

EVIDENCE BASED MANAGEMENT AND THE ROLE OF THE FOOL

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Introduction

This short paper is based on my attendance at the recent study day titled 'Meeting the challenge of evidence-based health management.' As I listened to the speakers and the audience I began to realise how provocative the title was. It was obvious, wasn't it, that thought should proceed action and that this thinking should be rooted in the best evidence? Doesn't everyone believe this? A simple review of my leadership experience demonstrates that what we think and what we do is often different and that there is often pressure to rush into action rather than think.

In exploring this pressure I have attempted to develop some ideas about how the information professional can intervene to slow this flight into action by drawing on the honourable tradition of the Fool.

Evidence, action and anxiety

I worked as a chief executive for seven years. When I started the job I had no idea what it was to be a leader except that I wanted to change things for service users. In my ignorance, I did have the sense to have a mentor who helped me to theorise what I wanted to do.

With his help I developed a coherent strategy. New language appeared in the organisation and the response to this language (what do you mean, this is just jargon, what has this to do with users, have you lost your mind David etc) was critical in securing co-operation and changing behaviours. The words brought into reality ideas that had just been a mix of hunches and instinctive responses. Without the words, which came from the research, there would have been no co-ordinated action, just a lot of noise.

My mentor was someone who knew about evidence. He knew what was out there, could discriminate in terms of quality and relevance and crucially knew what I was ready to read. Often I would find myself reading things I could barely make sense of, but over succeeding months I noticed my reading would emerge to explain and justify the action I wanted to take. This was important. The leadership task in change is one of persuasion. Authority comes from a willingness and ability to make sense of what is required. I was often confronted by senior colleagues about the pace and direction of the change. Being able to explain underlying concepts and ideas helped prove

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this was not just an idea I had dreamed up in an afternoon. A clear articulation of the evidence supporting action is a powerful intervention in itself. I think rightly that we want and need to question a leader who simply tells us to follow because he/she is right.

I want to suggest that there are similarities between the role of mentor and information expert. The role of mentor (based on this sample of one) might be helpful in developing the information professional role in relation to managers and leaders. Both have to be prepared to establish and maintain a relationship that is helpful in the sense that it connects with a need in the manager and is challenging. Challenging because bringing more and new information to bear on complex situations is disruptive. Asking someone to read something or listen to what others have found and done has a psychological consequence and this has to be managed. If I briefly return to my own experience to explain this - I would sometimes simply hate my mentor. He would introduce new ideas that would often leave me feeling stupid, which is a feeling that is hard to bear. It is easy to hate what we are ignorant of, particularly when I construed my leadership role as the 'one who should know'.

The management literature does value not knowing (French and Simpson, 1999). An influential writer in this area is John O'Brien (1987) writing about learning disability services. He argues that people's lives are blighted by managers and practitioners who refuse to consider that they may not know what service users want. That is managers, who avoid their 'not knowing'.

O'Brien is extending an invitation to be anxious and to think about this anxiety differently. Rather than frame the management task as working to minimise anxiety, we should seek it out and increase it. Anxiety leads us to what we do not know, or are unsure of, and in the context of human services is evidence of a commitment to be sceptical (Cecchin, 1987). That is, we are prepared to keep open questions about what we are up to and how we are making sense of things.

Of course being anxious is not easy but it is the critical capability. Schein in an interview for the Harvard Business Review (Coutu 2002) describes 'learning' and 'survival' anxiety. For learning to take place either our fears of being ignorant or looking stupid particularly in front of our peers and competitors has to be reduced, reflecting Argyris' view that similar anxieties block 'double loop learning' (1991). Or, we have to recognise that the cost of staying the same and not learning will be very high. We may lose our job, as well as our sense of ourselves as competent and capable.

What has this to do with information professionals? In my experience this anxiety is made worse when I behave as if there are no guidelines, no conceptual frameworks and experiences to guide me. I behave as if I am the first to travel the path. How much more bearable the uncertainty if the experience of others is brought to bear. Not in the sense of a slavish following but in the sense that ideas and experiences can be used as handholds and guide ropes to situations with which I am confronted.

Who do we imagine will help us find this information? It has to be someone who knows their way around the evidence and who can deliver it in a way that addresses the context in use, a context that at times may be resistant to new ideas, where emotions may be more powerful, the drive for agreement overwhelming, and where rational thought is in short supply.

An important article on evidence based management is by Homa (1998), an experienced chief executive in the NHS. He identified a number of reasons why using evidence to support decision making was the right thing to do. I have summarised these in my own words below with a question in mind. A question that says - so, if this is what leaders and managers committed to an evidence based approach say they want, what does it mean for the information professional?

- To be surprised and bounced out of our habitual ways of thinking and acting in away that liberates our creativity and leads to innovation.

- To notice our preferred assumptions for making sense of things and how these preferences may make us resist taking in new information because it does not 'fit' with what we already know.
- To be kept 'problem side'. That is to slow down the rush to solutions based on an inadequate scan of what is going on and what might be a useful way forward.
- To know what has been tried and worked before to increase the confidence to stay with the uncertainty, experiment and take risks.
- To have confidence in proposed actions to demonstrate the best use of scarce resources.
- To develop a shared approach and language to develop collaboration with clinicians who are already familiar with empirical approaches.

Implications

Implicit in Homa's paper (1998) is an expectation that the manager will access the evidence base. But what would it be like if the manager was approached by an information professional who offered this service and this service was sanctioned by the Board as part of the risk management strategy? An expert who knew this was not a simple task, but, a complex one that required the development of a relationship which was as important as the information offered. A person who could quietly insist, like an effective mentor on being heard and who also knew when to keep silent, because the person just has to act.

In short, what would it be like to think of the role of information professional as Fool? The person authorised by the organisation to tell it how it is, who cuts through the verbiage and the grandiosity we are all prone to and dishes it up raw. That would be some role.

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SEVEN STEPS TO PATIENT SAFETY

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Introduction

The Seven Steps to Patient Safety (2004) is the National Patient Safety Agency's (NPSA) guidance for healthcare professionals to help them improve patient care and safety. Patient safety is defined as the process by which an organisation makes patient care safer. This should involve risk assessment, the identification and management of patient-related risks, the reporting and analysing of incidents, the capacity to learn from and follow up incidents and the implementation of solutions to minimise the risk of them recurring. This paper will describe the rationale for the development and progress of the guidance from initial thoughts through to publication and evaluation.

Discussion

The NPSA was set up in July 2001 and by early 2003 it was clear that there were huge variations in knowledge, expertise and implementation of local risk management activity which meant that there was no consistent approach to patient safety.

My brief was:

- Provide guidance for the health service which will offer a framework which can be used to develop three-five year local plans to improve patient safety.
- Ensure that the guidance is relevant for all care settings and all staff using simple, clear messages.
- Provide tips and practical tools and techniques which can be actioned locally.
- Signpost NPSA 'products.'

The first task I had to undertake was to determine whether there was a need for a systematic review or if this had been done

elsewhere. An initial search concluded that there was no up to date systematic review which accounted for the global activity in patient safety. Therefore I needed to undertake a systematic review of patient safety research and interventions to identify and analyse all the available evidence. In addition, I carried out a stakeholder analysis which identified the relevant researchers and research organisations, government web sites, individual international safety experts and international organisations responsible for patient safety, risk management or quality in healthcare.

I carried out the systematic review using MEDLINE, EMBASE, CINAHL, PsycLIT, and internet search engines, and by scanning reference lists, conference publications and health and medical eJournals. To be effective in the search I would usually recommend involving an information expert who can design and execute complex search strategies, however in this case I conducted the search myself. This was because; the NPSA information manager was not available for the expected duration of the project. It was incredibly helpful to have had prior experience of undertaking systematic reviews; and that I could use my significant experience in risk management to identify the relevant sources.

There were two questions that needed answering: a) what do we know about the frequency and type of things that can go wrong in healthcare? and b) what are the effective interventions in healthcare which have been proven to improve patient safety? The content needed to include information which provided the theoretical basis for the guide, together with information which described interventions which

could be replicated locally in the NHS. These were not always evident in the published study and required follow up by discussions with the authors or relevant experts. In addition to the brief I decided that the lack of standard definitions and terminology would need to be addressed. The final guide was therefore a combination of a systematic review, discussions with international and national patient safety experts, and my experience and expertise obtained through the coupling of a clinical and a risk management background and an MSc in Clinical Risk Management.

Following the systematic review, the content for the guidance was identified. This involved a process of breaking down all the information into manageable pieces and themes. Each theme was then placed in the order of potential implementation. These themes were then described as 'steps' and the working title of Seven Steps to Patient Safety was created. Each step provided in order, the theory, the tools and techniques for change, the local role and the role of the NPSA. I used local case studies to demonstrate what could be achieved and which were endorsed by internationally recognised experts in safety.

The audience for the published guidance was primarily clinical governance and risk managers. However, it needed to be written in such a way that anyone who picked it up, from clinician, to porter, to chief executive, to patient would be able to understand it and see it as relevant to their lives. A key tip is to be clear about and know your audience. When writing the guidance I tried continuously to place myself in the role of the audience and implementer and through the NPSA patient safety managers and local risk managers I tested the language, content and interventions for applicability and usefulness.

Once written, the guidance required approval from the NPSA Management Team and Board as well as the Chief Medical Officer, Department of Health and the Welsh Assembly Government.

A communications and dissemination strategy was required to promote, implement and support change. The NPSA

developed a campaign theme Seven Steps to Patient Safety. A visual identity around the steps was developed to unify our communications, and all activity across the Agency was integrated to reinforce the Seven Steps message.

The campaign consisted of the following activities:

- Internal briefings with NPSA staff to encourage involvement across the Agency.
- A direct mail campaign: a Seven Steps overview guide was sent to the senior managers of every NHS organisation in England and Wales.
- A sponsored supplement in the Health Service Journal, the lead publication for NHS managers, with a foreword from NHS Chief Executive Sir Nigel Crisp.
- Tailored bulletins were disseminated via NHS internal communications channels.
- The first ever national patient safety conference to bring key stakeholders together, where the full guidance was launched.
- NPSA staff presented at hundreds of events in the NHS calendar using the Seven Steps framework.
- Press calls to launch aspects of the guidance.
- A personalised letter to every Chief Executive in the NHS, including a tailored briefing and checklist on the specific role Chief Executives could play in Seven Steps.
- A programme of visits to all NHS organisations in England and Wales by our 32 regional patient safety managers to present Seven Steps and hand deliver our supporting 200 page full reference guide to key implementers.
- All key implementers received personalised certificates to acknowledge their role in establishing key aspects of the guidance.

