

The implementation of evidence-based healthcare in Scottish health boards

PHASE I

JULY 1999

This bulletin presents the first phase of a review of the implementation of evidence-based healthcare, focusing on health boards.

Summary of findings

Evidence is having an increasing effect on the planning process, but there are a number of other important influences. Some key points for the NHS in Scotland have emerged:

- Evidence covers a wide range of information, from 'hard' scientific research findings to local opinion. The results of scientific research are generally rated higher than other sources of information.
- Access to evidence and to the skills needed to use it varies. The NHSNet will give better access to information, but developing the appropriate skills needs equal attention.
- Specialist strategy groups seem to have better links to planning and commissioning than generic clinical effectiveness groups.
- The evidence base for proposals contained within the first Health Improvement Programmes was generally unclear. Strategies should contain explicit references to the evidence on which they are based.
- Lack of evidence and resistance to change were commonly cited as difficulties in using evidence. This is particularly true where existing services were being reviewed.

- Even where evidence exists and resources are made available to support a new service there may be practical reasons, such as a lack of specialist staff, which prevent the implementation of evidence-based healthcare.
- In some cases decision-making is still based around perceptions that certain services are 'a good thing' regardless of the evidence.
- The introduction of the Scottish Health Technology Assessment Centre is considered to have potential to improve the evidence base of decisions about new technologies.
- Evidence-based policy-making and prioritisation were identified as vital if evidence-based decision-making is to be developed further.

The advent of clinical governance, with explicit responsibility for the quality of care provided by trusts, may address some of the areas of concern and uncertainty. Phase II of our review, to be undertaken next year, will cover the implementation of evidence-based healthcare in Scottish trusts.

Why look at evidence-based healthcare?

The need to base health care decisions on robust evidence is growing, under pressure from an ageing population, new technology and rising patient expectations¹. These trends increase the need to focus NHS resources on services and treatments which offer the maximum health gain.

Evidence comes from a range of activities such as randomised controlled trials (RCTs), consensus statements, observational studies and surveys of patient views. Evidence is sometimes synthesised to produce clinical guidelines and good practice statements. Meta-analyses and large sample RCTs are considered to provide the highest quality evidence, with expert opinion and clinical experience at the lower end of the evidence hierarchy^{2,3}.

Since the early 1990s there has been growing interest in using the results of research to improve both the health of the population and the provision of health services. This work is described in various ways, including 'evidence-based practice', 'clinical effectiveness' and 'implementation of research findings'. At the root of these activities is a concern that there is considerable scope for improvement in planning and decision-making in health services.

In Scotland there are a number of national initiatives which seek to provide support and advice in using evidence for health care decision-making. These are shown in Exhibit 1. A number of UK initiatives, including the NHS Centre for Reviews and Dissemination, the Centre for Evidence Based Medicine and the Cochrane Collaboration, are key sources of information. In addition to these initiatives, there has been exponential growth in the volume of information in journals, from the Internet, and in reports from a variety of professional and lay groups.

Exhibit 1: National initiatives

Existing	Being established
<p>Clinical Resource and Audit Group (CRAG) Acts as a national forum for considering clinical effectiveness issues including clinical audit, guidelines and outcomes.</p>	<p>Clinical Standards Board for Scotland Will develop and run a national system of quality assurance for clinical services. Its aims are to support NHS staff in their efforts to improve standards and to reassure the public that services are safe and delivered to the highest possible standard.</p>
<p>Chief Scientist's Office (CSO) Commissions research on a wide range of conditions, methodologies, new developments and techniques, supports seven research units and maintains a database of current and recently completed research work.</p>	<p>Scottish Health Technology Assessment Centre (SHTAC) Will evaluate and provide advice to the NHS on the clinical and cost effectiveness of all innovations in health care, including new drugs. It will draw on appropriate professional expertise to prepare this advice.</p>
<p>Scottish Intercollegiate Guidelines Network (SIGN) An intercollegiate venture which manages a substantial programme of guidelines development.</p>	
<p>Scottish Needs Assessment Programme (SNAP) A group of public health physicians and other interested health professionals from the health service and other agencies who work together to assess the needs of the population and develop a standard method of assessing health needs.</p>	

