

Research, evaluation and evidence: a guide for commissioners



INTRODUCTION

Research has an important role in providing evidence for commissioners to aid in making decisions about commissioning health services, delivering services and individual patient care. The Health and Social Care Act 2012, the NHS Constitution, the NHS Operating Framework and the NHS Outcomes Framework all place an emphasis on research and the use of research evidence in the commissioning and delivery of services.

The Health and Social Care Act 2012 places a statutory duty on NHS England and Clinical Commissioning Groups to promote:

- a) Research on matters relevant to the health service, and
- b) The use of evidence obtained from research to improve health services.

The purpose of this resource is to provide a practical guide to support boards and governing bodies of NHS commissioning organisations and commissioners, particularly within NHS England and CCGs, in:

- Delivering their statutory responsibilities in relation to research;
- Increasing participation in research;
- Developing evidence based commissioning;
- Increasing their research capacity;
- Identifying good practice examples, and translating these into practice locally.

This resource has been developed through the collaboration of research managers from the Association of Medical Research Charities (AMRC), Research and Development Directorate of the Department of Health, National Institute for Health Research (NIHR), NHS England, and the NHS R&D Forum Primary Care and Commissioning Working Group. Each section of the resource provides an overview of the topic followed by guidance and links to suggested resources.

GLOSSARY

AcoRD	Attributing the costs of health and social care research and development
AHSN	Academic Health Science Network
AMRC	Association of Medical Research Charities
CASP	Critical appraisal skills programme
CCG	Clinical Commissioning Group
CLAHRC	Collaborations for leadership in Applied Health Research and Care
CQC	Care Quality Commission
CRN	Clinical Research Network
CSU	Commissioning Support Units
CtE	Commissioning through Evaluation
ETC	Excess Treatment Cost
ETS	Excess Treatment Saving
HEE	Health Education England
HEI	Higher Education Institutes
HRA	Health Research Authority
HSG	Health Service Guideline
NETSCC	NIHR Evaluation and Trials Study Coordinating Centre
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
PHE	Public Health England
PPIE	Patient and Public Involvement and Engagement
RCGP	Royal College of General Practitioners
RCT	Randomised Controlled Trial
RDS	Research Design Service

SECTION ONE

The benefits and value of research to health care and the economy:

- Overview and introduction to evidence informed commissioning
- General overview and introduction to the benefits of research

Evidence informed commissioning

Evidence informed commissioning utilises best evidence in making decisions about commissioning health services, delivering services and individual patient care. Evidence, used effectively, has the potential to lead to innovation, enhance the quality of health care, reduce clinical variation and improve outcomes. The focus on improving the quality, efficiency and effectiveness of health and care services means that commissioners need access to good quality evidence of what is most effective.

Best evidence is based on information from a number of sources including relevant high quality research. Research is an important element of the knowledge pathway but there is often a gap between the world of research and health services, and a substantial amount of health related research is not translated into practice and is not used as part of the commissioning cycle.

Evidence informed commissioning should be systematic so that commissioning is based on robust evidence, knowledge and understanding of what works. Evidence, evaluation and research should be part of commissioning activity and should assist decision making.

At an individual and team level, there needs to be an understanding of how information, knowledge, evidence (including research) informs practice and decision making processes. Commissioners and providers of services need the tools, information, support and skills to make best use of information, knowledge and research to inform practice.

RESEARCH AS EVIDENCE

Benefits of research

- The use of evidence, including research evidence, leads to more effective commissioning and better services.
- The use of evidence to support decision making can help commissioners to commission the right services in the right place at the right time.
- Research findings can support service improvements.
- Using evidence and research to demonstrate what works can lead to improvements in patient outcomes and in the way services are delivered.
- People like to work in organisations that are innovative and forward thinking and research can help to create a more positive environment.

Key messages:

- Research is everybody's business.
- The quality of commissioned services can be improved by using the best research evidence.
- Use of research evidence leads to better commissioning and more effective services.

