POLICY BRIEFING

Using evidence to guide policy decisions

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Summary

The Scottish Government has made a commitment to devolve considerable responsibility for public service delivery to local authorities, and encourage them to produce strategy documents, such as Single Outcome Agreements (SOAs), with their public sector partners and stakeholders.

However, key commentators on central-local relations remain sceptical about the practical extent to which local authorities can go their own way in a meaningful sense: the Scottish Government still centralises many aspects of public service delivery; it controls the majority of local authority budgets; and, local authorities lack an equivalent research capacity to gather, interpret and use the evidence on best practice in local delivery. Therefore, local authorities rely heavily on the Scottish Government for information and advice on which interventions should be supported and funded.

This document focuses on the final obstacle to local authorities' autonomy: the ability to use evidence of policy success, from interventions inside and outside their local areas, to guide their decisions.

It aims to give a framework for discussion on evidence-based policy by highlighting three main ways to gather and use evidence, so that practitioners can clarify their choices. And it gives three illustrative examples of different evidence based policy

interventions: Family Nurse Partnership; My Home Life and Early Years Collaborative.

It will be of interest to members and officers in local authorities involved in policy research, particularly in early intervention and prevention work in areas such as social care, health, and early years initiatives.

Three ways to gather and use evidence

There are three ideal-types of evidence gathering approaches geared towards the roll out of best practice interventions.

They are policy emulation; story telling and improvement science. Each of these interventions prioritise evidence differently.

Policy emulation sees a specific intervention implemented in each area in the same way with evidence used to test the fidelity of that intervention and its effectiveness.. Story telling approach relies on conversations and reflection in gathering evidence and establishing best practice. The third approach of improvement science gives practitioners the scope to identify potential successful interventions and gather evidence of what works in their area. The three approaches are detailed in the table below.

Focusing on these three approaches allows us to identify the assumptions and approaches which underpin evaluations of success. They can be compared by asking three guiding questions:

- *How should you gather evidence of effectiveness and best practice*? In the policy emulation approach, the most important evidence comes from the systematic reviews of randomised control trials (RCTs), which are at the top of a hierarchy of evidence gathering. In the story telling and improvement science approach, there is less commitment to a hierarchy and more weight given to, for example, practitioner experience and service user feedback. In the story telling approach, there is also a high focus on the need to balance stories of success with governance principles (which relate closely *to what can be described as the* 'Scottish Approach to Policymaking' and its focus on the 'assets' of communities and individuals and the benefits of 'co-producing' services).

- *How should you 'scale up' from evidence of best practice?* The *policy emulation* approach requires you to introduce the same model in each area, with very limited discretion to adapt it to local circumstances and preferences. *The story telling and improvement science approaches* allow more space for

adaptation. Policymakers create a supportive environment in which practitioners and users can tell stories of their experience, and invite other people to learn from them in the story telling approach; or they train practitioners in a particular method then invite them to experiment in their local areas in the improvement science approach.

- *What aim should you prioritise?* Each approach places particular emphasis on one way to balance the use of evidence with other factors relevant to local policymakers: focus on *the correct extent of the intervention in the case of policy emulation*; be guided by governance principles and give practitioners and service users the space to exercise their autonomy *in the story telling approach*; or, encourage training and experimentation *in the improvement science approach*. These aims are not *necessarily* mutually exclusive, but in practice we face the need to choose between priorities and approaches.

Three ideal-types of evidence-based best practice

	Approach 1 Policy emulation	Approach 2 Story telling	Approach 3 Improvement science
How should you gather evidence of effectiveness and best practice?	With reference to a hierarchy of evidence and evidence gathering, generally with systematic reviews and RCTs at the top.	With reference to principles of good practice, and practitioner and service user testimony.	Identify promising interventions, based on a mix of evidence. Encourage trained practitioners to adapt interventions to their area, and gather data on their experience.
How should you 'scale up' from evidence of best practice?	Introduce the same specific model in each area. Require fidelity, to administer *the correct degree of intervention*, and allow you to measure its effectiveness with RCTs.	Tell stories based on your experience, and invite other people to learn from them.	A simple message to practitioners: if your practice is working, keep doing it; if it is working better elsewhere, consider learning from their experience.
What aim should you prioritise?	To ensure the correct administration *of the specific intervention*.	To foster key principles, such as respect for service user experiences.	To train then allow local practitioners to experiment and decide how best to turn evidence into practice.
Illustrative	Family Nurse	My Home Life	Early Years

