

# The art and science of non-evaluation evaluation

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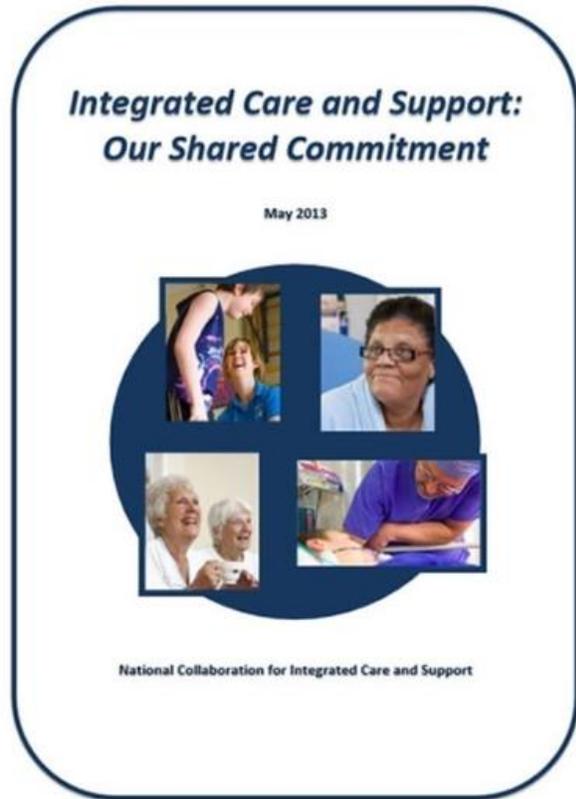
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University of Exeter, 7 November 2016

# Outline

- Limitations of dominant approaches to evaluation in the context of healthcare policies (from my experience)
- An alternative approach
- An example, to illustrate

# Early evaluation of the integrated care pioneers



Association of Directors of Adult Social Care, Association of Directors of Children's Services, CQC, DH, HEE, LGA, Monitor, NHSE, NHS!Q, NICE, PHE, SCIE, Think Local Act Personal

- Person-centred co-ordinated care
- Benefits for patients, carers and local community
- Local innovation
- Local objectives
- Address barriers
- Disseminate and promote learning
- National partners provide bespoke expertise and support
- National and international experts

A user experience-focused definition of integrated care that does not prescribe *how* this result is to be achieved at local level

- ‘Person-centred co-ordinated care’
- *My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.*” (National Voices 2013)

# 'I statements'

- I tell my story only once
- I am listened to about what works for me, in my life
- I am always kept informed about what the next steps will be
- The professionals involved with my care talk to each other. We all work as a team
- I always know who is coordinating my care
- I have one first point of contact. They understand both me and my condition(s). I can go to them with questions any time

# 14 successful out of >100 EoIs, November 2013

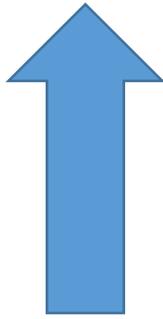
- Barnsley
- Cheshire
- Cornwall
- Greenwich
- Islington
- Kent
- Leeds
- Staffordshire and Stoke
- NW London
- South Devon and Torbay
- South Tyneside
- Southend
- Waltham Forest and the City (WELC)
- Worcestershire

# Multiple interpretations of the policy

- A badge
- An enabler of local objectives
- Discrete work streams
- A governance arrangement
- The integration agenda
- An ethos
- *An increasingly narrow set of initiatives (Care navigator, MDT, SPOC)*

# Dynamic and elusive

- Changed over time
- Depended on who you spoke to
- Difficult to know what was ‘in’ and what was ‘out’
- Difference between what people were doing and what people *said* they were doing for the purposes of the evaluation

