DevoManc: The role of health research & innovation

Part 2: Evaluating health and social care devolution(s)

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Evaluating health and social care devolution(s): some lessons and issues

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Lessons from large-scale reorganisations of health services: the example of acute stroke care

Page 1 of 10

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RESEARCH

Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis

OPEN ACCESS

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Centralised stroke care saves more lives, says study

Radical reorganisation of stroke care in London compares favourably with compromise arrangement in Manchester

Sarah Boseley, health editor
The Guardian, Tuesday 5 August 2014 23.30 BST

An ambulance outside a hospital. Photograph: Alamy

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Hundreds of lives a year could be saved by closure of local hospital stroke units

Chris Smyth Health Correspondent

Almost a hundred lives a year have been saved by closing local stroke units in London, according to a study which suggests that hundreds of people may ...

24/7 units saved lives and got patients out of hospital two days quicker.

In Manchester, where similar changes were watered down to assuage local fears about hospital closures, no extra lives were saved ...

care in fields from heart disease to cancer. The argument for doing more complex care in big expert centres is widely accepted in theory but the NHS has struggled to put it into practice in the face of widespread local opposition ...

HEALTH

Centralising stroke services 'is saving lives'

By Charlie Cooper
HEALTH REPORTER

Focusing NHS stroke services in fewer but more highly specialised hospitals has saved lives and ...

and above reductions in stroke mortality seen in the rest of the country. While there were no extra lives saved in Manchester, researchers said that, in the two years after the reforms were brought in ...

HEALTH

Some 400,000 suffer strokes a year

{i} A stroke occurs when the blood supply to part of the brain is cut off which is caused by blood clots or internal bleeding.