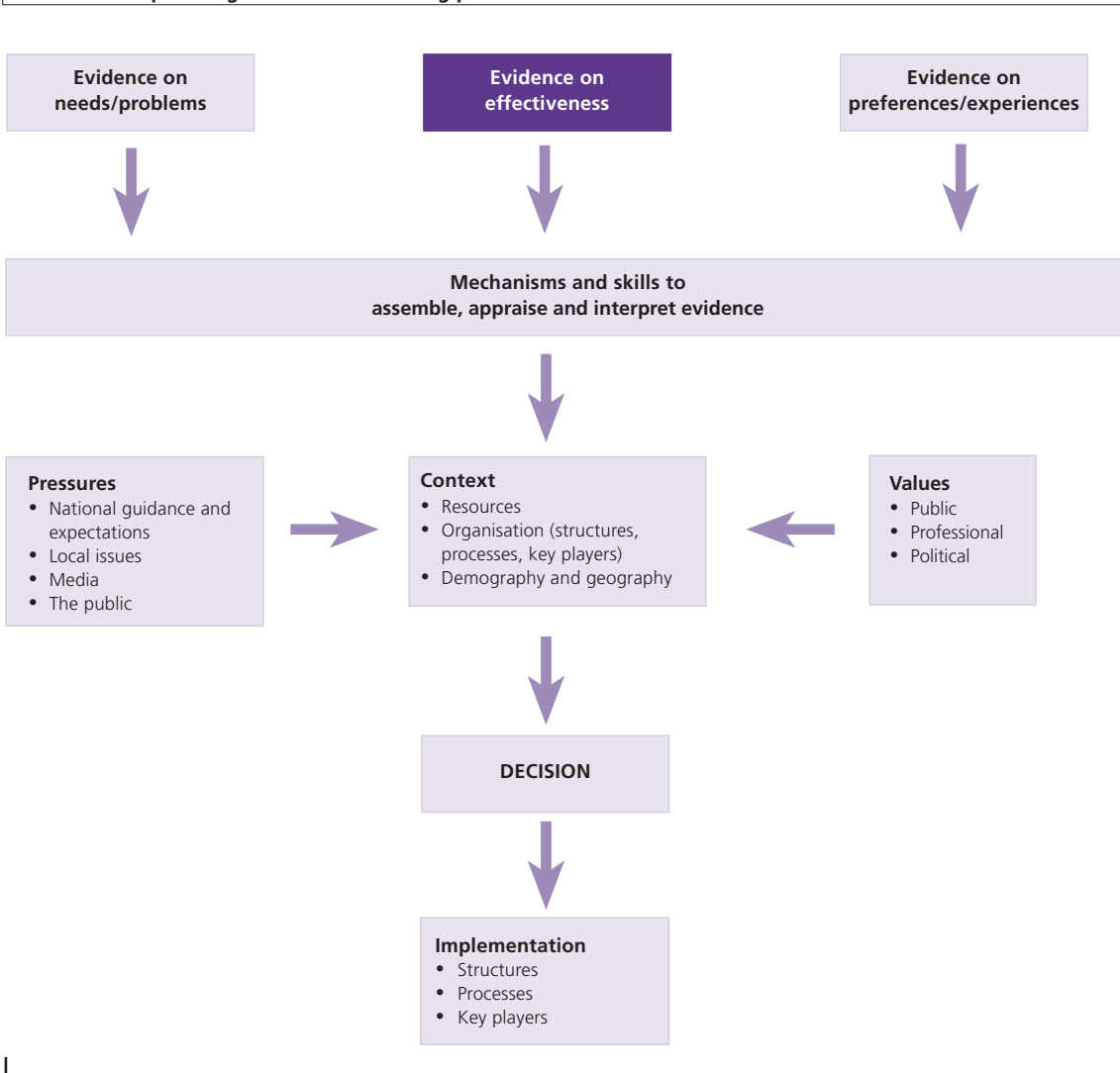
Recently the drive towards evidence-based activity has become much more explicit. In particular, 'Designed to Care'⁴ has placed clinical effectiveness clearly on the agenda. In setting out the objective of providing better services for patients, responsive to their needs and wishes, two areas relating to clinical effectiveness were targeted:

- improving clinical effectiveness by ensuring that performance meets agreed standards and that these standards are driven upwards
- promoting the adoption of more effective care based on evidence.