SECTION TWO

Identification of NHS relevant research questions:

- How to identify a research topic
- How to generate an answerable research question

Identify a research topic

Health service commissioners and providers can identify problems or uncertainties related to the services they are offering. They may want to improve patient experience or outcomes, or engage in service or pathway design or re-design. In order to address the problem or uncertainty they need information and knowledge. There are different levels of knowledge need:

- accessing evidence to support and inform commissioning decisions,
- service design, re-design, and service improvement,
- synthesis of evidence,
- sharing knowledge,
- knowledge management,
- developing the evidence base,
- translation of research findings into practice;

How important is the problem or uncertainty?

Before assuming that the problem or uncertainty needs to be formed into a research question, consider first what information and knowledge is needed to address the problem.

Does this knowledge or information already exist?

- Is there a systematic review or primary research evidence?
- If primary research evidence exists, is there a need for a rapid review or a systematic review of the evidence?
- How do you know that the evidence is relevant, valid, and of sufficiently high quality?
- If there is no evidence or insufficient evidence, how will the problem or uncertainty be best answered?

RESEARCH QUESTIONS

Generating a research question

The first stage of developing a research project or commissioning a project is to identify the research question. The research question sets out what you hope to learn about a topic; and, together with your approach, will guide and structure the choice of data to be collected and analysed. The question should be relevant, interesting, manageable, clear and simple.

Most people start with a topic rather than a question; but how do you turn this into an answerable question? Think about:

- Why is it important to examine this area?
- Who would it benefit?
- Is this a new idea or has it already been studied?
- If it has been done before, am I asking a different question or looking at it in a fresh way?
- Is this a local issue or a general population issue?

The question should identify the population (P), intervention (I), comparison (C) and outcome (O); this is referred to as the PICO model.

What next?

Having developed the research question, the next step is to consider how to turn this into a project. Questions to consider are:

- Are there any similar projects currently being undertaken or completed? For information on other projects, the following are useful resources:
www.nihr.ac.uk/research/programme-studies.htm
www.thecochranelibrary.com
- What are the options in taking this forward? Is this something that can be supported within the organisation or does it need a collaborative approach with, for example, local University partners?
- Is this a research project your organisation could commission?
- Is this a research question that could be submitted to the NHS England Research Needs Panel? Contact englandranddproposals@nhs.net to find out how to submit a research question for consideration.
- What advice, support and resources are needed?
- Is this a policy research question that could be considered by the Department of Health's Policy Research Programme?
- Is funding available or should funding be sought from a NIHR funding programme? <http://www.nihr.ac.uk/funding-opportunities/>

Advice and support can be provided by your local NHS R&D Primary Care Support Team; and the local NIHR Research Design Service also provide advice about developing grant funding applications <http://www.rds.nihr.ac.uk>

SECTION THREE

Statutory research responsibilities:

- Outline of statutory responsibilities
- Delivering responsibilities
- Induction of staff

Statutory responsibilities

The Health and Social Care Act 2012, the NHS Constitution, the NHS Operating Framework, the NHS Outcomes Framework and the NHS Mandate all place an emphasis on research and the use of research evidence in the commissioning and delivery of services. The Health and Social Care Act 2012 places a statutory duty on NHS England and Clinical Commissioning Groups to promote research and to use research based evidence in the health service.