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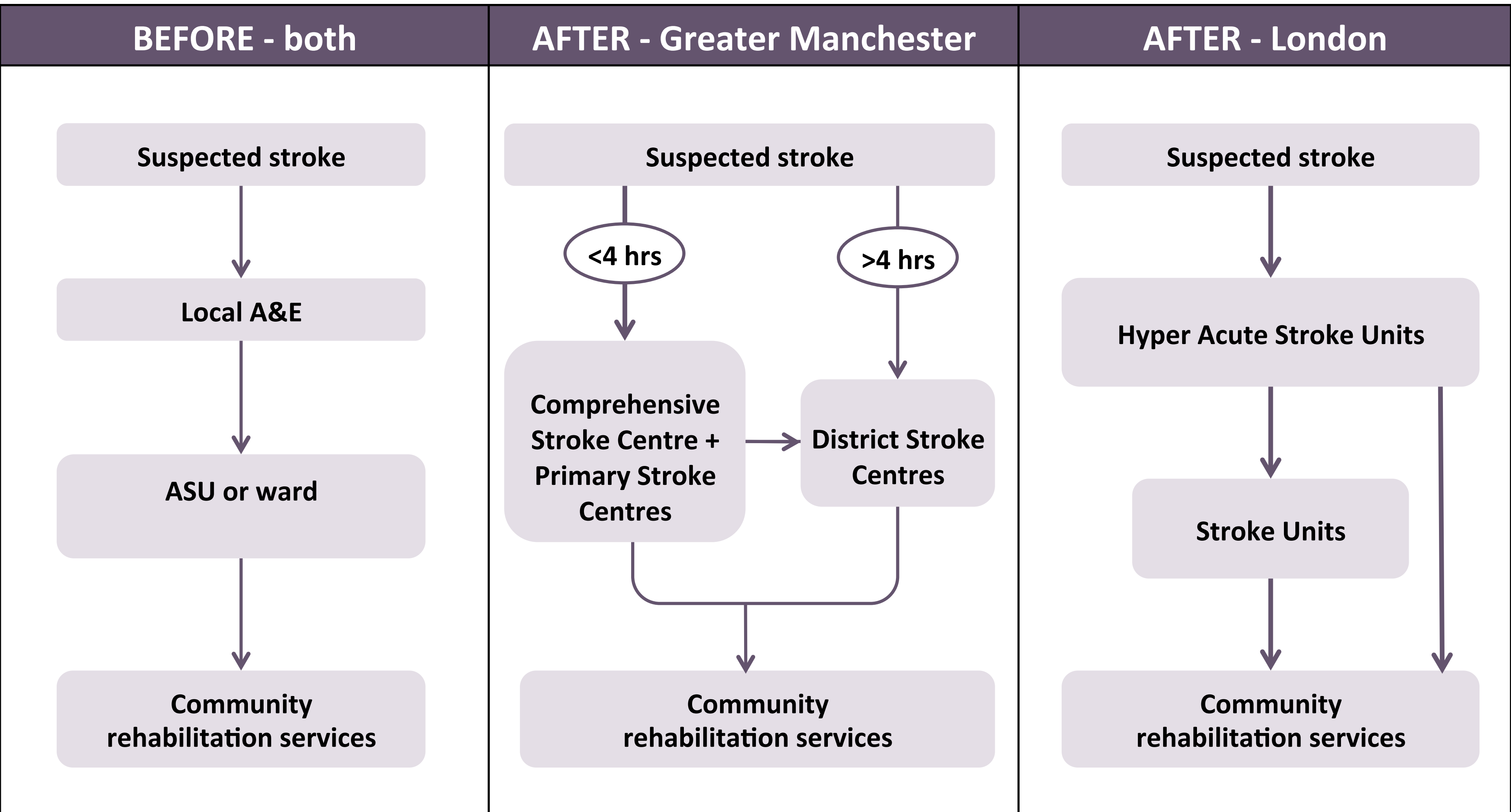
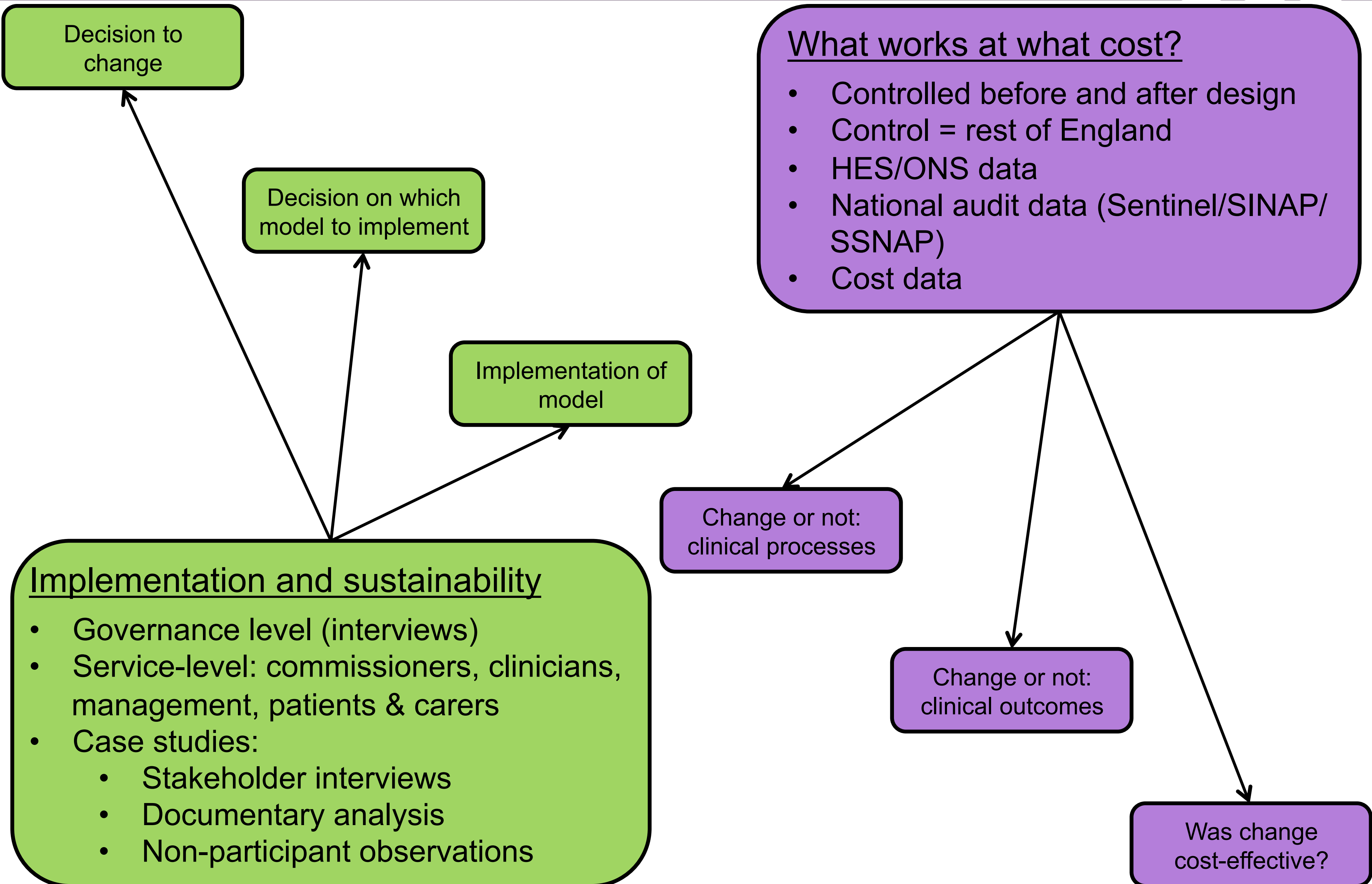
Stroke service models – before and after