Evaluation

Within **four months** of the campaign's launch we achieved the following:

- 10,600 copies of Seven Steps

had been downloaded from the web, with over 20,000 copies distributed (equating to 33 per organisation). An independent researcher conducted interviews with 32 NHS managers: 23 said their day to day work had been directly informed by the document. Comments included: "now become indispensable", "has saved me so much work" and "an excellent document that will be widely used."

- 900 NHS staff attended the UK's first national patient safety conference, with 78% of delegates rating the event 'very good' or 'excellent.'
- There were 42 articles about the campaign in national, professional and regional media.

Within **one year** we achieved the following:

- All 607 organisations targeted are now connected to the National Reporting and Learning System – the NPSA's national system for collecting patient safety incident reports.
- 8,000 NHS staff have signed up for the NPSA's root cause analysis training.
- We have printed another 30,000 copies of Seven Steps to meet continuing demand.
- The Seven Steps have been used for training over 500 Non-Executive Directors across England and has been used to frame a training course run by the Kings Fund for Clinical Leaders.
- The Seven Steps is currently being adapted for primary care trusts, local general medical, general dental and pharmacy practices.
- The Seven Steps guidance has been adopted in other countries, including Spain, the Netherlands, Australia, and Singapore.

Conclusion

The success of the Seven Steps appears to be that it sells a message which connects to the reader. Through Seven Steps the NPSA has been able to equip our key audiences with the evidence they need to leverage resources internally, to demonstrate that we could help them meet other

existing targets, to raise awareness across the NHS of patient safety, and provide useful solutions and interventions which can make a difference to patient safety locally.

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SATISFY MANAGERS' INFORMATION NEEDS: BECOME A KNOWLEDGE BROKER!

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**Message: New Knowledge
Broker Role offers potential
model for Evidence Based
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Managers face many challenges in seeking to practise Evidence Based Health Management (EBHM). Current initiatives support the value of knowledge exchange (formerly knowledge transfer) approaches, particularly using a knowledge broker role. This model can be used by health care librarians to address known deficiencies in the transfer of research into managerial practice.

Where shall we begin?

Take a look at our opening paragraph. Does this count as 'Reader-Friendly' writing (CHSRF 2001)? Regardless of whether or not it is 'the finished article' it employs many of the techniques of the 1:3:25 approach suggested as a way to present messages effectively to a manager audience. First is the Headline designed to be media friendly and to get attention. (Of course if you are not reading this it means that it didn't work!). Then comes the one-line message-somewhat inappropriately known as the bottom-line, an indicative title that conveys the article's content. Next comes the three-line version which highlights why the issue is important [first sentence], what the research, or in this case current practice, indicates [second sentence] and what action can be taken [third sentence]. Finally, in our slimmed down counterpart to the One Page: Three Page: 25-Page

approach to report writing, would come the 25 sentence version providing a greater degree of detail for those who are inclined to read more-(as we hope you are). This is just one of several techniques developed by what is known as 'Knowledge exchange'. Let us start, through, by defining why methods such as knowledge exchange and roles such as the knowledge broker are required to satisfy the needs of a management audience.

The original title for my presentation was "Information support to evidence based management: the unappreciated in pursuit of the non-existent". This deliberate misquote of Oscar Wilde's description of fox-hunting-the unspeakable in pursuit of the inedible' reminds us that:

- what people accept as evidence varies considerably (the nature of evidence).
- the usability of evidence is determined by local factors and considerations (context).
- and how evidence is viewed is determined by the prior disposition and beliefs of recipients (audience).

So whereas evidence is welcomed for its apparent objectivity, the reality is that 'evidence' involves both value judgements and subjectivity. Incidentally this is equally true of evidence based medicine although its early advocates appeared to overlook this. Our take home message is supported by a Canadian Health

Services Research Foundation Workshop (2004) which stated that:

"Evidence is a lot more than research and it includes a lot of contextual information. ...Evidence based decision making is a value-laden process as is the construction of the meaning of Evidence."

This resulting interplay of information and values is well illustrated in Health Services Research and Evidence-Based Decision-making (CHSRF 2000) which demonstrates that public policy questions such as "Do we fund heart transplants?" rely heavily on values while clinical policy questions such as "Who should receive heart transplants?" require information. In the middle, administrative policy questions such as "Where do we locate heart transplant services?" seek to balance both values and information in making a final decision.

A fuller discussion of definitions of EBHM may be found in the new NeLH Health Management Briefing on this topic (2005).

What does the research tell us?

Certainly when we look for support for evidence based health management the findings of research are far from encouraging. Dixon and colleagues (1997) looked for evidence in support of 144 proposals for health authority funding. Only 6.2% were supported by strong evidence and 21.2% by fair evidence. Evidence appeared to have an impact during the health stage of the prioritisation process. However by the time final decisions were made this effect had been lost. Local considerations and national priorities appeared to have overwritten the initial impact of the evidence. Johnstone & Lacey (2002) similarly found that evidence existed for less than half (48.4%) of 124 health policy decisions. Finally one systematic review of 24 studies including 2041 interviews with health policy makers found that personal contact, timely relevance and the inclusion of summaries of recommendations did most to help evidence-based decision-making⁷.

As a result of the above we are led towards the so-called "research

transfer paradox” (CRTN 2002) which tells us that the best chance of research being used for decision-making depends on how unlike research its presentation can be! Indeed emotion, trust, storytelling and careful rationing of information are crucial ingredients of successful research transfer.

Why are librarians un- or underappreciated by managers?

We might as well face it – if managers are from Mars then librarians are from Saturn. Where managers are active, librarians are reflective. For “seeing the big picture” read, “focusing on the detail”. For selective, comprehensive. Where managers emphasise outcomes and deliverables, librarians value their structures and processes. Managers like stories, librarians like facts. Managers set agendas, librarians respond to them. Managers necessarily have a limited attention span whereas librarians make a virtue of their tenacity. ‘Get to the point’- a manager may say, whereas librarians have a whole repertoire of jargon to convey their specialist procedures. One of the few redeeming features of the existence of these “two tribes”, and the fact that managers are not evidence based, is that there is little evidence available to support the cost-effectiveness of libraries. So just tell your manager a few of your success stories instead!

The good news is that we don’t have to change WHAT we do; we must change HOW we present. We need to grab attention, to summarise, synthesise, digest and energise-telling the manager not “Read this” but rather “Do this” [see figure 1].

Ten Tips for Reaching Managers


1.  Attention
2. Think Message not References
3. Not Structures/ Processes but OUTCOMES
4. Don’t Tease!
5. A.V.O.I.D abbrev. & Jargon
6. Make Life Simple
7. Need to Know (Just in Time not Just in Case!)
8. To ACT not INFORM
9. Apply the DO test
10. Most important at the top



Figure 1

If we as librarians are to be appreciated for our contribution to evidence based decision making we need to display four characteristics in our own work: transparency; reliability; incisiveness; and explicitness. We also need to counter criticism that EBHM privileges ‘research evidence over organisation evidence and political evidence’ (Klein 2000) by ensuring that these latter two elements are included in the debate. In this way we are not advancing our own self-serving cause but merely acting to correct an existing deficiency.

What is required? Boost and Bust!

Optionally any solution should seek to get research evidence to decision-makers and at the same time improve the prestige of information workers. Possible approaches, receiving much attention within healthcare in Canada, are the related concepts of Knowledge exchange and Knowledge brokering.

- Knowledge exchange is “collaborative problem-solving between researchers and decision makers that happens through linkage and exchange” (Canadian Health Services Research Foundation).

Work in Canada has focussed on the products and the methods of knowledge exchange. Examples of the former are Evidence Boost and Myth busters. These documents can be viewed at the Canadian Health Services Research Foundation’s web site at http://www.chsrf.ca/mythbusters/index_e.php and http://www.chsrf.ca/brokering/index_e.php respectively. The former aims ‘to boost’ a single topic by ‘highlighting evidence-based

management and policy options’. The latter seeks to ‘bust’ persistent myths by judicious use of the research evidence. Both use techniques such as the 1:3:25 method alluded to earlier. Knowledge exchange methods are highlighted in such series as Communication Notes. This can be viewed at the Canadian Health Services Research Foundation’s web site at http://www.chsrf.ca/knowledge_transfer/resources_e.php and covers such topics as Designing a Great Poster, How to give a research presentation to decision makers and Self-editing: putting your readers first.

A logical development of the knowledge exchange role is knowledge brokering which is a much more active interventional role.

- Knowledge brokering “links decision makers and researchers, facilitating their interaction so that they are able to better understand each other’s goals and professional cultures, influence each other’s work, forge new partnerships, and promote the use of research-based evidence in decision-making.” Please view the Canadian Health Services Research Foundation’s web site at http://www.chsrf.ca/brokering/index_e.php.

It includes such people skills as:

- **finding the right players** to influence research use in decision-making,
- **bringing these players** together,
- **creating and helping to sustain relationships** among them,
- **and helping them to engage in collaborative problem-solving.** (Gold & Villeneuve 2005),

What can we conclude?

So can we conclude that a knowledge broker role can ‘bust’ the research transfer gap by satisfying the needs of managers and thus ‘boost’ our profile too? In truth, it is too early to say - a body of evidence is currently being built up from projects and examples of good practice. Certainly the specific techniques of knowledge exchange and the

design of information products **do** have an established evidence base. Also the Knowledge broker role does seem to move the information intermediary from where we are now to where we earlier identified we need to be if we are to reconcile the 'two tribes' of managers and librarians.

Are librarians up to the task? The requisite skill set is by all means an exciting one and many, if not all, of us will need to add most of the following to our toolkit:

- Understanding of both the research and decision making environments (evidence & management!).
- Ability to find and assess relevant research.
- Entrepreneurial skills (networking, problem-solving skills, innovative solutions, etc).
- Mediation and negotiation.
- Understanding of the principles of adult learning.
- Communication skills.
- Credibility...