Delivering responsibilities

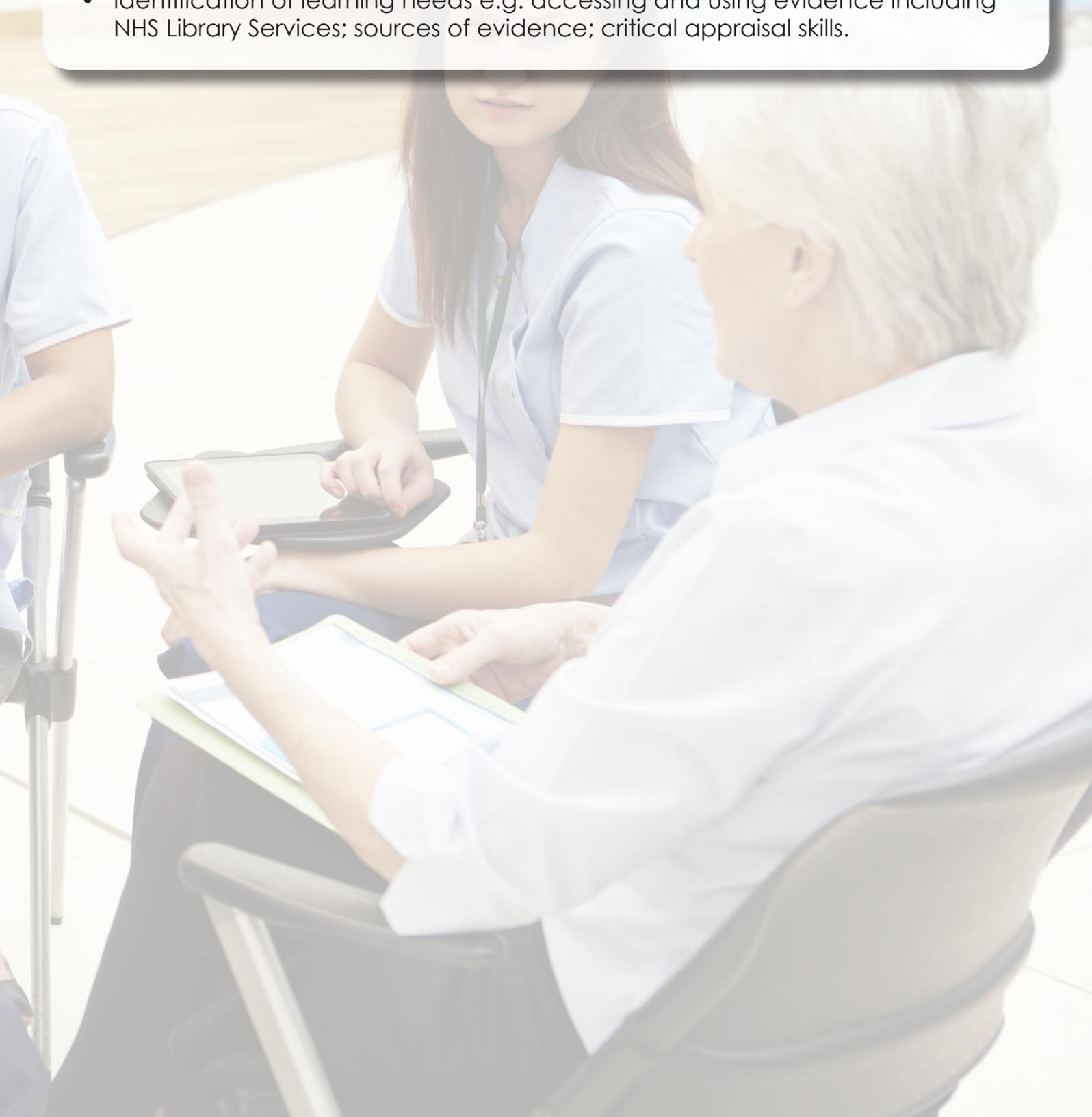
- Identify an individual at Board or Governing Body level that has responsibility for promoting and supporting participation in research.
- Put in place a plan to include research activity in all provider contracts issued within the next contracting round. The NHS Standard Contract contains a clause requiring provider engagement in research (SC26). Additional research requirements can be included in provider quality schedules.
- Ensure research is a standing item at Board or Governing Body meetings.
- Have in place a process and system for meeting treatment costs including Excess Treatment Costs ie a system that managers ETCs and Excess Treatment Savings (ETs) and can offset the former against the latter
- Ensure strong links with AHSN and other research networks.
- Support and encourage an increase in the number of member GP practices that are accredited as RCGP research ready: <http://www.rcgp.org.uk/clinical-and-research.aspx> and are engaged with the NIHR CRN.
- Ensure induction with new employees includes discussion about innovation and improvement and the use of evidence to inform service delivery and commissioning
- Ensure staff have access to NHS Library Services to enable access to online evidence
- Ensure the organisation has access to NHS R&D support.
- Provide a point of contact within the organisation and provide funding to ensure that there is someone within the organisation who is interested in and has dedicated time to support research.

STATUTORY RESPONSIBILITIES

Induction of staff

Suggested areas for inclusion in staff induction programme:

- Understanding information and knowledge needs;
- Understanding evidence and research findings;
- Use of evidence, research findings, research in practice;
- Identification of learning needs e.g. accessing and using evidence including NHS Library Services; sources of evidence; critical appraisal skills.