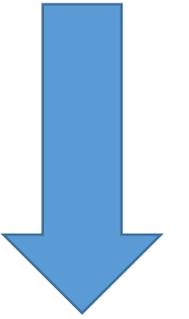


2013

Person-centred co-ordinated care

LA/H&WB

Bottom up



2015

Top down

NHS England

Progress/outcomes

Reducing emergency admissions/  
hospital spending

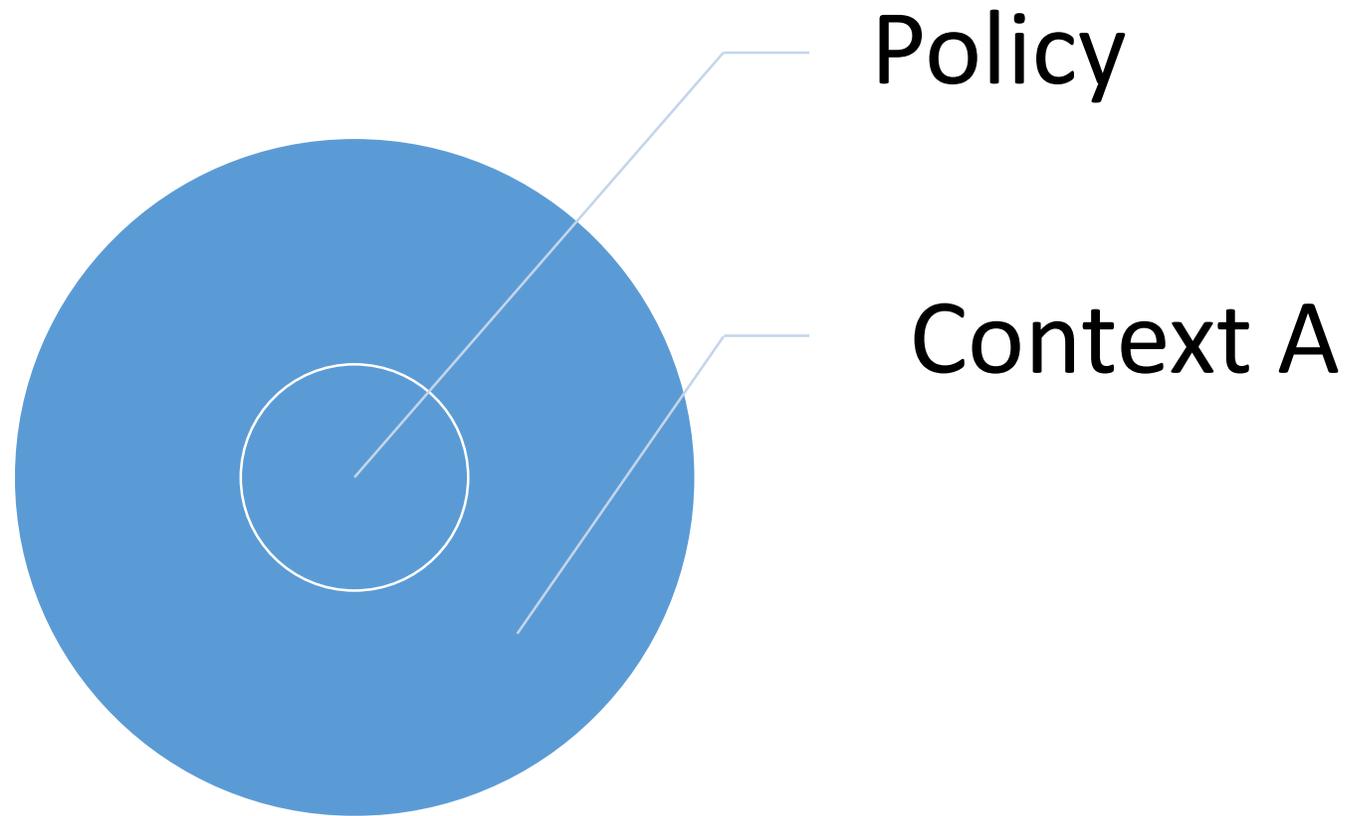
# Looking for a logic model in a haystack

- Multiple, conflicting, incoherent, contested
- *Mobilised* as part of the micropolitics of planning
- *Mobilised* for the purposes of evaluation

# Fiddling while Rome burns

- Tendency to focus on description rather than analysis (seen as an end rather than a means)
- Time intensive
- Normative and instrumental ( ‘barriers’ and ‘facilitators’ , ‘how can we make it work?’)