Do we want to take on a knowledge broker role? As usual there will be those who embrace this challenge, others who wish for a more gradual addition of the products and methods of knowledge exchange to their current repertoire, and yet others who espouse continuation of the status quo. Whichever scenario confronts us as health information workers we should certainly welcome the opportunity to learn more about such advances, as offered by both this IFM study day and its constituent workshops.

Dedicated to the memory of our former SchARR colleague, Helen Bouchier who just over a year ago shared the platform at the IFM Healthcare Study Day on 'Quality Information for Social Care's (23 February 2004).

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ARE WE BEING DIM? DISSEMINATING INFORMATION TO MANAGERS

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Dissemination of new knowledge is an essential aspect of changing the behaviour of practitioners. Lomas (1993) places dissemination as a link in the communication chain between a scattergun approach (diffusion) and the deliberate process of implementation.

Field and Lohr (1992) define dissemination as a "means of delivering information to its intended audiences in ways that promote the reception, understanding, acceptance, application and positive impact of the information." It involves "identifying and engaging with specific groups who would be involved in implementation, understanding their work practices and characteristics, and then working through specific strategies to change their awareness, knowledge and practices" (King, Hawe & Wise, M. 1998).

Targeting information to managers

Required to respond to ever-changing national initiatives, NHS managers are publicly graded on the basis of a "star system" while working in an environment in which there is scant room for reflection or learning. Managers place very little value on explicit, theoretical management knowledge, because it has no contextual relevance. (Greener 2004). Forty-eight managers completed the Buckinghamshire and Milton Keynes Knowledge Needs Assessment questionnaire. Asked if they "use/are expected to use research evidence?", 52.5%

replied 'No', 43.5% said 'Yes' (MacGuigan 2002).

Managers are afraid of missing key information but lack time, and experience information overload (MacGuigan 2002). Snell (2000) notes the paradox: "They call this the information age and the NHS ... is in the throes of an information revolution. But it's no bloodless coup and the casualties are those health service managers buckling under the sheer volume of information now fired at them from all sides".

For information managers the responsibility to disseminate information thoughtfully has never been greater:

- What do we mean by 'Managers'?
- Senior, operational, front-line managers or clinical managers? There are discrete audiences for whom different dissemination techniques are appropriate.
- What do these managers mean by 'Information'?
- Data? Information source? Information? Knowledge?
- What do managers view as 'Evidence'?
- If management is more art than science, what does this mean for the types of evidence they want? How can we find and share evidence from the evaluation of a specific change or the relative effectiveness of different management approaches?

Information needs

A search of the literature revealed scant material on the information needs and preferences of managers (See references and Appendix 1). Personal communications proved important, e.g. Urquhart recommended the Dawson report on Senior Executives (2005).

Alongside data on finance, quality, activity and staffing, Dawson et al (2005) revealed information needs which remain pertinent:

- Efficacy of clinical interventions.
- 'Soft intelligence' to support multi-agency working, requiring the co-ordination of data from different sources.
- Market intelligence, e.g. waiting times, GPs' views on providers, staff attitudes, consumer feedback.

These respondents wanted information to be more appropriately targeted, summarised and packaged. The research team observed that Public Health Departments play a critical role, acting as a conduit for constructive information flows between providers/purchasers and other sources, or obstructing the flow (Dawson 2005).

Stanley's (2004) research into a sample of 20 NHS organisations focussed on performance data but also reported some information needs:

- Finance: Cost effective data
- General: Political data sensitive to aims & objectives
- Monitoring: Corporate data
- Planning: National trends, demographic data
- Results: Clinical effectiveness/ Outcome data
- Marketing data
- Performance data

How closely do librarians work with analysts, epidemiologists and intelligence units within their

Trusts? Is there a need to develop greater dialogue to achieve a more integrated information service to managers?

A local study

Studying managers at the Royal Berkshire and Battle Hospital, Duncan (2004) interviewed seven library users and five non-users. With such a small sample these findings cannot be generalised. Nevertheless, they make the potential needs of managers more concrete and point the way for further studies.

Library users wanted:

- Corporate information from within Trust: reports, policies, developments, finance, clinical information.
- Information on the organisations “around us.”
- Public health data; especially that which interprets its impact “on our Trust.”
- National documents: directives, standards, targets “in my area.”
- Best practice guidelines.
- Clinical information from organisations “in my field.”
- Patient information leaflets.

Non-users also wanted information on modern management techniques, general NHS news, accountancy within and outside NHS and clinical information for specific projects. The Institute of Healthcare Management web site <<http://www.ihm.org.uk>> may serve as a ‘weathervane’ for current ‘hot topics’. Library managers might review whether they are optimising access to the National Library for Health (NLH) Health Management Library <<http://libraries.nelh.nhs.uk/healthManagement/>>.

Information preferences

The NLH User survey carried out by TFPL found twelve studies conducted or commissioned by health librarians that included managers or senior managers. These suggest that the information sent to managers - and how it is sent - is as significant “as what they actively seek”. Styles of

information access and use differ between former health professionals (who have a better sense of what libraries can do for them) and “lay managers”. Please view the NLH user survey Briefing no 2. at

<http://www.library.nhs.uk/ForLibrarians>. This is significant as 27% of NHS Chief Executives have a clinical background and an increasing number of clinicians are taking on management functions (Edwards 2004).

The study also shows that “Content will not matter without access” – as relevant to the design of electronic resources to physical access to resources. Bell’s (2002) work on developing a web-based resource for managers is well worth a look.

Disseminating information to managers

For librarians to champion the dissemination of important information across a Trust alone is neither realistic nor effective. The goal is to get information across to help the Trust deliver its priorities and improve local healthcare. To be successful, librarians need to understand where leadership lies for each initiative and to work collaboratively, as well as to understand how to shape communication mechanisms for each purpose. This may call for less in the way of diffusion (e.g. generalised current awareness bulletins) and more planned dissemination supporting top-priority initiatives.

The Reading study showed that managers favour information sources that are concise and up-to-date, easy to digest and delivered to the door (Duncan 2004). Librarians are well placed to optimise their skills in abstracting, producing high class summaries for managers (preferably with the ‘bottom line’ at the top).

Planning to get the message across

Palmer and Fenner’s (1999) excellent and highly readable report on ‘Getting the message across’ focuses on three dimensions: the information; the context; and the process.

Fraser (2001) recommends considering each of the following aspects:

- The message - focus on benefits. Read what managers read and write to be sure to use the right terminology.
- Opinion leaders: whose opinion will this target audience trust?
- The sender: the credibility of the signatory impacts on the motivation of the recipient.
- Being careful to brand communications as the work of the library service, is it possible to send material out under the name of a local authority?
- Channels: multiple methods of communication are needed at different stages of the process. What channels does the library use? What else is available?
- “Noise”: can this wait until initiatives competing for the attention of this group are underway.
- Feedback: What methods can we use to check the message is getting through?

Drawing up a communications plan

Six of the eight ‘new’ services requested by library users at Reading were already available (Duncan 2004) - suggesting a need to disseminate information about the library’s services. There are plenty of resources on preparing a communications plan (See Appendix 2) and this also offers an opportunity to liaise with the Trust’s communications staff.

Shaping services for managers

Discussing unpublished research carried out in the North East, Susan Childs (personal communication) indicated that NHS managers saw potential to move towards a smaller physical library, freeing staff from collections management to focus on information management, developing more personalised services and helping colleagues to learn from experience elsewhere. 17 Again this work cannot be generalised, but highlights issues that librarians may wish to explore in their own locality. There are examples of Knowledge

Managers transferring collections to larger libraries in order to develop new models of service e.g. within Buckinghamshire Shared Services.

Cooper (cited in Snell), an Occupational Psychologist, proposes that "senior staff need to think about whether they should be delegating tasks such as carrying out internet searches." Librarians might reflect on how much they are doing to help NHS managers in this respect. Interestingly, MacGuigan recommended a rule that if staff spend longer than 10 minutes searching the Internet, they should stop and ask the library to help (MacGuigan, 2002).

TFPL report that alerting services are highly valued by most managers. The report can be viewed at the NLH web site at <<http://www.library.nhs.uk/ForLibrarians>>. NLH plans to develop current awareness services using RSS technology. A national primary care current awareness service is being developed, building on the work of the Trent Information Network.

Greener (2004) learned that managers welcome the possibility of talking to peers outside their immediate organisational context. TFPL report that for some managers online communities are a practical and valuable source of information, support and problem solving. Facilitating online communities may be a powerful means through which librarians can serve managers. Similarly, we might support exclusive Learning sets, allowing Chief Executives to learn outside the 'spotlight' (Chapman & Confessorre 2002).

Working smarter

There may be some need for services to shift the focus of daily activities to do more to help NHS managers, and the Trusts which they lead, become more effective. As information managers we will do well to:

- Get to know our managers
- Take a planned approach to disseminating information
- Focus on the business of the Trust
- Facilitate new channels through which managers can

learn to become more effective

- Market our information services to maximise their impact

Are we being DIM? Certainly not – but we can all learn to work smarter.

Acknowledgments:

My thanks to Belinda Hylton, Christine Urquhart, Jill Duncan, Kathy Johnson and Susan Childs for their help in identifying studies of the information needs and preferences of healthcare managers.

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Appendix 1. Further reading

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Appendix 2. Preparing a communications plan

Palmer, C and Fenner, J. *Getting the message across: review of research and theory about disseminating information within the NHS*. Royal College of Psychiatrists offers a Checklist on developing a dissemination strategy.

Plenty of relevant resources can be accessed via the web:

A sample communications plan is available at: http://www.nhsia.nhs.uk/nhsuk/pages/lins/lindocs/LIN_Comms_Plan_example.pdf.

Library service managers will certainly be able to apply the general principles set out by the Prime Minister's Strategy Unit: http://www.number-10.gov.uk/su/survivalguide/skills/m_s_comms_plan.htm.

JISC guidance to help people promote discussion lists is of more general interest: http://www.jisc.ac.uk/uploaded_documents/Creatingaplan060603.doc.