SECTION FOUR

NHS costs:

- Overview of NHS costs
- NHS costs to be attributed
- Payment of treatment costs
- Research Capability Funding

NHS costs

The costs of research have to be identified and funded; and the NHS responsibility extends to ensuring that the treatment costs, including Excess Treatment Costs (ETCs), of patients involved in non-commercial research are met. Excess Treatment Costs are the difference between the standard cost of treating the patient and the treatment cost arising out of the patient's participation in a research study.

NHS costs to be attributed

The responsibility for meeting patient care costs, resulting from research and development, was set out in HSG (97)32. Further guidance (AcoRD) was issued by the Department of Health in May 2012 and sets out the basis for Attributing the Costs Of health and social care Research and Development (AcoRD) including Excess Treatment Costs for non-commercial research. See guidance: <https://www.gov.uk/government/publications/guidance-on-attributing-the-costs-of-health-and-social-care-research>

There are three main categories of cost to be attributed:

1. Research costs, which relate to the costs of the research and are activities that end on completion of the research study. These costs are generally met from the research grant which has been awarded for the study.
2. Support costs, which are additional patient care costs that end once the research study concludes and are generally met from the NIHR Clinical Research Network budget.
3. Treatment costs, which are costs incurred if the care to the patient will still be provided when the study has ended.

Payment of treatment costs

Treatment costs (TCs) are the costs of patient care that would be incurred if the care/treatment was still provided after a research study had ended, even though we won't know whether this will be the case until the research study has ended. TCs include all types of patient care services i.e. diagnostic, preventative, continuing care, rehabilitation and health promotion. They should be paid through normal commissioning arrangements for patient care.

Excess treatment costs (ETCs) are the difference between the total treatment costs and the cost of standard treatment; they are part of the treatment costs, therefore normal commissioning arrangements apply. ETCs should be identified at an early stage of a research study and where possible, costs should be minimised and discounts negotiated. For further guidance see: <https://www.england.nhs.uk/wp-content/uploads/2015/11/etc-guidance.pdf>

Subvention support may be available from the Department of Health (DH) in exceptional cases, generally where the excess treatment costs are very high or where there are very few centres. The level of subvention costs is determined by the DH.

Excess treatment savings (ETS) may be made on patient care costs during a research study, for example, due to industry providing drugs or devices. The sav-

Research Capability Funding (RCF)

RCF is a NIHR funding stream designed to help research-active NHS organisations act flexibly to support and maintain research capacity. RCF is allocated to NHS organisations in proportion to the total amount of other NIHR income received by that organisation, and either on the number of NIHR Senior Investigators associated with the organisation or through recruiting 500 participants to NIHR CRN adopted non-commercial studies. For CCGs this relates to participants recruited through their GP member practices. Examples of how CCGs could use their RCF allocations to support and maintain research capacity include:

- time to champion and embed delivery of research as core business in a practice, or emerging GP Federation
- time for practices to work with academics to contribute research ideas and provide clinical input to NIHR grant development or for those with expertise and experience to develop their own research applications
- sessional research lead posts in CCGs and primary care R&D support services
- a local academic to conduct preparatory work required to submit a NIHR grant application on research question of strategic importance to the CCG

SECTION FIVE

NHS and public participation in research:

- Increasing NHS staff participation in research
- Why public participation in research is important
- Increasing public participation in research

Actions to increase NHS staff participation in research

There are a number of actions that commissioner organisations can take to increase staff participation in research studies:

- Proactively engage with the National Institute for Health Research (NIHR), Clinical Research Networks (CRN), Academic Health Science Networks (AHSN) and other initiatives such as the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) .
- Ensure induction of new employees includes discussion about research innovation and improvement and the use of evidence to inform service delivery and commissioning.
- Enable employees to have access to appropriate research related training and offer a range of research opportunities.
- Incentivise and reward staff to engage in research.
- Build research into job descriptions and ensure dedicated time is allocated.
- Include research skills and evidence appraisal as desired criteria in NHS jobs.

The importance of public participation in research

The NHS Constitution (2013) includes a commitment to inform patients “--- of research studies in which you may be eligible to participate”. NHS England supports the goal for “every willing patient to be a research patient” (Department of Health 2011). This benefits both the NHS and patients alike and increases the availability of patient data which inform research priorities and improve patient safety.

