Delivering Health: Clinical, Management Delivery, and Policy Challenges

Lecture 1: Why is it so difficult to implement evidence-based decision making?
January 23, 2017; 6:00pm-7:20pm

Richard Gleave, Public Health England

Is “accountability” an important reason why it’s so difficult to implement the evidence-base on improving and protecting the public’s health?

- Re-forming of the question
- Three different perspectives – practitioner, academic, policy maker
- How do you deal with dilemma between establishing an intervention that’s trying to be effective and contrasting evidence
- Projects - single person ultimately answerable for completion
- Who do we hold to account? And for what?

Improving the public’s health requires us to look wider than Evidence-Based (EB) Medicine

- Evidence based medicine
  - Based in positivist and empiricist frameworks
- EB public policy
  - More interpretive, specific issues of implementation
  - Understanding the value-laden policy, perceptions and values around what we’re trying to do
- EB practice
- EB health care
- Using evidence to design population-level interventions that can be implemented leading to a population-level health benefit
- “What matters is what works”- Tony Blair but also “what does not work” is important

The Evidence Challenge

- A new “Health of the Public” research paradigm recommended by the Academy of Medical Sciences in their new report “Improving the health of the public by 2040”
- Document stimulates what research we should be doing about the public’s health for the next decades
- Specific recommendation – to work with the research community to strengthen the mechanisms for obtaining and collecting independent evidence on improving the health of the public. Directed at health and social practitioners but this needs to be taken on board by many other groups as well

Evidence to inform policy on the “Health of the Public”

- Make us think about the evidence we’re going to use
• Causal model
  o No simple, linear cause to problems in the public’s health

• Economic goal
  o Cost effectiveness and return on investment are different (and managers have more focus on ROI)

• Timescale
  o Retrospective, prospective and addresses risk
  o Things that take such a long time, have to establish a different way of collecting and using evidence

Tobacco control
• Multi-causal approach
  o Mayor Bloomberg and Public Health Service in NY designed community level interventions to improve health

• Cost effectiveness and return on investment
  o Link between the two is becoming more evident
  o Example: NICE’s work on brief interventions to help people stop smoking, adding some self-help elements creates a more cost-effective intervention while the ROI Takes about 3 years to make savings to cover the costs

• Prospective evidence
  o Have to use research you have, such as expert opinion
  o Differing findings – methodological flaws? Different contexts?

Journey of evidence into practice
• Academic studies – large growth
• Increased surveillance data
• Synthesis of academics and increased surveillance
• Government advisory committee
• Journey is built up over the years
• “Muddling through” – policies evolve and you have to think through them alongside the practical realities of public implementation
  o Studies – synthesis – advice – decision – implement

• Framing government policy on “health inequalities”
  o Have a statement of intent from the Prime Minister but should we be focusing on implementing the evidence or implementing best practice – they may not be the same thing

Academic Health Science Network
• These were set up to have both a “License to operate” to do the things they think are right in implementing the evidence and contracts to deliver specific projects required by the NHS nationally
• Horizontal accountability between local partners is key
• Trying to address the issue of independence and evidence conflicting with influence and timing
Dr. Sue Dopson, Said Business School

Why is translation of evidence so hard in health care settings?
- Failure of system to anything research says about why change is difficult
- Leadership is difficult in complex systems
- Know that networks are seen as vehicles for translating evidence into practice
- Started talking with clinicians about what influenced their practice
- Not just their guidelines, blended approach
- Evidence is malleable- can mean a lot of different things
- We don’t spend enough time thinking about context
- Leaders don’t transfer evidence in a rational way, they transpose it and mould it

What’s the burden of disease and what’s our moral responsibility around wellbeing?
Adaptive leadership
- Courage to see patterns
- Understand subcultures
- Can’t expect a strategy to land the same way with everyone
- People will follow you if they understand why, and see what’s in it for them
- Convene conversations that wouldn’t normally happen

Case Study – The Genetic Knowledge Path Idea
- No specification of what the networks were there to do
- More we understand the context, more likely we can get some success
- Community: medical science, NHS medical science, social science, policy community- clashes between all these groups
- Institutional and epistemic affiliation play a key role
- Everyone wanted to work together to get good evidence into practice with genetic research, but there were those clashes

The challenge of change
- Not enough time spent by leaders thinking about what problems you want to solve
- Three kinds of problems
  o Critical challenges: commander
  o Tame challenges: management
  o Wicked challenges: leadership
- Can learn a lot from studying the historical development of an organisation
- We inherent context, but leaders can shape them
- Great leadership could have nudged the system and lead to better translation of what was good science
- Approaches to change management - unfreeze, movement, refreeze

Concluding thoughts:
- Need to think about innovating with new models of managing change
- Importance of being curious
- Need to get on the balcony to see why things aren’t working
• Identify the context, the challenge
• Leaders who provide safe spaces for conversations to happen are more likely to get translational work
• If can nudge context, can get effective evidence into practice
• How do we know what works?
• Are we interested in best practice
• Material difference between best practice and best evidence?

Questions

Evidence based policy is different from evidence based medicine, is evidence based health policy always based in medicine?
• Answers won’t always just draw on medical base. Need to draw on organisational theory. Need to be able to look both ways, issue is that there aren’t many people who can straddle both worlds

Are there good examples of leaders who have solved wicked health problems?
• At the local level, yes. Ingredients to being a high performing system… Characteristics are people who have emotional intelligence, self aware, great networking skills, curious about using evidence, create self spaces. Also play in performance management box, change what incentivizes people. Build a great team