Participants in the workshop were also directed to the excellent resources available from the FOLIO course on 'MAXIMising the impact of the service' at <http://www.nelh.nhs.uk/folio/maxim/home.htm>.



THE ROLE OF THE CLINICAL LIBRARIAN: CAN OUR EXPERIENCE OF SUPPORTING CLINICIANS BE TRANSFERRED TO MANAGERS?

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The term 'Clinical Librarian' (CL) has been used to cover many different methods of service provision throughout the UK. (Ward 2005) refer to references at end? This paper explores the concept of the clinical librarian as an outreach librarian that proactively supports Clinical Governance and the use of evidence based medicine in the clinical setting. The CL targets and joins clinical teams on ward rounds, audit meetings, clinics and other multi-disciplinary meetings. In becoming a validated member of the clinical team, the CL is able to contribute to clinical care by providing highly specific, quality filtered, patient centred information to clinicians at the time and place of need. As a team member, the clinical librarian encourages the dissemination of knowledge across the multidisciplinary team as well as promoting awareness of library services in the clinical setting.

The above definition has been adopted in order to set a framework for service delivery and a target standard that meets the organisation's aims and objectives.

When formulating your service, set boundaries as to what you are

or are not prepared to undertake. The next task is to conduct some field work to determine the scope of provision required by your target individual or team. You will find that no one individual or group will conduct their working practice in the same way, even if they come from the same department or have the same job title. The service you create will need to be flexible in order to adapt to different settings, as well as different user needs.

Evidence based management could be seen as just another label to add to the increasing long list of evidence based subjects within healthcare. As in clinical areas, there is much discussion as to the reality of implementing research evidence. It is often controversial and at times, subject to cynicism and the availability and quality of the research base is often questioned. It can also be argued that the term 'research evidence' may not even apply to management, as management is proactive not reactive. In a constantly changing environment, health managers have highlighted that the use of explicit knowledge in practice takes third place to gut instinct and tacit knowledge (Greener 2004).

To help you with this, get to know the 'evidence base' on hot topics, which can be obtained along with management briefings from the National Library for Health (NLH) specialist library for health managers, found at <http://libraries.nelh.nhs.uk/health/Management/>. The use of such services as well as 'grey literature' for benchmarking from other NHS Trusts will assist you in making the case for using research evidence in addition to gut instinct and tacit knowledge.

In implementing the CL service the following process has been used successfully and is based purely on communication and listening skills and as such is easily transferable to 'management.'

It involves the ability to promote a vision that is both desirable and achievable. It is far too easy to stick to familiar ground and to extend existing set format services to new target areas. You may feel that by providing a good current awareness service to managers, you have the area covered, but how much do you really know about the people you are trying to serve? Trying something new could be the start of something that will make a real impact.

Locating potential users

There are several methods to help you locate potential users:

- Your Trust's organisational chart

Identify the strategic areas you want to include. The term 'manager' is very broad. There are also 'managers' who have dual roles as clinicians. Rosemary Stewart's (2002) definition of "the word 'manager' is used to include all those with responsibility for other people, whatever their professional background"

Your Trust's telephone directory

This is important as it will provide you with the names and contact details of personal assistants and secretaries to your selected managers.

- Your Trust's Intranet

This may provide you with

background information on the area you wish to target and to other key people that although not a 'manager' per se, may have an operational/supporting role, and who can assist you in determining whether to approach the area as a group or as an individual target.

• **Your Trust's Newsletter**

Scanning the archives will provide you with some background into key issues that have been addressed by the Trust in relation to policy and practice. It may provide you with topic areas that you can use to compile an example of the type of service you could offer. It may also provide a brief insight to the possible information needs of your target areas that you can use to formulate a semi-structured interview guide.

Initial consultation

Now that you have identified your contacts, you will need to approach them with your idea. Your first line of approach could be indirectly via a personal assistant or secretary, who will provide you with a meeting time for your initial contact as well as a list of possible service contact points in terms of regular team meetings. Taking the time to get to know this person will prove invaluable for the implementation of your service.

For the initial consultation, take a brief written outline (leaflet) and an example of the type of work that you do. This will be focused and relevant to the people you are meeting and will enable you to open discussion and to formulate jointly a vision of a service. It is important to emphasise what you can do (your professional skill base) not what title you have. You are in the process of defining a product which you will need to successfully market, not in promoting the profession, although when you are successful the latter will prevail.

Vision

Achieving a common vision is a joint process that is open to flexibility and experimentation. You may wish to ensure that every search summary that you have worked on is acted upon and seen through to an identifiable end

result. This is achievable, but it can take time to implement change. It is important that this joint vision is realistic. Don't just limit the vision to current procedure, as there should always be an element of 'what if we try...?'

Driving force

Now it is up to you and your users to ensure that the vision happens. Putting together the infrastructure to support the service implementation will be work intensive. It may also require the user to change working routines to accommodate your new input and for them to disseminate to their team the importance they hold for the new venture. The momentum of the service needs to be constant in order for it to be embedded in the users' environment.

Implementation

With your driving force and enthusiasm, you will now be able to put the idea into action. Your infrastructure will develop over time but you will need to consider the impact your service may have on existing library services. You may also need to work closely with your Trust's Computing Services to create web sites and/or Intranet databases to enable direct access to the searches conducted. This will enable global dissemination, transparency and a learning tool for the whole Trust.

Ensure that your timetable for outreach work is balanced with the time you require to conduct the work you have obtained. You may also need to consider whether travel to and from sites is feasible and whether you have IT access in the outreach setting, so that you can work 'on the spot' during meetings.

Acceptance

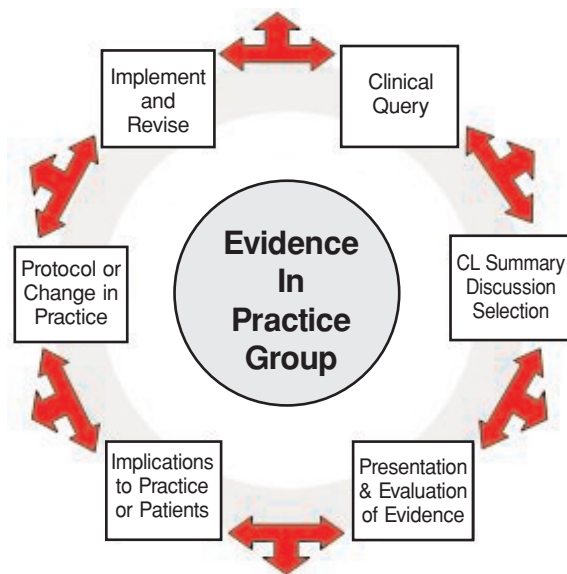
Being accepted as a part of the team can be a slow process. You will need good interpersonal skills, be experienced in your profession and be naturally proactive, and even a little assertive! If you do not believe that you have a role in the team and think of yourself as 'library staff' then you will probably not succeed. However, if you embrace your new subject area and have relevant and active points to make in the discussions,

you will find that you are not only accepted as an equal but looked upon as a fundamental part of the working process of the team. You will gain credibility and develop trusting relationships that further contribute to the success of the service.

Models

There are several models that can be used to provide information for use in different settings:

Evidence in Practice Group model

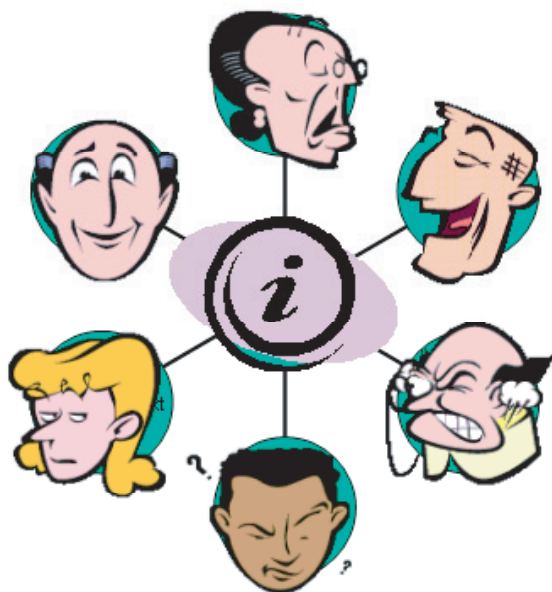


The Evidence in Practice Group can be multi-professional. It provides a non-threatening environment where each person has the opportunity to take part in presenting and discussing the evidence pertaining to a search question. The work of this group is on-going and can lead to the compilation of departmental protocols, research projects, publications, presentations and changes to individual patient management.

These meetings are documented providing an audit trail and assisting with the follow up of action points by individual team members. The EPG provides a forum to close the loop ensuring that time spent on searching and providing information is used effectively to the point of an outcome. The search summary, bibliographic details, clinical decision and documents produced are then added to a database and made accessible via the Intranet.

The work of this group can be extended to a wider field by inviting relevant experts from other fields to the discussions and by involving the relevant national official organisations, such as the Royal Colleges. It may be that the work compiled could be incorporated into national knowledge and answering services and/or NLH specialist libraries.

The 'info drop' model



The Clinical Librarian provides an information digest on a topic of interest:

- to a group of individuals prior to a meeting

This is the approach used for meetings that may or may not require your presence. This model has been used to provide information for the Trust's Medical Ethics Committee. The agenda for the next meeting along with the topic for discussion is e-mailed in advance. A search is then conducted and summarised and sent to committee members well in advance of each meeting, enabling them to conduct a more informed discussion/debate over the issues pertaining to the chosen ethical dilemma.

- to an individual for group presentation

You can provide information to an individual to present to a specific meeting. For example: a case history or a review of evidence for

a clinical audit meeting.

The evidence-plug model

You provide:

- automated updates on key areas of interest to specific groups or individuals.

For example – you may have set up alerts or have TOC services running that keep you informed of updates in areas that you know to be of interest to individuals or groups.

- individual search summaries for sensitive critical incident or legal issues.

You may be required to search for information that would be deemed to be confidential.

The journal club model

You facilitate the evaluation of evidence by providing:

- Generic critical appraisal training sessions via a library training programme.
- Tailored outreach critical appraisal sessions to specific groups.
- Attendance at departmental journal clubs.
- A targeted training event for managers is also a useful way of making contacts and make good opportunities for marketing your service. Such sessions could cover the NLH health management specialist library and the management databases and journals available on Dialog.