# Orthodox approaches to evaluation



In real-world empirical contexts:

- change often driven less by problems than by solutions
- both changes, and the intentions behind changes, are transformed by the process of change

*‘it is difficult to describe a decision, problem solution or innovation with precision, to say when it was adopted and to treat the process as having an ending’*

(March and Olsen 1989, p63)

# Sociopolitical accounts of policy:

- ‘a set of shifting, diverse, and contradictory responses to a spectrum of political interests’ (Edelman 1988)
- Conceptions of national, organisational and personal goals, minor and major forms of negotiating and bargaining, and ‘foul ups’ form a *collage* that constitutes government action on an issue (Allison 1971)
- Ambiguous (Baier et al 1986)
- Symbolic (Edelman 1988)
- Some policies are too controversial to be articulated (Yannow 1987)
- *Represented* as rational decision making - a cultural resource that is used to create meaning and accomplish activities (Jones 2016)

# Orthodox approaches neglect:

- The use of rhetoric
- The role of knowledge and expertise
- The effects of discourse

# Non-evaluation evaluation

- The value of research that is not necessarily framed as evaluation or implementation but nonetheless is relevant to policy and practice
- ‘Bottom up’ and ethnographic approaches
- Uses social and political theory to understand ‘what is going on’

# Ethnographic approaches

- Multiple perspectives
- Strategies of local actors
- The interaction of policies
- Consequences and unintended consequences

# Social and political theory

- Interpretive- attends to multiple meanings
- Critical - differences in access to resources, strategic action, and relations of submission and domination
- Discursive – use of rhetoric, the role of knowledge and expertise, and the effects of discourse

# Example – acute care reconfiguration

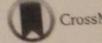
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## Framing in policy processes: A case study from hospital planning in the National Health Service in England

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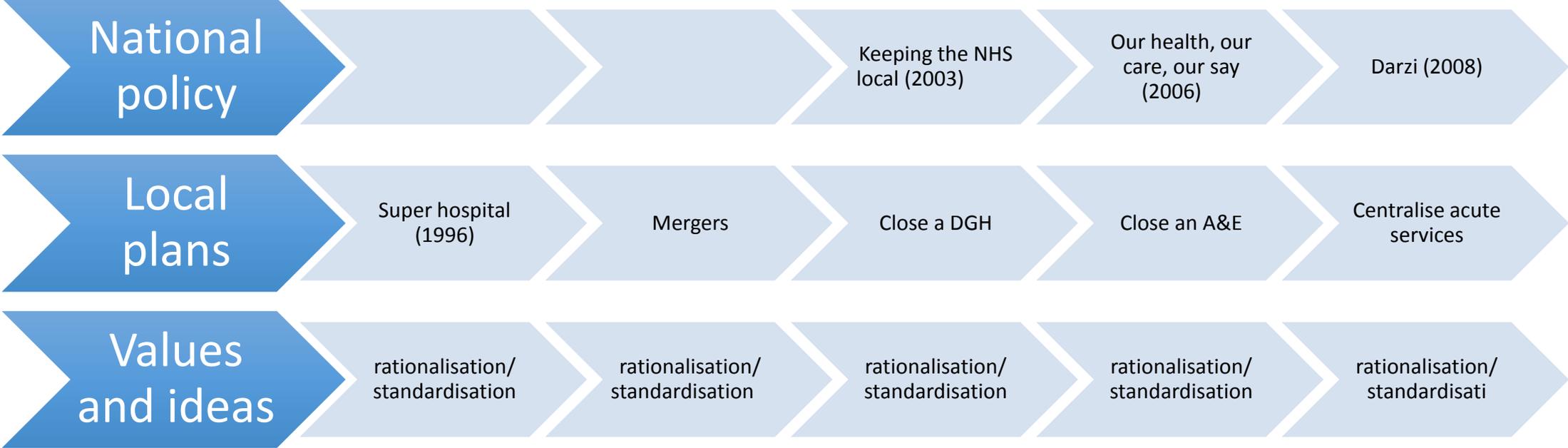
### ABSTRACT