Current research in this field has tended to focus on activities to promote evidence-based clinical practice rather than on the broader framework of health service planning⁵. The aim of this report is therefore to review how evidence is used at a more strategic level, how it is influencing the planning process, and the priority being given to the implementation of evidence-based healthcare (EBHC).

The planning process in health boards is complex. There are a number of influences, of which evidence is only one. Exhibit 2 illustrates some of the key components of planning and decision-making.

Exhibit 2: The planning and decision-making process



This review seeks to identify the issues which affect the use of evidence in this process. We examined the progress achieved so far by Scottish health boards in developing their planning to make it more, or more explicitly, evidence-based. Our review involved interviews with key staff in all 15 health boards, and also examined each board's Health Improvement Programme (HIP) for 1998-2003. Our findings are outlined in the following sections.

What is evidence and how important is it?

What constitutes 'evidence' is a matter of both uncertainty and contention. Some respondents distinguished between 'hard' evidence (such as the results of RCTs and meta-analyses) and other 'softer' sources of information for decision-making (such as consensus statements, uncontrolled trials or evaluations, clinical audit data, qualitative research, the views of the public and patients, and local clinical knowledge). There was universal agreement about sources of 'hard' evidence, but little consensus on the other sources of information, particularly those which are not the result of research activity.

Although respondents tended to rank clinical scientific research higher, there was a general recognition that other types of evidence contribute in different ways to the wider perspective needed for informed decision-making. One director of commissioning referred to the 'healthy tension' between the clinically oriented view of evidence and the broader realms of social science-based research.

That evidence is only part of the picture is demonstrated by Exhibit 3. Our interviewees judged evidence on locally identified issues to be less important than either central policy directives (of which the Waiting List Initiative and restrictions on the use of Sildenafil (Viagra) were given as recent examples), or historical patterns of resource allocation in practical decision-making. On the other hand, evidence outweighed public or professional pressures and accepted practice. The spread of responses in Exhibit 3 is also significant. There was considerable variation between individuals, and in some cases diametrically opposed responses were obtained within the same board.

Exhibit 3: The role of evidence compared with other factors in decision-making

	Evidence is much less important	Evidence is less important	Evidence is equally important	Evidence is more important	Evidence is much more important
Policy drivers, eg Management Executive letters (%)	32	26	26	6	11
Public/patient pressures (%)	1	6	34	52	7
Clinician/trust pressures (%)	4	10	23	44	19
Primary care pressures (%)	0	15	48	28	9
Historical allocation (%)	27	33	12	13	14
Waiting List Initiative (%)	55	27	5	8	6
Budget constraints (%)	0	34	19	35	13
Accepted practice (%)	7	10	11	54	18

Note: The table shows percentage of respondents providing a response capable of being accommodated in the table (n=43-48). Some respondents provided a group response.

Summary

- While definitions of 'evidence' differ, it was generally recognised that there are many types of evidence used in decision-making.
- Evidence is only one factor in the social and political processes of decision-making.

Bringing evidence into the planning process

Evidence-based planning requires commitment from all levels of the organisation, starting with the Board itself. We examined the degree to which the use of evidence has been discussed at Board level. Nine boards had devoted a session to the approach, often alongside a wider debate about values and prioritisation; the other six boards reported that evidence for individual topics is routinely presented and discussed.

For evidence to impact on the planning process below Board level, the following are required:

- a means of assembling and interpreting evidence
- a means of ensuring that evidence is disseminated to the appropriate players in the planning process
- a means of ensuring that evidence is used as part of the planning process.

Assembling and interpreting evidence

We asked health boards to identify the information systems and the means by which evidence can be accessed which are available to staff. Those most commonly mentioned are shown in Exhibit 4.

Exhibit 4: Common means of accessing evidence

Health board	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total
Internet	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		13
Medline	✓	✓	✓		✓	✓	✓	✓		✓	✓		✓		✓	11
Cochrane Library	✓	✓	✓	✓	✓	✓					✓	✓	✓		✓	10
Health board library/ resource centre		✓	✓	✓	✓					✓	✓	✓		✓	✓	9
Hospital library	✓					✓	✓	✓	✓		✓		✓			7
NHSNet		✓					✓			✓		✓		✓	✓	6
Number of sources	4	5	4	3	4	4	3	3	2	4	5	4	4	3	4	

A few health boards reported problems with access to sources of evidence, the most common being access to library facilities. Nine boards have their own library, but not all have a librarian. The other boards use the library services in the local hospital. At the time of the review, access to electronic information sources varied among health boards: in most cases, it was limited to just a few PCs or to the health board library (Exhibit 5).