example	Partnership		Collaborative

Three case studies

1. Policy emulation: the Family Nurse Partnership (FNP)

The FNP began in the US as the Nurse-Family Partnership, designed to engage nurses with first time mothers (deemed to be at relatively high risk of poor life chances) *on a monthly basis*, from pregnancy until the child is two. The criteria for inclusion relate to age (teenage), income (low), and partnership status (generally unmarried). Nurses give advice on how mothers can look after their own health, care for their child, minimise the chances of further unplanned pregnancy, and access education or employment. It combines an intervention to address the immediate problems of mothers and early intervention to influence the longer term impact on children.

The US' Coalition for Evidence-Based Policy gave it 'top tier' status, which describes 'Interventions shown in well-designed and implemented randomised controlled trials, preferably conducted in typical community settings, to produce sizable, sustained benefits to participants and/or society'. It describes reductions in pre-natal smoking, child abuse and neglect, and second pregnancies, and improvements in *children's* cognitive function and education attainment at a low cost.

The FNP requires fidelity to the US programme (you can only use it if you agree to the licensing conditions) based on evaluation results which showed that the programme was most effective when provided by nurses/ midwives and using a license 'setting out core model elements covering clinical delivery, staff competencies and organisational standards to ensure it is delivered well' (Department of Health, 2012: 6). Fidelity is a requirement because, 'If evidence-based programmes are diluted or compromised when implemented, research shows that they are unlikely to replicate the benefits'.

This focus on continuous evidence-gathering and fidelity is reflected in the Scottish pilot study in NHS Lothian (2010), in which the first evaluation of progress, in year one, lists achievement according to: recruitment from as early in pregnancy as possible but no later than the 28th week of pregnancy; and, all nurses meeting the qualification criteria, attending all training, working exclusively on the FNP, and having a case load no higher than 25 (Martin et al, 2011). The Scottish evaluation

involves quantitative data to monitor implementation fidelity (one part of the license requirement), and longitudinal qualitative interviews with participants, stakeholders, and practitioners, to help understand the issues that arise 'on the ground' during implementation. There is no Scotland-specific RCT to determine if the FNP produces better outcomes than existing provision. Rather, previous RCTs have been used to justify its introduction, the 'UK RCT' takes place in England (and *initial results suggest that it did not deliver the expected increase in good outcomes*), and new evidence in Scotland comes from user feedback and professional experience. The FNP has now been adopted by the majority of health boards.

The FNP was initially funded and its license held directly by the Scottish Government, in part because it is not expensive, and providing the funding directly was easier and quicker than generating widespread local agreement to merge budgets. Most health boards have now agreed to part-fund and support the FNP in their strategic plans.

2. Story telling: *My Home Life* (Scotland)

My Home Life began as a UK initiative 'to promote quality of life for those living, dying, visiting and working in care homes for older people through relationship-centred and evidence based practice' (http://myhomelife.uws.ac.uk/scotland/). In Scotland, it is coordinated by the University of the West of Scotland, Age Scotland and Scottish Care. It relates closely to Scottish Government's 2011 aim, 'that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting', supported by a well-integrated health and social care system, 'a focus on prevention, anticipation and supported self-management', and an assumption against in-patient hospital treatment.

The pursuit of a 'homely setting' in care homes involves, for example, the inclusion of residents in care home decisions, and processes of reflection regarding a manager's relationship with staff and staff attitudes to residents – via 'caring conversations' over an extended period (perhaps one year).

With this approach, evidence is gathered and used in a very different way to the RCT-driven FNP. Much derives from individual feedback, with a focus on the richness of experience. The result is a set of principles to inform future practice, not a specific intervention *to be measured for fidelity and effectiveness*. The principles are deliberately broad, to allow practitioners and service users to make sense of them in specific settings. For example, Dewar, Cook and Barrie (2014: 5) identify principles to underpin care home design in West Dunbarton, to produce eight 'best practice themes', including the need for: services to facilitate 'personalisation'; *to help* residents, their relatives, and staff make care home decisions; and, continuous staff and management training or reflection to adapt to new circumstances. This

approach contrasts markedly from the FNP's requirement to follow the model closely and gather quantitative data to measure fidelity. With 'my home life', there is no model, and practitioners and service users use their experiences to guide future practice and develop favourable institutional cultures.