Much of the life-saving clinical research carried out in the NHS could not happen without hundreds of thousands of members of the public volunteering every year to participate. Those who volunteer in this way report a range of benefits and are pleased to be potentially helping others like themselves with the same condition.

RESEARCH PARTICIPATION

Increasing public participation in research

Although more than 600,000 people across England volunteered to take part in a clinical trial or study in 2013/14; research overall has a low visibility in the NHS. To change this and to ensure that patients are more aware that research takes place in all settings of the NHS, there are a number of actions that commissioner organisations can take to increase public participation in research studies, for example:

- Require provider organisations to actively engage in research studies and open up research opportunities for patients. This will support an increase in the number of patients taking part in National Institute of Health Research portfolio research studies.
- Require provider organisations to demonstrate that they provide information to every patient about opportunities to be involved in research.
- Require provider organisations to demonstrate that patients are engaged in study design and development.
- Promote the 'OK to Ask' campaign: <http://www.nihr.ac.uk/get-involved/ok-to-ask.htm>
- Ensure information about research is available in accessible formats.
- Ensuring that there are mechanisms in place to avoid problems in set-up and delivery e.g. meeting the costs of treatment at the onset of the study and additional treatment costs that may occur through protocol amendments.

Key messages:

- Patients should be given the opportunity to participate in research;
- Information about research should be made available to patients and the public in accessible formats;
- An active research organisation provides incentives and motivation for staff to engage in research; and the mechanisms to ensure robust set-up and delivery.

SECTION SIX

Increasing capacity:

- Why do we need to increase capacity?
- What are the aims of the NHS?
- Practical actions to increase capacity

Why do we need to increase capacity?

Clinical research provides the evidence needed to evaluate the effectiveness and (increasingly) the cost implications of new or different treatments, so that the NHS can continue to improve the quality of care for patients within the available resources.

An evidence-informed NHS requires more people (leaders, managers, healthcare professionals and patients) to be aware of the importance of clinical research to patients and the NHS, and to become actively engaged in the conduct of clinical studies.

Whilst figures from the National Institute for Health Research show that almost all (99%) NHS Trusts and Foundation Trusts are involved in clinical research to some extent, the level of research engagement across different therapy areas can be patchy and there is still much work to do to increase clinical research capacity across all parts of the NHS, so that patients have equality of opportunity to take part in clinical research studies.

As a commissioner of healthcare services, you can encourage service providers to extend their capacity for clinical research, which in turn will increase the overall ability of the NHS to answer research questions that lead to better care, and affordable treatments.

The NHS aims to:

1. promote, conduct and use research to improve the current and future health and care of the population.
2. commit to the use of anonymized information to support research and improve care for others.
3. inform patients of research studies in which they may be eligible to participate.

INCREASING CAPACITY

Practical actions to increase capacity

When commissioning new services, consider the extent to which the service provider is actively engaged in conducting clinical research studies, and therefore building the evidence base to support quality improvements.

You can also use your influence as a commissioner to motivate providers of NHS services to increase their participation in clinical research activity across all therapy areas, and signpost towards those organisations that can help:

The NIHR Clinical Research Network supports NHS organisations in the delivery of clinical research studies: www.crn.nihr.ac.uk

You can encourage the healthcare providers that you commission to develop the clinical research skills of their workforce and increase their capacity to conduct studies. Signpost to:

Clinical academic development programmes from the National Institute for Health Research <http://www.nihr.ac.uk/faculty/Pages/default.aspx>

Good Clinical Practice and Valid Informed Consent training from the National Institute for Health Research
<http://www.crn.nihr.ac.uk/learning-development/>

Research Ready self-accreditation tool (to support primary care practices in becoming active in clinical research)
<http://www.rcgp.org.uk/clinical-and-research/our-programmes/research-facilitation-and-support/research-ready-self-accreditation.aspx>

You can foster local relationships with the CRN to understand and maximise the support and funding that may be available.

SECTION SEVEN

Adoption of research:

- Adoption of research into practice
- Knowledge transfer

Adoption of research

The adoption of research improves patient outcomes and improves the quality of services. Achieving the adoption of research into practice can be challenging and requires a variety of strategies such as:

- continued education
- dissemination and implementation of guidelines
- opinion leaders or knowledge champions
- engagement of stakeholders i.e. commissioners and researchers at an early stage of a research project
- timely sharing of findings.