Exhibit 5: Level of access to the Internet

Level of access	Number of health boards
All staff have access via their PCs	1
Most staff have access via their PCs	2
Access is limited to a few PCs	6
Access via health board library/resource centre only	5
No direct access	1

Access to information alone is insufficient to ensure that evidence is used in the planning process. This also requires access to skills in information retrieval and interpretation. Librarians, or suitably qualified information officers, can assist in information retrieval, but only six health boards have a librarian on site. This means that staff spend more time doing literature searches, which may be of poorer quality. Seven boards reported that making time to find evidence was a major barrier to evidence-based planning.

Reviewing evidence requires critical appraisal skills. These skills enable planners to identify high quality evidence, to interpret it, and to understand its implications for the problem they are trying to solve. Some staff, particularly those in public health, obtain these skills as part of their training, and six boards identified public health staff as a major source of critical appraisal skills. However, few health boards have addressed the training needs of other staff involved in the planning process. Four boards reported that they had a shortage of the necessary staff skills for finding and reviewing evidence. Only two health boards had undertaken a formal assessment of staff training needs in critical appraisal. One was in the process of undertaking such an assessment, while another planned it for the future. No such assessment had taken place in nine health boards.

Good practice example

In Fife Health Board, staff training needs have been reviewed by a project team. A resource pack has been produced by the Clinical Effectiveness Co-ordinators Group. This identifies the resources that are available both locally and nationally, and how they can be accessed.

Dissemination of evidence

One way of ensuring that evidence is integrated with the planning process is to make this the responsibility of a senior, named individual. In seven health boards the director of public health has been given this responsibility. In one health board, this role is shared between the director of public health (responsible for clinical information) and the director of information (responsible for information on non-clinical areas). In another it is the responsibility of the director of health gain. Six health boards, however, have not identified any single individual, commenting instead that this is a collective responsibility.

The department of public health plays a key role in considering and disseminating information on evidence. Other departments and individuals within health boards are also involved. Those mentioned most often by respondents are shown in Exhibit 6.

Exhibit 6: Individuals/departments identified as having a key role in evidence-based planning

Individual/department	Key role mentioned by number of health boards
Department of Public Health	9
Clinical Effectiveness Co-ordinator	6
Commissioning teams	3

The planning process

Most boards mentioned two main types of group as having a role in bringing evidence into the planning process: clinical effectiveness groups, which cover a wide range of issues, and specialty strategy groups, which focus on a particular topic. Eight boards have a clinical effectiveness group and six boards have a specialty strategy group. Four boards have both types of groups and five boards have neither. Specialty strategy groups were reported to have good links with both the planning and the commissioning processes, but a number of clinical effectiveness groups did not appear to have such good links (Exhibit 7).

Exhibit 7: Structures in place to ensure evidence impacts on the planning and commissioning processes

	Links to planning process			Links to commissioning		
	Good	Mixed views	Not good	Good	Mixed views	Not good
Clinical effectiveness group	2	2	4	1	2	5
Specialty strategy group	6			6		

Good practice example

Ayrshire and Arran Health Board has specialist project boards for each of the service strategies. These involve clinicians from the board, trusts and primary care, and have clinical leadership from the Director of Service Development or a lead commissioner. The groups review topics within particular specialties, produce commissioning plans and follow these up with regular review.

Other processes to bring evidence into planning are also in use (Exhibit 8).

Exhibit 8: Other processes used to bring evidence into planning

- Area Clinical Audit Committee
- Committee for Improving Health
- Commissioner and Consultant in Public Health Medicine part of same team
- Drugs and Therapeutics Committee
- Guidelines Group
- HIP Planning Group

Good practice example

Lanarkshire Health Board has a HIP planning group which is the key mechanism through which evidence comes to influence planning decisions in secondary care. It involves the board, trusts, primary care, representatives from the two local authorities and Lanarkshire Health Council. This wide membership strengthens the links between the Health Improvement Programme and the Community Plans for which local authorities have a leading role. Cancer groups are in place, with a remit to review and collate evidence for improving services and to consider the range of views being expressed. Their recommendations go to the HIP planning group and form the basis of planning decisions. These groups involve local clinicians and are supported by public health staff.