Conclusion

You may wish to market a particular model or even use all four models as an example of the scope of service provision that can be delivered. It may be that you can even create a model of your own that is specific to your group's requirements.

These methods and models can be used and adapted to provide a service tailored to managers. As we have seen, managers can come under many guises, so define who you are going to target. Once the service is successfully

implemented in one area, you are then able to expand using the same approach, but using a 'champion' from your existing service.

Implementing evidence in practice is not a straightforward task. More often than not there is little evidence available to summarise. It is necessary to be open to different types of information that can also be of assistance in decision making.

The role of a Clinical Librarian is multi-faceted and dependant on the depth of integration achieved within the targeted area. The skills acquired by a CL are not unique to working with clinical staff, as they are transferable to any outreach service provision. Remember that planning and detailed field work are required in order to gain access to specific individuals or groups. Trust in your service is gained by an ongoing process of validation, confidentiality and reliability, but it will lead to a much more analytical and knowledgeable workforce.

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IFM HEALTHCARE NEWS [HTTP://WWW.IFMH.ORG .UK/](http://www.ifmh.org.uk/)

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Welcome to...

Kath Wright, NHS Centre for Reviews and Dissemination (Email: kew5@york.ac.uk Tel: 01904 321460) who has been co-opted to the IFMH committee to take forward the roles of IFMH Treasurer and Membership Secretary. Kath takes over these posts from Julie Glanville, who has kindly agreed to remain as a corresponding member of the IFMH committee.

CPD Opportunities

There will shortly be a vacancy for Joint Inform Editor on the IFMH Committee. The post is shared with at least one other person, and the main responsibility involves coordinating the collection of materials for the IFMH newsletter Inform. Inform is published three times a year, with the majority of materials coming from regular contributors and study day presenters. No previous experience is required and the post provides an excellent opportunity to develop new skills, and to meet with like-minded professionals in the area of health information management. If you would like to find out more about what is practically involved, please email me at m.j.grant@salford.ac.uk or call me on 0161 295 6423.

VSO Sponsorship

IFMH is to sponsor Anita Pearson

(Disabilities Social Worker) and Machteld Olthof (Physiotherapist/Occupational Therapist), VSO volunteers, in the production of a training manual for a community based disability rehabilitation project. Anita and Machteld will be based in Namibia and the manual will be used to structure and organise volunteer training. Further details of the project and reports from Anita and Machteld will appear on the IFMH web site [<http://www.ifmh.org.uk/>](http://www.ifmh.org.uk/) and in forthcoming editions of Inform.

Date for Your Diary

November 2005 - The next IFMH study day will be a joint event organised in association with Libraries for Nursing. Further details will be distributed shortly. To avoid missing them, please join the IFMH members' discussion list at [<http://www.ifmh.org.uk/discussion.html>](http://www.ifmh.org.uk/discussion.html).

Erratum

In the Winter 2004 (Volume 15 Number 3) issue of IFMH Inform, the 'The Organisation and Delivery of Public Health in England' Management Briefing should have indicated that it was compiled by Caron Hartley and not Siobhan McClelland and Kathy Johnson. The IFMH editorial team apologise for any offence caused by this error.

Farewells to...

IFMH bade farewell to Bertha Low and Sarah Sterry who have stepped down from the committee. IFMH would like to thank them for their contributions to IFMH activities, and wish them both well for the future.

And finally...

Thanks go to Julie Glanville for acting as IFMH Chair during my temporary absence.

IFMH COMMITTEE MEETING: 4TH MARCH 2005: DIGEST OF MINUTES

Karen Macpherson

**Secretary, Information for the Management of
Healthcare (IFMH)**

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Study Days

The next Study Day will take place on April 19th. The theme will be 'Meeting the Challenge of Evidence-based Health Management: the Information Professional's Role'. The following Study Day will be a joint event with Libraries for Nursing to be held in November.

Abstracts of articles relating to Study Day presentations will now be made available on the IFMH web site.

Results of the Inform survey

Responses received to the recent survey of reader's views on Inform indicated that little change was wanted either to the content or the format of the newsletter. To facilitate access to appropriate content, issues of Inform will now be listed by theme on the IFMH web site.

LIS-Medical

Notification will now be sent to LIS-Medical when Study Day presentations are uploaded to the IFMH web site and when new issues of Inform are published.

Marketing

The committee is currently developing a Marketing/Communication strategy. Actions arising from this should start to be seen later in the year.

Treasurer and Membership Secretary

Julie Glanville will be stepping down from her role as Treasurer and Membership Secretary. Kath Wright, from the Centre for Reviews and Dissemination, University of York has been co-opted to the committee to take over these positions. Julie has acted as Chair of IFMH during Maria Grant's maternity leave and the committee expressed its thanks to her for taking on this role.

VSO Sponsorship

Following discussions last year about sponsoring a VSO volunteer working in an area related to health information, the group received details of two projects from VSO. One of these projects was selected as fitting more closely with the aims and remit of IFMH. It involves the production of training manual for a community based disability rehabilitation project in Namibia. Further details of the project and feedback from the volunteers will be made available in Inform.

CILIP Group Review Questionnaire

The committee prepared a response on behalf of IFMH to the questionnaire circulated by CILIP regarding Special Interest Groups.

An archive of summarized minutes from IFMH committee meetings is available on the IFMH web site at <http://www.ifmh.org.uk/archive.html>.

IFMH

Inform

HEALTH POLICIES & HEALTH SERVICE RESEARCH: RESOURCE GUIDE

Bertha Yuen Man Low
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Health policies and health service research are two key elements of evidence-based health management. This section highlights several related resources in the two areas.

Health Policies

First ports of call for health policies ...

- Department of Health (DH) Policy and Guidance
<http://www.dh.gov.uk/PolicyAndGuidance/fs/en>
- Health of Wales Information Service (HOWIS)
<http://www.wales.nhs.uk/>
- Scotland's Health on the Web (SHOW)
<http://www.show.scot.nhs.uk/>
- Northern Ireland Department of Health, Social Services and Public Safety
<http://www.dhsspsni.gov.uk/>

Health Policy Monitor
<http://www.health-policy-monitor.org/en/index.html>, provided by International Network for Health Policy and Reform, presents current health policy ideas about legislation in different stages of preparation or implementation in various countries. By searching the online databases, one can retrieve health policy issues, health statistics and information specific to the UK.

Health Service Research

DH Policy Research Programme
<http://www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/PolicyResearchProgramme/fs/en> aims to provide, through high

quality research, a knowledge base for health services policy, social services policy and central policies directed at the health of the population as a whole. Major strategic research developments in seven key DH priority areas: cancer; mental health; coronary heart disease (CHD); ageing and older people; public health; genetics; and diabetes are listed.

NHS Service Delivery and Organisation (SDO) Programme
<http://www.sdo.lshtm.ac.uk/> is a national research programme that has been established to consolidate and develop the evidence base on the organisation, management and delivery of health care services.

DH Policy Collaborative
http://www.modern.nhs.uk/scripts/default.asp?site_id=62 is an experimental change management programme which aims to improve policy development through action learning. The programme was started in spring 2003 and completed in March 2005.

Health Services Research Network
http://www.nhsconfed.org/influencing/health_services_research_network.asp was established by the NHS Confederation and is supported by the Department of Health, the National Co-ordinating Centre for Service Delivery and Organisation, the Health Foundation and the Nuffield Trust. It connects all universities, commercial and professional organisations, charities and NHS bodies with an interest in health service research. It aims to influence policy makers and managers to support better use of

research and will organise events to promote health service research and provides opportunities for dialogue between researchers and with managers.

Policy Hub

<http://www.policyhub.gov.uk/>, developed by the Cabinet Office Government Social Research Unit, provides access to initiatives, projects and tools supporting better policy making and delivery, extensive guidance on the use of research and evidence in the evaluation of policy, and links to a wide range of research resources and tools from the UK and around the world. It has extensive listings of resources from evidence research units and on putting evidence into practice.

EvidenceNetwork

<http://www.evidencenetwork.org/home.asp> aims to serve as a starting point for accessing social science research publications relevant to policy and practice. It provides search tools and a referable framework to enable users to pursue their enquiries, and a forum for discussion of issues related to evidence-based policy.

Kings Fund

<http://www.kingsfund.org/> aims to shape informed policy in health and social care through research, analysis and debate. Its works include research on health policies, management and leadership development programmes, and resource guides on health issues.

Nuffield Trust for Research and Policy Studies in Health Services
<http://www.nuffieldtrust.org.uk/index.html> aims to promote independent analysis and informed debate on UK health care policy. Its four main themes include: policy futures; role of the state; quality in healthcare; and public health.

There are many academic health service research units across the country. To name a few ...

- Health Economics Research Group (Brunel University)
<http://www.brunel.ac.uk/about/acad/herg/>
- Health and Social Care (London School of Economics)
<http://www.lse.ac.uk/collections/LSEHealthAndSocialCare/>

- Health Services Research Unit (University of Aberdeen) <http://www.abdn.ac.uk/hsru/>
- Health Economics Research Unit (University of Aberdeen) <http://www.abdn.ac.uk/heru/>
- Health Services Management Centre (University of Birmingham) <http://www.hsmc.bham.ac.uk/>
- Institute of Health Sciences and Public Health Research (University of Leeds) <http://www.nuffield.leeds.ac.uk/content/home/home.asp>
- Health Economics Resource Centre (University of York) <http://www.york.ac.uk/res/herc/>

BMJ has topical collections on health services research http://bmj.bmjournals.com/cgi/colletion/health_serv_reasearch and on health economics http://bmj.bmjournals.com/cgi/colletion/health_economics.

Canadian Health Services Research Foundation http://www.chsrf.ca/home_e.php supports the evidence-based management of Canada's healthcare system by facilitating knowledge transfer and exchange. They provide separate sections for researchers, decision makers and knowledge brokers. The section, Mythbusters & Evidence Boost, provides summaries of research evidence behind some of today's major debates in health services management and policy.

Other Resources

Health Service Research for Managers by Powys Local Health Board <http://www.wales.nhs.uk/sites3/docmetadata.cfm?orgid=501&id=40074&pid=8107> is a booklet providing information on health service research for managers, produced by the NHS Staff College Wales and the Institute of Healthcare Management (Welsh Division).