This paper reports from an ethnographic study of hospital planning in England undertaken between 2006 and 2009. We explored how a policy to centralise hospital services was espoused in national documents, how this shifted over time and how it was translated in practice. We found that policy defined hospital planning as a clinical issue and framed decisions to close hospitals or hospital departments as based on the evidence and necessary to ensure safety. We interpreted this framing as a rhetorical strategy for implementing organisational change in the context of community resistance to service closure and a concomitant policy emphasising the importance of public and patient involvement in planning. Although the persuasive power of the framing was limited, a more insidious form of framing was identified in the way the framing disguised the political nature of the issue by defining it as a clinical problem. We conclude by discussing how the clinical rationale constrains public participation in decisions about the delivery and organisation of healthcare and restricts the extent to which all courses of action can be considered.

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# Some key features

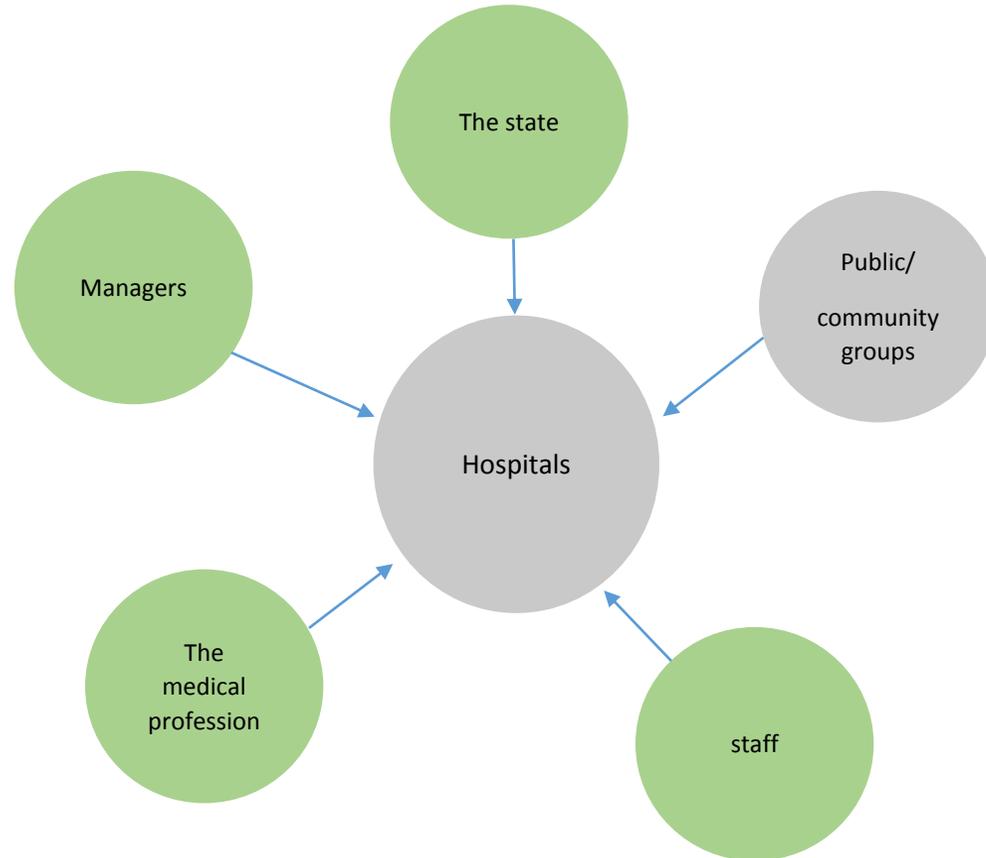
- Centralising acute services (fewer, larger units)
- Multiple and shifting rationales
- ‘An evolutionary process with ambiguous boundaries’  
(Fulop et al 2005, p129)
- Orthodoxy in the NHS despite little evidence of clinical or economic benefits



Politically contested



# The politics of hospital planning



# Research plays a central role in stimulating, legitimating and channelling action

Clinical epidemiology	Policy and management sciences	Social science
What is the relationship between volume and outcome?	What is the problem? What should be done? How should it be done? Does it work?	Who benefits? What does it mean? What is going on?