Summary

- Access to information sources, including library facilities and electronic sources of information such as Medline and the Internet, varies across Scotland.
- Few health boards had undertaken a formal assessment of training needs for staff involved in planning.
- Nine health boards have identified an individual with executive responsibility for ensuring that evidence is used in the planning process.
- There are a number of mechanisms in place to bring evidence into the planning process. The most common are clinical effectiveness groups and specialty strategy groups. Respondents reported the latter to be effective at ensuring evidence feeds into planning and commissioning.

Using evidence in the Health Improvement Programme

The Health Improvement Programme is a key part of the planning process for health boards. It sets out their priorities and plans for improving the health of their populations, and should contain information on the evidence base underlying these decisions. To investigate how far this is the case in practice, we reviewed each health board's HIP for the period 1998-2003.

Nine boards included the use of evidence as a major topic in its own right, and four referred to evidence as a minor topic. Structures and processes for using evidence were given in explicit detail by three boards, in lesser detail by five boards, in general terms by four boards and not at all by three boards. The most common means of using evidence mentioned in HIPs were guidelines, audit, and research and development (R&D) (Exhibit 9).

Exhibit 9: Number of HIPs mentioning specific tools for implementing EBHC

	In general	In the context of particular health care topics
Audit, evaluation	13	13
Guidelines, SIGN, protocols, pathways	13	13
R&D	9	9
Monitoring outcomes	9	5
Education, Continuing Professional Development	7	4
Surveys of public/patient views	6	5
Library, information sources	4	1
SNAP	4	1
Health economics	3	0
Priority setting	3	0

Good practice example

Highland Health Board makes a useful terminological distinction in its HIP between EBHC at the strategic level and clinical effectiveness at the operational level.

We reviewed service proposals in the HIPs for the three national clinical priority areas and for the strategic aim of reducing inequalities. The extent to which these were explicitly based on evidence varied, with most basing proposals on national policy direction. Proposals for cancer were mainly based on Calman-Hine recommendations (in nine of the 12 boards with service proposals), while those for mental health were mainly based on the Mental Health Framework and reprovion plans. For Coronary Heart Disease (CHD)/stroke proposals, two HIPs made specific mention of evidence, nine made minor mention and one made no mention. Three HIPs had no proposals for CHD/stroke. Of 12 HIPs with proposals for tackling inequalities, 11 made no mention of evidence and one made minor mention.

Even though the evidence base in HIPs may not be explicit, this does not necessarily mean that they are not evidence-based. This lack of an explicit evidence base was recognised by most respondents who attributed it to various factors, only one of which was lack of evidence. Other factors included:

- the inclusion of evidence in 'supporting documents' such as pre-existing strategic plans, Director of Public Health annual reports, local and national needs assessments, and SIGN guidelines
- the importance of other influences, such as central guidance and policy directions, and local pressures and priorities
- the tight timescale for producing the first HIP.

Health boards are increasingly working in partnership with other agencies, but this can present further challenges. The role of evidence in developing joint strategies is growing but is currently limited. Different organisations tend to take different views of 'evidence'. Differences of philosophy, culture, emphasis, and political and decision-making processes hinder the achievement of a common language of 'evidence'. One board cited the example of drug policies, where its local authority wanted the message to be 'just say no', despite evidence suggesting that this approach does not work. This made joint working in this area very difficult.

Good practice example

Borders Health Board and Scottish Borders Council have a strong culture of joint evaluation. The board cited the example of a dementia project based at Craw Wood, which has allowed the transfer of patients from Dingleton Hospital. This is currently being evaluated.

Summary

- The evidence base for plans proposed in HIPs is usually not transparent, but this does not necessarily mean that the plans are not based on evidence.
- National policy direction is very influential.
- Achieving evidence-based joint strategies is challenging, as health boards and their partner organisations may have differing views on evidence.