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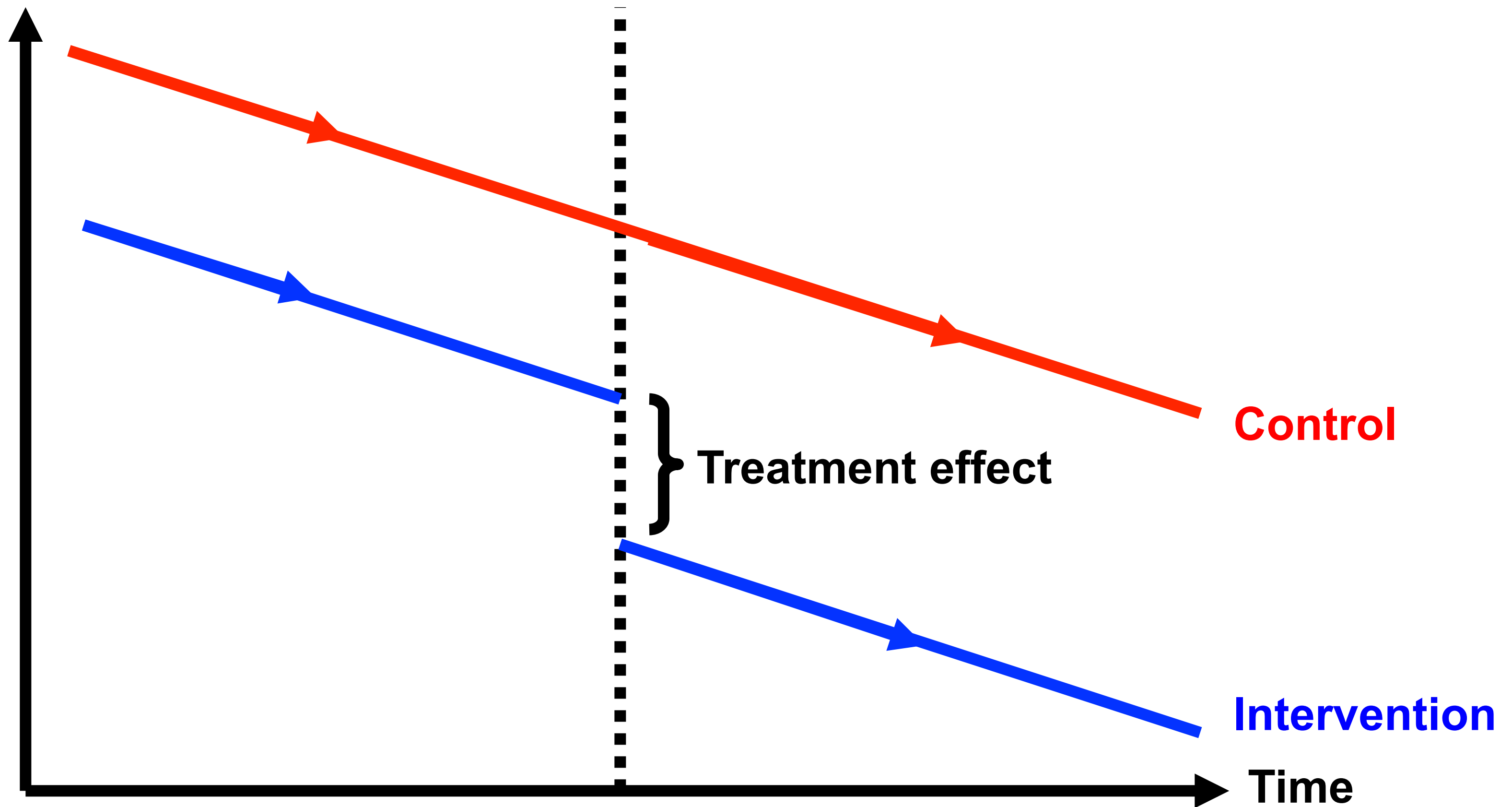
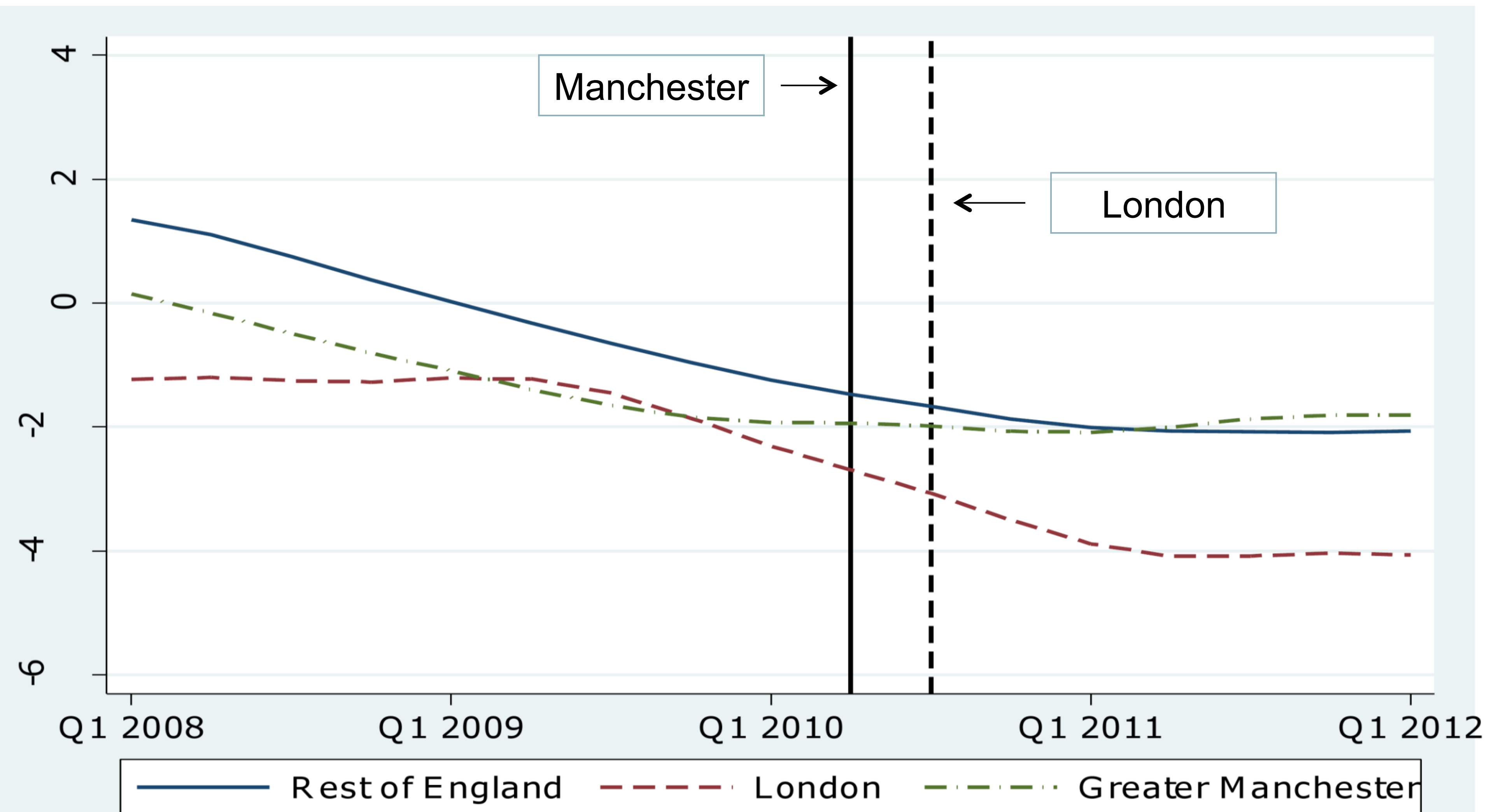
Decision to change
Decision on which model to implement
Implementation of model
Implementation and sustainability
Governance level (interviews)
Service-level: commissioners, clinicians, management, patients & carers
Case studies:
Stakeholder interviews
Documentary analysis
Non-participant observations
What works at what cost?
Controlled before and after design
Control = rest of England
HES/ONS data
National audit data (Sentinel/SINAP/SSNAP)
Cost data
Change or not: clinical processes
Change or not: clinical outcomes
Was change cost-effective?

