DECISION ABOUT PROPHYLACTIC OOPHORECTOMY IN WOMEN UNDERGOING A HYSTERECTOMY

I Pell, J Dowie, A Clarke, A Kennedy, V Bhavnani
Quality and Safety in Health Care, **11:** 32-39 (2002)

Abstract:……..

No. 3

AVAILABILITY OF INFORMATION MATERIALS TO PROMOTE EVIDENCE-BASED PATIENT CHOICE

Researcher team: Angela Coulter, Vikki Entwistle, David Gilbert King's Fund

Project Summary:
A four-stage study to investigate the availability of patient information materials about treatment choices for ten conditions for which high quality systematic reviews exist; to assess the materials in terms of scientific validity and acceptability to patients; to develop guidance on the production of patient information; to provide practical help to health authorities and health care providers on evidence-based patients choice.

ARTICLE:

SHARING DECISIONS WITH PATIENTS: IS THE INFORMATION GOOD ENOUGH?

Angela Coulter, Vikki Entwistle, David Gilbert
BMJ, **318:** 318-322 (30 January 1999)

Summary points:……..

No. 4

A SYSTEMATIC REVIEW OF RISK COMMUNICATION – IMPROVING EFFECTIVE CLINICAL PRACTICE AND RESEARCH IN PRIMARY CARE

Research team: Adrian Edwards, Kerenza Hood, Elaine Matthews, Daphne Russell, IanRussell, Jacqueline Barker, Michael Bloor, Philip Burnard, Judith Covey, Roisin Pill, Clare Wilkinson, Nigel Stott.
University of Wales College of Medicine.

Project Summary:
The study of risk communication involves consideration of the characteristics of the communicator; the nature of the communication and the methods used to convey it; and the characteristics of the target person. The review will seek medical, nursing and social science literature for theoretical models and evidence from risk communication studies.
It will focus on general practice based primary care and on "one-to-one" communication. The principal aim is to produce up-to-date guidance to improve clinician/patient communication on issues such as risk status, risks involved with screening and treatment procedures etc. This would enable better use of available research findings and thus facilitate more cost-effective health care. Subsidiary aims are: (1) to identify a future research agenda for risk communication in primary care and (2) to establish a database of qualitative literature on risk communication studies.

ARTICLE:

THE EFFECTIVENESS OF ONE-TO-ONE RISK-COMMUNICATION INTERVENTIONS IN HEALTH CARE:A SYSTEMATIC REVIEW

Adrian Edwards, Kerenza Hood, Elaine Matthews, Daphne Russell, Ian Russell, Jacqueline Barker, Michael Bloor, Philip Burnard, Judith Covey, Roisin Pill, Clare Wilkinson, Nigel Stott.
Medical Decision Making, **20:** 290-297 (2000)

Abstract:……..

Appendix 7: Questionnaire to Heads of Midwifery and Researchers in the Maternity Care Field

Dear colleague,

Evaluation of the NHS R&D Implementation Methods Programme: Projects Related to Maternity Care.

We are seeking your views as part of the assessment of a major R&D programme aimed at enhancing effective health care.

The National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) now have responsibility for the NHS's R&D Implementation Methods Programme. Most of the programme's projects are now finished, therefore the Health Economics Research Group at Brunel University was commissioned to conduct an evaluation. This is intended to inform thinking about issues such as research commissioning in this field.

One element of the evaluation is to gather the views of potential users of the programme about its value in their field. Attached is a one page questionnaire followed by brief details of three projects, out of the 36 commissioned by the programme, that could be classified as relating to maternity care (Projects were selected for funding on the basis of their approach to studying research implementation. It seems appropriate, however, for the evaluation to seek the views of reasonably coherent groups of potential users based on their medical field or professional grouping.)

We hope you would be willing to read the enclosed brief, one page, details of each of the three projects, and then complete the single questionnaire that covers all the projects using the ID number given to each project.

The answers will be treated in the strictest confidence and neither the project database, nor the final report, will identify any respondents. Information about this evaluation will be available in a few months time on the NCCSDO web site.

Please return your answers to me by 23 October using the enclosed prepaid envelope.

Please contact me if you have any queries about the questionnaire.

Best Wishes

Dr. Stephen Hanney.

PLEASE ANSWER THESE QUESTIONS USING THE I .D. NUMBER GIVEN TO THE ATTACHED PROJECTS.