National Library for Health (NLH) Health Management Specialist Library <http://libraries.nelh.nhs.uk/healthManagement/> identifies quality information resources and compiles Management Briefings on health management issues.

Health Management Online <http://www.healthmanagementonline.co.uk/index.asp> of Health Management Library, Scotland, is funded by the Scottish Executive Health Department. The site provides access to UK health policies and Management Briefings (Scotland).

Health Services Research Web Sites <http://www.nlm.nih.gov/nichsr/hsrsites.html>, compiled by National Library of Medicine, lists key US organizations in relation to health service research, health policies and economics, data sources and evidence-based practice.



SURFS UP - INTERNET SITES OF INTEREST

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1) New sites

Alcohol Concern - "How's Your Drink?"

<http://www.howsyourdrink.org.uk/>
This site from Alcohol Concern contains information for the public about drinking, facts on the effects drinking has on health and tips for cutting down on alcohol intake. It also features an interactive test, which helps people decide whether they need to change their drinking habits, and recommends what kind of help they might need. The recent Public Health White Paper emphasised the prevention of ill health and the importance of early intervention - in line with this "How's Your Drink" intends to play an important role in meeting public health targets.

Cancer Research UK - Information Resource Centre

<http://info.cancerresearchuk.org>
This new site aims to provide access to all of Cancer Research UK's information resources, including health living/lifestyle information, the public and policy agenda, information for young people on cancer, and the charity's research. The intention is for the site to bridge the gap between the professional information on the Science & Research site (<http://science.cancerresearchuk.org/>) and the patient-focused information on CancerHelp UK (<http://www.cancerhelp.org.uk/>).

Care Services Improvement Partnership

<http://www.csipconsultation.org.uk/>
The Care Services Improvement Partnership (CSIP) was launched on 1 April 2005. Working at

national, regional and local levels, CSIP has been set up to support improvement and development, spanning services across health (including prison health), local government and social care.

Centre for Ethnicity and Health, University of Central Lancashire

<http://www.uclan.ac.uk/facs/health/ethnicity/>
The Centre for Ethnicity and Health, University of Central Lancashire has launched a web site which has information on the centre's research, teaching and learning. Many of the reports published by the centre can be downloaded from this site.

Food in Schools

<http://www.foodinschools.org/>
"Food in Schools" is a joint Department of Health and Department for Education and Skills programme that aims to help schools implement a whole school approach to food education and healthy eating. The web site provides guidance and resources for teachers, governors, parents, caterers and health professionals.

Health and Social Care Information Centre (HSCIC)

<http://www.ic.nhs.uk/>
The Health and Social Care Information Centre works to coordinate and streamline the collection and sharing of data about health and adult social care. The Health and Social Care Information Centre is a special health authority that became a statutory body on 1 April 2005.

Hospital Episode Statistics (HES)

<http://www.hesonline.org.uk>

HES is the national statistical data warehouse for England on the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals. At the beginning of April, HES left the Department of Health to join the Health and Social Care Information Centre (HSCIC).

NeLH Specialist Libraries

<http://www.nelh.nhs.uk/specialist/>
The National electronic Library for Health has launched five more Specialist Libraries as follows:

Cancer

<http://libraries.nelh.nhs.uk/cancer/>
The Cancer Specialist Library is being developed to support health professionals in finding the cancer information they need in order to keep up-to-date. A special feature of the site is 'What's New in Oncology' - a collection of critically appraised summaries from the latest research published in leading oncology journals.

ENT and Audiology

<http://libraries.nelh.nhs.uk/ent/>
The ENT and Audiology Specialist Library aims to provide healthcare professionals with access to the best available evidence in ENT, audiology and thyroid disorders.

Genepool

<http://libraries.nelh.nhs.uk/genepool/>
Genepool is a specialist library for clinical genetics. It aims to provide a collection of clinical information on genetic conditions, aimed primarily at healthcare professionals who are not genetics specialists.

Mental Health

<http://libraries.nelh.nhs.uk/mentalhealth/>
The Mental Health Specialist Library aims to meet the information needs of health care professionals who work in the field of mental health. The site contains the best available evidence to support people who are making mental health care related decisions, including NICE guidelines, technology appraisals, Cochrane systematic reviews, and a range of best practice articles.

Skin Conditions

<http://libraries.nelh.nhs.uk/skin/>
The Skin Conditions Specialist Library contains quality, evidence-based information on skin conditions and their treatment. It aims to bring together a wide range of resources and information including national guidelines, PRODIGY guidance and Cochrane systematic reviews.

Medicines and Healthcare products Regulatory Agency “Yellow Card Scheme”

<http://www.yellowcard.gov.uk/>
The “Yellow Card Scheme”, run by the MHRA, is used to collect anonymous information from health professionals and patients on suspected adverse drug reactions. Visitors to the scheme’s web site can download collected information on medicines and/or report suspected adverse drug reactions.

National Patient Safety Agency “Clean Your Hands” Campaign

<http://81.144.177.110/cleanyourhands>
The National Patient Safety Agency (NPSA) has created a micro-site for the “Clean Your Hands” campaign. The site has been designed to introduce NHS staff to the campaign and help to explain why hand hygiene has been targeted as a key patient safety issue. The site contains all the background to the campaign and supporting documents such as the evaluation report from the campaign pilot.

Patient Group Directions

<http://www.nelm.nhs.uk/PGD/default.aspx>
There is now a Patient Group Directions web site which is part of the National electronic Library for Medicines (NeLM). The site is being developed to support all healthcare professionals who provide care under PGDs, and includes examples of good practice. Please note that this site supersedes the “Group Protocols” web site.

Training in Infection

<http://www.trainingininfection.org.uk/>
Training in Infection provides links to key resources for trainees specialising in infection. These resources include journals, textbooks and information on societies, conferences and grants. Training in Infection has been

developed by the City eHealth Research Centre and aims to be an online version of the Training in Infection manual originally developed by Imperial College.

2) Changes to existing sites

Department of Health - NHS Factsheets Database

<http://www.dh.gov.uk/PublicationsAndStatistics/FreedomOfInformation/ClassesOfInformation/NHSFactsheets/fs/en>
The Department of Health web site now hosts a database of NHS Factsheets. NHS Factsheets are internal Department of Health briefing sheets on individual Strategic Health Authorities and NHS Trusts. They contain organisational information, contact details and selected published statistical information.

IDEA Knowledge

<http://www.idea-knowledge.gov.uk/>
The Improvement and Development Agency (I&DeA) has completely overhauled its web site IDEA Knowledge. Changes include:

- the integration of the IDEa’s corporate information.
- removal of compulsory registration which speeds up access to the site.
- a series of interviews and features on the big issues in local government.
- improved structure of the web site which aims to enable easier access to information and resources.
- new sections on “Recognising success”, “Councillor information” and “ihelp” for any queries and further information on IDEa’s products and services.

Integrated Care Network

<http://www.integratedcarenetwork.gov.uk/homepage.php>
From 1 April 2005, the Integrated Care Network (ICN) has formed part of the Care Services Improvement Partnership (CSIP). In line with this, the ICN web site has been revamped to be more interactive, making it easier to access information on integration, share practice, contribute to discussion forums and register for the network’s national and regional events.

National Council for Palliative Care

<http://www.ncpc.org.uk>
The National Council for Palliative Care are an independent body providing up-to-date information on all areas of palliative care. The Council have recently redesigned their web site.

NatPaCT

<http://www.natpact.nhs.uk/>
The National Primary and Care Trust Development Programme (NatPaCT) closed on 31 March 2005. The web site is no longer being updated.

NHS Connecting for Health

<http://www.connectingforhealth.nhs.uk/>
The National Programme for IT (NPfIT) has now changed its name to NHS Connecting for Health.

NHS Direct Online

<http://www.nhsdirect.nhs.uk/>
The NHS Direct web site has launched a range of new features and updates including six interactive tools covering pregnancy, eat 5-a-day, safe drinking, body mass index, stopping smoking, and exercise and calories.

NHS Modernisation Agency

<http://www.content.modern.nhs.uk/cmsWISE/default.htm>
The NHS Modernisation Agency has been migrating its web content to a new web portal, known as ‘WISE’ (Web Information Sharing Environment). There is a new homepage, and a directory of “Improvement Themes” is replacing individual Modernisation Agency web sites.

NHS Networks

<http://www.networks.nhs.uk/>
NHS Networks is a new initiative that aims to promote good practice in the NHS by connecting clinicians, managers, users of health services etc., encouraging the sharing of experiences and success.

National Institute for Health and Clinical Excellence

<http://www.nice.org.uk/>
The Health Development Agency joined with the National Institute for Clinical Excellence on 1 April 2005 to become the new National Institute for Health and Clinical Excellence (still to be known as

NICE). The new National Institute for Health and Clinical Excellence has taken on the functions of the Health Development Agency to create a single organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

Partnerships UK - PPP/PFI Projects Database

<http://www.partnershipsuk.org.uk/projectsDatabase/projectsdatabase.html>

Partnerships UK have launched a database of Public Private Partnerships and Private Finance Intitative projects. The freely available database has statistical, operational and financial data on over 600 projects. The database contains public information and aims to contribute to a better understanding of the market and assist the public sector in compiling data and reports on an aggregated basis.

Primary Care Contracting

<http://www.primarycarecontracting.nhs.uk/>

Primary Care Contracting are now working seperately from NatPaCT and therefore have revamped their web site. The new site includes sections on dentistry, pharmacy and optometry.



SIDELINES

Jo Davey, Julie Glanville, Su Golder, Kate Light, Lisa Stirk and Kath Wright

**Centre for Reviews and Dissemination
University of York**

Web: <http://www.york.ac.uk/inst/crd>

The Sidelines abstracts in this issue focus on effective searching via search filters, the continuing discussion around clinical trial registration, assessments of health management information sources, how to present information to health care professionals and guidance on preparing grant proposals.

Jenkins M, Johnson F. (2004) 'Awareness, use and opinions of methodological search filters used for the retrieval of evidence-based medical literature – a questionnaire survey', *Health Information and Libraries Journal*, vol. 21, pp. 33-43.