Difference-in-difference estimation



Mortality at 30 days



Summary: mortality

- In London, the risk of dying from stroke fell significantly more than in the rest of England
- 96 fewer deaths in London p.a. than would have been expected
- No equivalent effect in Manchester

Morris et al. Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis. BMJ 2014

Why differences between London and Greater Manchester?

How resistance was managed

Greater Manchester: ‘consensus’

“the minute it felt like unanimity was being compromised on that clinical discussion on the 24 versus the 4 hour pathway, I think we were always going to be minded then to tilt towards holding unanimity and taking what might be a small step, but still the right step.” (Commissioner)

London: ‘holding the line’

“Stroke was their [clinician representatives’] life, and they wanted to get the best for stroke […] but actually what got it through was being straight with them, trying to explain it to them, but in the end holding the line.”

(Commissioner and Project Board Member)

Lessons from large-scale reorganisations of health services: the example of acute stroke care

Requirements for reshaping health economies on a large scale:

- Need combination of top-down, system-wide (‘designated’) leadership and bottom-up, clinically-led (‘distributed’) leadership.
- But requires system-wide leaders with necessary authority to align stakeholders & capitalise on distributed leadership i.e. **‘Holding the ring’**

Lessons from large-scale reorganisations of health services: the example of acute stroke care

- Public engagement – real not just symbolic
- Professional/clinical leadership and engagement – but not capture

Approaches to evaluation (1)

- Not just 'does it work?'
- [NB What is the 'it'?]
- But also study of organisational and governance issues – requires process evaluation
- What is the underlying programme theory/theories for this change? What are the problems these huge changes are trying to solve?
- Very often the outcome hoped for e.g. reduced admissions to hospital isn't likely to be achieved from the programme or set of interventions

Approaches (2): appropriate evaluation

For example:

- Single service or programme in one locality
- Aim is to demonstrate success locally, for example to commissioning body
- Using locally held/ gathered data
- Descriptive analytic methods

For example:

- Complex interventions, multiple organisations working regionally
- Aim to demonstrate success nationally, creating new generalizable knowledge
- Involves complex qualitative and quantitative data
- Advanced analytic methods

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Embedding evaluation in large-scale transformations

- Opportunity to build in evaluation from the start
- And, as important, build in lessons from previous research in designing e.g. governance arrangements, service/pathway redesign etc.
- Range of evaluation methods and levels – internal evaluation and external, generalisable evaluation
- Requires capacity/capability for both internal and external evaluations

Mind set change required in both the ‘evaluators’ and the ‘evaluated’

- More ‘evaluators’ need to move out of the traditional academic research paradigm to work in collaboration with ‘evaluated’
- ‘Evaluated’ have to be prepared for possibly ‘uncomfortable’ findings
- Importance of independence of the research and critical distance