1. Had you previously heard about the NHS R&D Implementation Methods Programme:

   Yes No

2. Regardless of whether your answer to the above question is yes or no, please give the **ID numbers** of any of the three projects from the Programme, listed overleaf, about which you had previously heard:

   _____

3. List the **ID numbers** of any of these three projects from which you had read either the article described in the abstract or a different article:

   _____

4. List the **ID numbers** of any projects whose findings have already influenced:

a) The clinical practice of yourself or your unit: _____
b) Your research: _____
c) Your teaching: _____

5. List the **ID numbers** of any projects whose findings you expect to influence:

a) The clinical practice of yourself or your unit: _____
b) Your research: _____
c) Your teaching: _____

6. If you have not used, or do not intend to use, the findings from any projects relevant to your area of work, please give your reasons:

   _____

   _____

   _____

7. List the **ID numbers** of any projects you think already have been, or will be, used by ***others*** to make a contribution to enhancing effective health care:

   _____

8. Please state your role(s) in relation to the health service (such as, midwife, university-based researcher): _____

9. Please make any other comments you wish about the Implementation Methods Programme:

   _____

   _____

   _____

THANK YOU FOR YOUR ASSISTANCE AND PLEASE RETURN THE QUESTIONNAIRE USING THE PREPAID ENVELOPE TO:

DR. S. HANNEY, HERG, BRUNEL UNIVERSITY, UXBRIDGE, UB8 3PH

No. 1:

EFFECTIVE COMMUNICATION: AN EVALUATION OF TOUCHSCREEN DISPLAYS FOR PROVIDING INFORMATION ON PRENATAL DIAGNOSIS

Lead Researcher: Dr A Pat Smith Aberdeen Royal Hospitals NHS Trust

Project Summary:
Touchscreen information packages are already used in a variety of situations to facilitate public access to details on a huge variety of topics. One area of particular need is adequate, accessible and appropriate information for women and their partners on prenatal diagnostic tests. A touchscreen system to meet this need has recently been developed in Aberdeen.

The objectives of the proposed study are to evaluate the effectiveness of this touchscreen at providing information, to determine its acceptability to women, and to measure its impact on informed decision-making regarding prenatal diagnostic tests. A randomised controlled trial will be conducted, with one group of women exposed to the touchscreen and supporting information leaflet and the other receiving only the leaflet.

ARTICLE:

RANDOMISED CONTROLLED TRIAL COMPARING EFFECTIVENESS OF TOUCH SCREEN SYSTEM WITH LEAFLET FOR PROVIDING WOMEN WITH INFORMATION ON PRENATAL TESTS

Wendy Graham, Pat Smith, A Kamal, A Fitzmaurice, N Smith, N Hamilton
BMJ, **320:** 155-6 (15 January 2000)

Abstract:……

No. 2:

UPTAKE OF EFFECTIVE PRACTICES IN MATERNITY UNITS

Lead Researcher: Dr Jenny Hewison University of Leeds

Project Summary:
This is a national study of changes in adherence to four obstetric care standards over time, conducted in 20 hospitals selected at random. It has two objectives, to estimate adherence to standards which are strongly supported by evidence from a well publicised database of systematic reviews (the Cochrane Database and its electronic and published precursors); and to relate this quality measurement to the knowledge and attitudes of clinicians, and to the rigour of the procedures established for implementing change. The standards are: use of 1) prophylactic antibiotics for Caesarian Section, 2) steroids when pre-term delivery can be anticipated, 3) the ventouse for instrumental delivery, 4) suture material used to repair episiotomy, and 5) the management of eclampsia. Current levels of adherence will be placed in the context of past performance. The results will determine the scope for further improvement and indicate topics for intervention studies.

ARTICLE:

THE LEEDS UNIVERSITY MATERNITY AUDIT PROJECT

B Wilson, J G Thornton, J Hewison, R J Lilford, I Watt, D Braunholtz, M Robinson
International Journal for Quality in Health Care, **14**: 175-181 (2002)

Abstract:……

No. 3:

EVALUATION OF INFORMED CHOICE LEAFLETS IN MATERNITY CARE

Lead Researcher: Professor Mavis Kirkham University of Sheffield

Project Summary:
A study to evaluate the use of the informed choice leaflets in maternity care by means of:

- Mapping present use;
- An ethnographic study of 3 differing sites of current use;
- A 12 site RCT in Wales.

This will measure outcomes in terms of knowledge, attitudes, psychological, emotional and physical outcomes and relevant organisational and economic factors.
Qualitative work within the RCT will examine the process of leaflet prescription and use. Tools will be developed for local use – monitoring and assessing leaflets in use.
The results will be likely to be useful in many areas concerned with informed choice and of wider significance in maternity care.

Funded jointly with the Central R & D programme.

ARTICLE:

QUALITATIVE STUDY OF EVIDENCE BASED LEAFLETS IN MATERNITY CARE

Helen Stapleton, Mavis Kirkham, Gwenan Thomas.
BMJ, **324:** 639-643 (16 March 2002)

Abstract:……..