The development of methodological search filters, or search strategies combining search terms relating to research methodology, has been seen as one way that health librarians can contribute to evidence-based practice. Filters designed to retrieve specific types of study such as systematic reviews, randomised controlled trials or diagnostic studies, are now available. This survey found that there was generally a high level of awareness of filters among health librarians, but this did not necessarily correspond with a high level of use. Confusion had been created by the variety of terms used to describe methodological search filters, such as clinical queries, hedges, quality filters, and optimal search strategies. In addition, there was no one web site where all the available filters were listed. Reported difficulties in the use of filters revealed some lack of understanding. For example, are filters an "inclusion" or an "exclusion" tool? Should they be amended? Is there a need to quality assess the papers retrieved when a filter has been used? The findings of the survey lead the authors to conclude that there needs to be greater promotion of the concept of filters

and more guidance on how they can be used effectively.

Jenuwine ES, Floyd JA. (2004) 'Comparison of Medical Subject Headings and text-word searches in MEDLINE to retrieve studies on sleep in healthy individuals', *Journal of the Medical Library Association*, vol. 92, no. 3, pp. 349-53.

This article compares the performance of two search strategies in the retrieval of primary research papers on the sleep of healthy people, from MEDLINE. The first strategy used Medical Subject Headings (MeSH) only, and the second used text-words only.

A 'reference standard' set of relevant articles was obtained by hand searching the journal *Sleep* from 1996 - 2001. This provided a set of 137 papers to be retrieved.

The study found that the subject heading search provided higher specificity than the text-word search (i.e. fewer irrelevant records were retrieved by the subject heading search), but resulted in lower sensitivity (i.e. fewer of the relevant articles in the reference standard were retrieved than by the text-word search). Each strategy retrieved some records that the other did not.

The authors concluded that for optimum sensitivity and specificity, a combination of MeSH subject headings and text-words produces the best results. Subject heading searching provides a more precise search, but text-word searching allows a large number of terms to be used, to account for variations in the terminology used by authors.

The study authors suggest that the information professional can play an important role in informing

authors of scientific publications of the value of consistent use of terminology in the titles and abstracts of their publications, thus maximising retrieval of research from online databases.

Montori VM, Wilczynski NL, Morgan D, Haynes RB for the Hedges Team. (2005) 'Optimal search strategies for retrieving systematic reviews from Medline: *analytical survey*', *BMJ*, vol. 330, pp. 68.

This is one of a series of papers produced by the Hedges Team at the McMaster University on developing optimal search strategies. This paper focuses specifically on retrieving systematic reviews from MEDLINE.

In addition to new strategies the authors test three previously published search strategies, one previously proposed by the Hedges Team, one from the Centre for Reviews of Dissemination (CRD) developed to populate the Database of Abstracts of Reviews of Effects (DARE) and one from Shojania and Bero who developed a search for PubMed, as a clinical query, and for OVID as a limit.

The methods used in this paper are similar to those used in the previous research by the Hedges Team on developing optimal search strategies. 161 journal titles indexed in MEDLINE and published in 2000 were hand searched for systematic reviews. These journals were for the fields of general internal medicine, family practice, nursing, and mental health, and indexed on MEDLINE.

4862 unique terms compiled from clinicians, librarians, published strategies and others were tested in MEDLINE (Ovid interface). Those individual search terms with a sensitivity of more than 50% or a specificity of more than 75% were selected. These terms were then combined, with the Boolean OR operator, up to a maximum of five term strategies and tested for sensitivity, specificity and precision. This procedure yielded an impressive 782,485 unique strings of one to five terms for analysis.

The results indicate the best single performing search terms, the best multiple term strategies

maximising sensitivity and the best multiple term strategies maximising precision.

The authors, however, do appreciate the limitations of their study and acknowledge that searching the Cochrane Database of Systematic Reviews (CDSR) and DARE may be more appropriate in many circumstances to identify systematic reviews quickly.

Kyffin RGE, Goldacre MJ, Gill M. (2004) 'Mortality rates and self-reported health: database analysis by English local authority area', *BMJ*, vol. 329, pp. 887-8.

This article compares the use of mortality rates and surveys of self-reported health in the assessment of the health of a population.

Mortality rates are commonly used as measures of population health, but are often criticised because although they are readily available and objective, they are an extreme measure of ill health. However, self-reported health, such as the data gathered from questions in the UK Census, tends to be regarded as flawed because of its subjectivity.

For each local authority in England, the authors gathered the age standardised mortality rates for the major causes of death for 1999 and 2001 from the Compendium of Clinical and Health Indicators. This was then compared with the age standardised rates of self reported health status for the same areas using data from the 2001 Census. The study found that the mortality rates were highly correlated with the census measures of self-reported ill health, although this was not true for all local authorities. This suggests that despite the conceptual concerns about each method, the two different measures both result in a similar health profile for a given population.

Inouye, SK, Fiellin, DA. (2005) 'An evidence-based guide to writing grant proposals for clinical research', *Annals of Internal Medicine*, vol. 142, pp. 274-282.

This article gives advice to physicians applying for grants, particularly those intending to carry out patient-oriented research. Rather than merely dispensing advice from on high, the authors have attempted a systematic approach, basing their

recommendations and suggestions on a critique of previous grant applications. The evidence for the advice is culled from an examination of 66 grant applications made to the Clinical Research Study Section of the National Institutes of Health. Some of the comments and criticisms made by the grant reviewers on each key section of the 66 proposals are given. These are followed by the authors' suggestions, which respond to these criticisms, about how each section might be addressed in a more focused, clear and methodical way. Criticisms range from proposals not clearly explaining the importance of the proposed research to poor presentation and spelling. The authors stress the importance of writing a proposal that engages the reviewer from the start, making it stand alone without the need for appendices and other supporting material, and ensuring the writing is grammatically correct and not sloppy or careless. The article contains graphic timeline examples as well as a useful 'Checklist for the grant-writing process'. Although the paper is written primarily as a guide for US grant applicants, the advice given would be applicable to any grant proposal.

Vans T, Gulmezoglu M, Pang T. (2004) 'Registering clinical trials: an essential role for WHO', *Lancet*, vol. 363, pp. 1413-1414.

On behalf of WHO, the authors of this commentary highlight the need for a comprehensive and international system of trial registration that aims to either build one single register or to link all the existing registers. The ISRCTN (International Standard Randomised Controlled Trial Number) scheme is viewed as an encouraging start to achieving this goal. It is argued that such an initiative would increase international access to health-related knowledge, improve decision making by practitioners, researchers, policy makers and funders.

Haun MT. (2004) 'Information to go: publishing organisation-specific information for personal digital assistants', *Joint Commission Journal on Quality and Safety*, vol. 30, no. 5, pp. 286-289.

This article suggests how to package information and other

resources for physicians to access using personal digital assistants (PDAs). The advantages of PDAs over print resources include quick and easy accessibility to information, portability and the ability to provide files that will "self-destruct" when they become out of date.

Stevens AJ, Raftery J, Roderick, P. (2005) 'Can health technologies be assessed using routine data?', *International Journal of Technology Assessment in Health Care*, vol. 21, no. 1, pp. 96-103.

This study explores the potential of routine data to provide an alternative, or complement, to the use of randomised controlled trials (RCTs) in health technology assessment. Routine data is defined as information that is required to be collected regularly at national or regional level and uses standard definitions.

The authors identified 270 databases that met these criteria but were disappointed by the small number of databases that were suitable for their needs. Problems included the type of information collected. For example, many datasets contain information about health technologies but not about the healthcare state for which they were used. There are also difficulties with the way information is presented. For instance, the International Classification of Diseases (ICD) is widely used to classify information, but lacks the kind of detail required to inform health technology assessments. Issues around confidentiality also make it difficult to access information on a range of topics (for example, sexual health).

The article ends with examples of how routine data has been successfully used in other countries but warns that the issues outlined above must be urgently addressed if we are to make use of routine data.

The theme of this issue – the role of the information professional in evidence-based management – is not only very important but also very timely! I'm writing this the day before NLH hosts a national meeting on learning and development for library staff, specifically to address changing and evolving roles. The meeting follows the study commissioned

NATIONAL LIBRARY FOR HEALTH UPDATE

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by NLH and carried out by a team at the University of Wales Aberystwyth, led by Dr Christine Urquhart. Library staff and representatives from HLG, LKDN, CILIP, UKCHIP and many other key groups in the health library and information world will gather to discuss how to take forward the study's findings.

The report, which will be published by the time you read this, highlights priorities and recommends action to be taken. It suggests that training provision should:

- Offer variety in terms of how it is delivered (face to face, e-learning, blended) and where it is delivered (both national and local provision is necessary).
- Exploit opportunities for cross-sector training within the library and information sector.
- Allow the trainee to build on existing skills and competencies – more explicit scaffolding is required, rather than the 'quick fix'.
- Be accredited if possible.

The study synthesised findings from recent training needs analyses and found that the training priorities for health library staff are:

- Research and information retrieval skills for more advanced, specialist practitioners.
- Technical and knowledge management skills for those involved in intranets and outreach activities.
- Leadership and strategic management skills for the managers.
- More specific, specialist training for some paraprofessionals.

The report also suggests innovative ways of helping library staff to put their learned skills into practice:

- Mentoring schemes with trained mentors, with more opportunities for health library staff to team up with those working in patient information services.
- Coaching schemes for the leadership skills required, with more opportunities for health librarians to team up with health professionals.
- More emphasis on action learning, and reflection on learning, to support organisational learning as well as personal learning.

The national meeting will come up with a short list of concrete objectives to take forward these and other recommendations in the report. So watch this space!

News and snippets

- *User needs* : The user needs questionnaire closed on 6th May, having been live for one month. Response has been good and we have a lot of rich data. TFPL will be extracting key themes and preparing a final report which will be available during Summer 05.
- *Primary care work* : Sue Lacey-Bryant has been commissioned by NLH to lead a project on support for primary care and public health librarians. Sue will focus on ways to share good practice and support collaborative working, as well as promoting the value and contribution of library and information services. This work incorporates the development of a Primary Care Current Awareness Service and

contributing to wider NLH developments.