An 'Intractable policy controversy' (Schön and Rein 1994):

- Marked by contention, more or less acrimonious, more or less enduring
- Resistant to resolution by appeal to evidence, research, or reasoned argument

# A conflict in frameworks of meaning

Hospitals need  
rational planning

Hospitals as  
places of social  
and emotional  
significance

## Frames and framing

Interest groups and policy constituencies, scholars working in different disciplines, and individuals in different contexts of everyday life have different frames that lead them to see different things, make different interpretations of the way things are, and support different courses of action concerning what is to be done, by whom, and how to do it. (Rein and Schön 1993)

- Action frames – implicit in the content of policy
- Rhetorical frames – underlie the persuasive use of argument

*Frames are about action, and the desire to do something usually leads to a commitment to make the action we seek realizable. We often do so by ‘hitching on’ to a dominant frame and its conventional metaphors, hoping to purchase legitimacy for a course of action actually inspired by different intentions (Rein and Schön 1993, p151).*

# Findings

- Strategic ‘reframing’ of a policy – from ‘care closer to home’ to ‘clinical necessity’
- Decisions to close services given a ‘clinical rationale’ - based on the evidence, necessary to ensure safety

## Co-optation of medical elites

- Strategic use of medical leaders at both national and local levels

*I think in terms of the medical directors who are the key ones and especially (the medical director) at Forest who was very helpful and because he can stand up and – and that's what [the public] want – they don't want to hear people like me or even our Chief Executive, what they want to see is an actual consultant saying 'this only makes sense – why wouldn't we want to do it?' and so that's why it was always essential that we had their engagement ... (Manager, PCT)*

- A rhetorical strategy deployed in the context of community resistance to hospital closure and a concomitant policy that emphasizes the importance of public and patient involvement in decisions about how health care services are delivered
- As rhetoric designed to convince other stakeholders of the need for change it was unsuccessful
- More successful in the way it channelled thinking in a particular direction, making a particular course of action appear inevitable
- Defining the issue as ‘technical’ and excluding the public from decision making

# Other courses of action

E.g. improving outcomes in maternity care

- reduce obesity and diabetes in the population,
- improve uptake of antenatal care,
- improve identification of ‘at risk’ women in the third trimester
- employ additional staff
- improve teamwork
- use clinical networks
- innovations in telehealth

*So we went through a whole load of loops really, to get to where we are which is basically that there are a number of Royal College clinical best practice requirements have gone out as commissioning intentions to the providers and they've come back with proposals, some of which are about greater networking, or indeed moving services to one hospital site, rather than having them spread across all three and it was agreed by the (health overview and scrutiny committee) that we could effectively go out...through engagement rather than formal consultation. So we were all set to do formal consultation and then at the end it looked like we could say effectively well this is just about good practice and why would anyone disagree with us following Royal College guidance?*

(PCT manager)

# Problematizes current orthodoxies of strategic change

e.g. Choosing the right framing, clinical champions, co-design

- In practice these have been used as co-optive devices
- May 'backfire' in that when they seem to be strategic and manipulative it erodes trust

# Conclusion

Value of research that is more broadly conceived, ethnographic, and that uses social and political theory to understand ‘what is going on’:

- ‘opening up’ policy alternatives
- Understanding the multiple perspectives on an issue can inspire more creative and more acceptable response to local circumstances
- Focusing on what actually happens in real-world contexts is of practical benefit to decision-makers in helping make more realistic decisions and avoiding serious mistakes

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