Support for the implementation of research is available through the Academic Health Science Networks (AHSNs); which are tasked with supporting their local health community with the translation of research into practice including bio-medical and health services research.

They are a collaboration between academia and the NHS, working with industry, social care and public health: <http://www.england.nhs.uk/ourwork/part-rel/ahsn/> Collaboration leads to better research questions and an increase in adoption of research into practice.

Knowledge transfer

Having identified the evidence of 'what works', commissioners have the challenge of how to share and manage the knowledge to ensure the evidence is translated into their commissioning practice and decision making. The process of transferring evidence into practice is often known as knowledge transfer.

Knowledge transfer refers to the process of transferring information and evidence from one part of the organisation to another. It involves the creation, capture, organisation or distribution of information, and evidence, to ensure its availability for future users.

ADOPTION OF RESEARCH

The five elements of the model for transferring knowledge into action are:

1. Problem - identifying and clarifying the problem.
2. Context - analysing the context of the producers and users of the knowledge and evidence.
3. Knowledge - developing and selecting the knowledge and evidence to be transferred.
4. Intervention - selection of the knowledge transfer activity or intervention.
5. Use – consideration of how the knowledge and evidence will be used in practice.

Case study:

The Centre for Healthcare Innovation and Improvement (CHI²), the University of Bath and the West of England Academic Health Science Network are working together to model the impacts of Atrial Fibrillation management on whole health and social care systems.

At present there is no standardised approach to the management of Atrial Fibrillation across the West of England. There are a wide range of approaches from anti-coagulation services which are predominantly GP led, through to those where INR outpatient clinics in acute hospital settings are the main provider.

The long term aim is to develop a modelling toolkit for use nationally by local communities and commissioners to help with decisions around the organisation of anti-coagulation and stroke prevention services in terms of patient outcomes. Find out more at: <http://www.bath.ac.uk/chi2/project/atrial-fibrillation/>

SECTION EIGHT

Service evaluation:

- The role of service evaluation in commissioning
- Good practice
- Clinical Audit

Service evaluation in commissioning

Service evaluation is a key part of the Commissioning Cycle (Figure 1) and is “--- the systematic collection of information about the activities, characteristics and outcomes of programmes, personnel and products to reduce uncertainties, improve effectiveness, and make decisions.” (Patton, 1982).

The role of evaluation is to:

- Provide a basis for decision-making and policy formation
- Assess achievement
- Evaluate against performance criteria
- Monitor expenditure of public funds
- Drive improvement of health and care programmes, services and interventions
- Accreditation of institutions/ providers.

Different types of evaluation:

- Formative – assists development of a programme, intervention or innovation
- Summative – assesses the effects and effectiveness of a programme or intervention
- Process – systematic observation and study of what actually occurs in a programme or intervention
- Outcome – how far a programme or intervention meets its stated objectives.



Figure 1. The Commissioning Cycle

SERVICE EVALUATION

Good practice for organisations in evidence based commissioning

The organisation:

- recognises the need to use best evidence from research and evaluation to inform commissioning decisions.
- has processes for accessing, interpreting and applying research evidence appraisals to inform service redesign and commissioning policy
- can demonstrate how achievement against the NHS outcomes framework informs the design and commissioning of services.
- can demonstrate that it has processes in place to ensure the evaluation of services it commissions.
- has processes and structures for routinely accessing relevant evidence including research evidence appraisals, service evaluation and grey literature to inform service redesign and commissioning policy.
- can provide evidence of using the [Commissioning Intelligence Self-Assessment Tool](#) or other appropriate and validated tools to support their commissioning decisions.
- can show how it uses information from performance against the outcomes framework to generate research priorities and questions.
- can demonstrate that policy development has taken account of the underlying rationale and supporting evidence.
- has processes in place for ensuring that appropriate service evaluation is a routine element of the commissioning cycle.
- has explicit structures and processes for continuing quality improvement of services.

The Health Foundation publication, "Evaluation: what to consider", is a helpful resource <http://www.health.org.uk/publication/evaluation-what-consider>

Clinical Audit

Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.

Visit: <https://www.england.nhs.uk/ourwork/qual-clin-lead/clinaudit/>

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