- *Health promotion units* : In February a questionnaire, commissioned by the NLH, went out to all England-based Health Resources Units (HPUs). The project, led by Sandie Nicholson, aims to provide a picture of the staff, skills, and services of HPUs. This will be used as a basis from which a vision for HPUs, within the context of the National Library for Health (NLH), can be crafted. A report on the project will be available during Summer 05.
- *Clinical question answering service* : The NLH Clinical Question Answering Service has now answered over 300 reference questions and in recent weeks has achieved its target weekly volume. 81% of users rate the service as excellent and 91% said they were very likely to use the service again. The Service is provided to NLH by Attract, and is available from the NLH web site.
- *Directory* : Work is progressing on an online directory of health libraries for the UK and Ireland. Led by a partnership of HLG with the Royal College of Nursing and NLH, the project is gathering pace. Meetings with current directory managers were held during March. A proforma database is in preparation and discussions are underway on the structure of individual records.

Keep up to date with all the news by subscribing to the NLH News feed

(<http://nlhnews.blogspot.com/atom.xml>) or take a look at the weblog <http://nlhnews.blogspot.com>.

NLH MANAGEMENT NEWS

[HTTP://WWW.NELH.NH
S.UK/MANAGEMENT](http://www.nelh.nhs.uk/management)

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Andrew Booth, in his new NLH Management* briefing on evidence-based health management (EBHM) to be found in this issue, refers to EBHM in its purest sense as using clinical research evidence in making management decisions. However he goes on to say that 'the term has also been used to describe using evidence about the effectiveness of non-clinical interventions. For example evidence about the effectiveness of models of service (case management or team work), or about changes to organisation (changing skill mix or merging two organisations). In its broadest sense EBHM describes using any "acceptable evidence" to make better informed management and policy decisions'.

In compiling new briefings for NLH Management, our authors very often find themselves using "acceptable evidence" rather than, for example, randomised controlled trials. For many management topics clear-cut research evidence in the clinical sense does not exist. Health managers and information professionals working with them must acknowledge a more flexible concept of evidence of effectiveness, which can include the opinions of stakeholders if gathered using accepted systematic methods. Some of our briefings, particularly those which cover new areas of NHS activity, may need to draw on sources which are comparatively anecdotal in nature, in order to answer the standard briefing questions 'What are the implications [of work in this area]?' and 'Where can I find examples of good practice?'.

NLH Management is, however, aware that some management topics have more research evidence behind them than others. In acknowledgement of this we are beginning work on a new series of evidence-based briefings, which will draw on more research evidence than our existing briefings. Watch out for these new briefings as they start to appear on <http://www.library.nhs.uk/management>. Topics will include NHS mergers and organisational culture.

Other news: we're keen to check that we are still providing a service that meets the information needs of NHS managers, and so have compiled a questionnaire along similar lines to the one which we originally used to inform our thinking when setting up the Specialist Library for Management. It asks questions such as 'What information do you require in order to do your job effectively?' and 'What types of information essential to your job do you currently find it difficult to obtain?'. We will of course be sharing the results with the library community. If you can help publicise the questionnaire to health managers, by having print copies on your counter or by adding a link from your intranet to the e-version on the NLH Management Web site, please let us know as soon as possible.

Our twice-weekly email news alert service now has nearly 600 subscribers. You can click through from our home page to subscribe to it; there's no charge. The emails include brief details of new DH policy announcements, important publications and other headlines of interest to those

working in health management, with web links to click on for further information.

* NLH Management dropped the word 'electronic' from its title in November 2004, in line with the transition from NeLH to NLH

(Send feedback on the site to Lynette on 020 7307 2560 / l.cawthra@kingsfund.org.uk)

05/01

National electronic Library for Health

April 2005

Compiled by: Andrew Booth

Health Management

Evidence Based Health management (EBHM)

What is... Evidence Based Health Management?

Evidence based health management (EBHM to distinguish it from evidence based medicine (EBM)) refers to using research evidence in making management decisions. Defined narrowly it describes using evidence from randomised controlled trials investigating the effectiveness of clinical therapies and procedures in management decisions (for example, whether to add or discontinue a therapy in a service or revise guidelines). The term has also been used to describe using evidence about the effectiveness of non-clinical interventions. For example evidence about the effectiveness of models of service (case management or team work), or about changes to organisation (changing skill mix or merging two organisations) or about new financing arrangements (e.g. primary care purchasing), or about public health or health promotion programmes. This accommodates a more flexible concept of evidence of effectiveness which can include the opinions of stakeholders if gathered using accepted systematic methods.

In its broadest sense EBHM describes using any “acceptable evidence” to make better informed management and policy decisions. Such evidence could be a survey of opinions about the likely value of a change or new policy, or an internal data gathering project to collect service statistics and assess their validity for informing a decision. An example of this concept is research informed management (1) or “Evaluation-informed management” defined as “making more informed management decisions by using research evidence and evidence from inside the organisation, and making more effective actions and projects by using evaluation concepts to plan management interventions” (2).

In the only book on the topic Stewart defines evidence based management as: “The collection and integration of various information resources (e.g. best practice data, research results, managerial expertise, and other verifiable sources) that form a reliable pattern of evidence for operational and strategic decision” (3). In a recent review Young examines whether the same paradigm applies equally to healthcare management and clinical practice (4). Tensions exist between EBHM as an activity by which managers make their own practice accountable and as a facilitative practice to help clinicians with evidence-based practice.

Most authors acknowledge the limited research base for management activities within the health service. Other barriers include policy constraints, lack of time, attitudes towards research activity, lack of appropriately processed data, lack of skills enabling information seeking and appraisal, inappropriate format of publications, ineffective dissemination of information and absence of services facilitating access to evidence (5, 6). Nevertheless, most conclude that ideally management culture should be firmly based in evidence.

What is...?
Why is it important?
What do I need to do?
What are the benefits?
Whom can I contact?
Where can I find
examples of good
practice?
Resources
References
Comments

Why is it important?

The wider concept of evidence-based policy and practice (EBPP) received impetus from the Government policy making vision expressed in Professional Policy Making. One of nine core features identified was that policy making should use “best available evidence from a wide range of sources” (7). This contrasts with how models for organisation and management in health care over the last 20 years had been based on popular trends and fads rather than research on organisational and management practice. Strategic decisions typically follow the recommendations of consultants with the information upon which these are based remaining unchallenged. As evidence based healthcare was popularized among health care professionals there came increasing recognition that these ideas should be adopted in management.

	<p>Management innovations that are not evidence-based include the use of organisational mergers in tackling service quality; decisions on the optimal size of organizations for capacity or financial viability; substitution of doctors with other health professionals and the move towards home care as an alternative to hospital inpatient care (8).</p>	
<p>What do I need to do?</p>	<p>Practising EBHM requires:</p> <ul style="list-style-type: none"> • Stronger and more timely evidence • A stronger culture of evidence based management • Efficient and effective dissemination of evidence to decision-makers, and • Stronger evaluation of efforts to practice evidence based management” (9) <p>When making decisions ask yourself:</p> <ol style="list-style-type: none"> 1. What do we really know about our management processes? 2. What don't we know that we may think we know? 3. How do we find the answers to those things that we need to know? 4. How can we implement this new information best into our management practices? (10) <p>In practising EBHM first define a problem (11). Next find and examine relevant empirical evidence. A literature review (12), should include general and specific elements and focus both within and outside healthcare. It should search thoroughly for studies of organizations that have tried the approach in question and an analysis of the results of such initiatives. Then assess the quality of conducted studies (13). Look at who performed the study, whether the researchers were independent, and who paid for the research. Assessing the quality of the evidence may require managers who have been trained to critically examine research findings or contracted health services researchers. Once the evidence is found and considered, decisions can be made based upon the evidence. This may result in a change in how something is done or indeed a decision to make no change. Finally, after implementing a change, results should be tracked to feed back for future decisions.</p>	
<p>What are the implications?</p>	<p>EBM involves informing management decisions with empirical evidence of best practices drawing on values, resources and evidence. As such it addresses limitations of experiential approaches to managerial decision-making. However there is little evidence on benefits of this particular approach. A systematic review by Innvaer and colleagues examined health policy makers' perceptions of their use of evidence and found the most commonly reported facilitators were personal contact, timely relevance, and the inclusion of summaries with policy recommendations (14).</p>	
<p>Whom can I contact?</p>	<p>National Co-ordinating Centre for NHS Service Delivery and Organisational Research and Development (NCCSDO) The King's Fund Information & Library Service can help in identification of health services management research and materials on implementation.</p>	<p>This briefing will be reviewed and updated in April 2006</p>
<p>Where can I find examples of good practice?</p>	<p>Health Evidence Network (HEN) http://www.euro.who.int/HEN An information service for public health and health care decision-makers in the WHO European Region. It comprises two services:</p> <ul style="list-style-type: none"> • answers to questions to support the decision-making process; and • easy access to sources of evidence such as databases, documents and networks of experts. <p>Evidence Boost, and Myth Busters http://www.chsrf.ca/mythbusters/index_e.php Health-Evidence.ca http://health-evidence.ca/home.aspx</p> <p>The following articles may be useful:</p> <ul style="list-style-type: none"> • Rosen R (2000) Applying research to health care policy and practice: medical and managerial views on effectiveness and the role of research. <i>J Health Services Research Policy</i>. 5(2):103-8. 	<p>Management Briefings are short briefing papers produced by experienced health management librarians. Their purpose is to provide a brief introduction to topics of current concern.</p>

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Resources	Articles and Papers Stewart R Evidence-based Management: a practical guide for health professionals. Radcliffe Medical Press. ISBN 1-85775-458-1. Board on Health Care Services/Institute of Medicine <i>Keeping Patients Safe: Transforming the Work Environment of Nurses</i> Chapter 4 Transformational leadership and evidence based management (2004). Sutton and Pfeffer. <i>Dangerous Half-Truths: The Case for Evidence-Based Management</i> . Forthcoming Spring 2005. [Debunks current management theory and describes how to use best—rather than most widely believed and used—evidence to make things happen]. Information is obtained from the HMIC database and from desk-based Web research.	Information is obtained from the HMIC database and from desk-based Web research. Readers are advised to consider further information before acting on information contained in Management Briefings.
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