3. Improvement science: the Early Years Collaborative (EYC)

The Early Years Collaborative aims to boost the outcomes for children and their families by using the improvement science approach. Improvement science first earned its reputation in the Scottish Government from the NHS patient safety programme, which used the 'Breakthrough Series Collaborative Model' from the Institute of Healthcare Improvement (IHI) in Boston. 'Collaborative' refers to a group of organisations using the best available evidence to solve a specific problem in a limited amount of time. Participants identify a specific aim, measures of success, and the changes to test, then gather quantitative data on their effects, using a form of continuous learning summed up by a 'Plan-Do-Study-Act' cycle.

The EYC is an attempt, from 2012, to adapt and use the IHI's method for single organisations to coordinate a *multi-agency* project, working with local and health authorities through the Community Planning Partnerships in the 32 areas. The Scottish Government's first 'learning session', in January 2013, involved an audience of 800 practitioners. It focused on introducing the improvement method, discussing the EYC's core aim ('best place in the world to grow up'), and outlining key aims such as to reduce infant mortality and achieve developmental milestones under 5s.

The second event focused on the development of specific projects, but on the general assumption that there is no set of known, effective interventions from which to choose. Instead, practitioners use the IHI method to guide their pilot projects. An important strand of this approach is learning as you go, with a long term aim to gather comparable data on local practices to aid learning, supplemented by 'word of mouth' measures of success and local ad hoc decisions to expand projects that practitioners feel are successful. This is often justified with reference to the poor alternatives: the excessive gaps between the RCT evidence on a problem and resultant practice; and, the 'old school' approach to pilots, in which the world had changed before a two-three year programme reported back with recommendations. In this new process, local practitioners identify problems in their own areas, choose their own pace of change, and learn as they deliver – as a way to help translate evidence into cultural or organisational change.

In the EYC, there is less focus (than the FNP) on the efficacy of an 'active ingredient' and more on the bespoke mode of delivery, underpinned by broad principles about how the public sector engages with people, organisations and communities ('co-production' and 'assets based' approaches). For example, at least half of the indicators of success underpinning EYC strategies relate to public service leadership, management, communication, joint working and 'family centred' responses, supplemented with reference to, for example, nutrition and dental health (Scottish Government, 2014: 38-40). Further, rather than attempting to direct local activities, a small Scottish Government team helps practitioners develop and use a 'toolkit' for improvement.

Where do we go from here?

These examples show us that there is more than one way to use evidence to generate a model for further action, and that there are important trade-offs between the criteria used to generate evidence and scale up programmes.

One—policy emulation as represented by Family Nurse Partnerships-- may be described as the pursuit of relative certainty through a centrally funded and directed programme. *The other approaches of storytelling and improvement science can be described as the pursuit of flexibility and localism, with an emphasis on new forms of leadership, and 'letting go' or developing staff capacity and the confidence to challenge top-down leadership.*

In that sense, policy emulation focuses on the active ingredient, *the effect of the* intervention, and the need to implement it in the correct way, while the other two approaches focus more on the complex environment in which policy is delivered and the broad principles underpinning good practice. Within the latter approach, there are also different emphases, with the storytelling approach focusing more on guiding principles and relative autonomy to act in complex situations, and the improvement science approach focusing more on training and guided experimentation.

This discussion does not provide a blueprint for action, but it helps clarify local government choices by asking practitioners to be clear on their answers to the following guiding questions:

1. What kind of evidence do you value most, and do you adhere to a hierarchy of good evidence?
2. How should you balance the evidence on best practice with other factors, such as the best principles on which to base policies?
3. How much are you willing to introduce well-evidenced programmes which require 'fidelity' and limit your ability to tailor policies to local circumstances?

It is tempting to state simply that we want to use *all* relevant evidence and to somehow combine their insights to produce a range of excellent policies. However, these examples show us that different programmes are built on different kinds of evidence and approaches which are not always compatible with each other.

Perhaps more importantly, they present different ways in which to gauge value for money and present different opportunities to invest and evaluate the consequences (for example, the costs and expected benefits of the Family Nurse Partnership are relatively clear, and you have to commit fully to the programme).

Consequently, this framework for discussion should help practitioners produce clarity not only on the evidence of good practice, but also how you gather evidence and weigh it up against other factors.

Readers may be interested in

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