Difficulties in implementing evidence-based healthcare

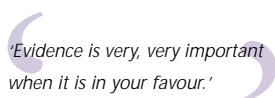
Even where there is a clear link between the use of evidence and the planning process, boards identified a number of difficulties which may hinder the progress of EBHC. Six key issues were identified (Exhibit 10). The single most common response related to a lack of available evidence, although three boards commented on an overload of evidence output from national groups. Some of the output from national groups was viewed as unrealistic because it failed to address the resource implications of its recommendations. Resistance to change by both NHS staff and the public was the second most common response. This highlights the need for clear messages about the role of evidence and the benefits of change.

Four boards suggested that even where clear evidence exists and resources are available to support the implementation of a new service, it may not be possible to recruit staff to provide the service. One board cited specialty accredited cancer surgeons as an example.

The implications of change in terms of training and organisation were cited by three boards as a practical problem in implementing evidence.

Exhibit 10: Difficulties implementing evidence-based healthcare

Issue	Difficulty	Number of boards reporting the difficulty
Evidence	Lack of evidence	11
	Unrealistic recommendations from national groups	3
	Evidence overload	3
Resource constraints	Time constraints	7
	Opportunity cost	6
	Lack of skilled staff	4
Attitudes	Resistance to change	10
	Negative views of EBHC	4
Practicalities	Shortage of staff to provide evidence based services	4
	Implications of doing things in a new way	3
External influences	Political pressures	4
Board organisation	Lack of integration	4



*'Evidence is very, very important
when it is in your favour.'*

Case studies

The majority of boards felt that the role of evidence in the decision-making process had increased significantly in recent years, and that decisions reflect the evidence base, at least in part, where such evidence is available. Problems remain, however, with both the availability and the consistency of evidence. Evidence is easier to bring into the planning process when new developments are proposed. It is more difficult to establish evidence to support a reconfiguration of services, or a reduction in existing services. Where contradictory evidence exists, or the evidence is open to some degree of interpretation, this can lead to 'evidence wars'.

In planning for resource transfer, a health board looked at the threshold for frail elderly people to remain in NHS provision, based on both dependency and quality issues. A particular aim was the provision of single rooms, but this was challenged by the clinicians who claimed evidence existed that patients 'preferred wards'. Resolving this delayed the implementation of the community care plan.

Boards were asked for case studies where evidence played either a central role, or was considered less important than other factors in the decision-making process. Many of the case studies identified concerned service specifications, which are generally not decided at Board level. This includes issues such as the use of steroids in preterm labour, or the introduction of guidelines for a particular disease. Other decisions are a direct result of central guidance, such as the use of Recombinant Factor VIII for haemophilia, over which boards have little influence.

The most frequently cited examples where evidence was reported to play a central role in decision-making concerned drugs (five boards), cancer services (four boards) and diabetes initiatives (three boards). Interestingly, drugs (three boards) and cancer services (two boards) were also mentioned as examples where evidence was deemed to have been less important than other factors. In addition, infertility services were cited as an example by three boards as an area where evidence was reported to have been less important. There was also a wide range of other case studies identified in both acute and priority services, where evidence played either a central or a less important role; very few examples were given relating to primary care.

Decisions about new drugs

Decisions about new drugs were the most commonly cited case studies where evidence played a significant role. This is an area where decision-making structures are well established⁶, and recent evidence is likely to be available. The two most commonly cited examples were Donepezil (four boards) and Beta-interferon (five boards).

Grampian Health Board had based a decision about introducing anti-thrombolytic therapy into the community on evidence of effectiveness and cost-effectiveness. The drugs are funded from the hospital budget. The training requirements for interpreting ECGs are now being addressed.

Three further boards cited examples where decisions about drugs had been taken on the basis of clinician pressure and not on the basis of the evidence available (Beta-interferon in two boards and Sildenafil in one board).

Cancer services

Cancer is one of the three clinical priorities for the NHS in Scotland. As a result, all boards are producing plans for the organisation of cancer services for their resident population. Four boards specifically identified decisions about cancer services as evidence-based.

Argyll & Clyde Health Board's cancer investment programme was based on a review of the available evidence and on clinical opinion. Evidence was used in the first phase of the cancer purchasing plan to decide on priorities and the best use of limited resources.

Two other boards identified particular decisions about cancer services where the evidence was less clear: the organisation of colorectal cancer services, and multi-disciplinary working within discrete cancer services.

Diabetes initiatives

Although diabetes is not a priority area for the NHS in Scotland, it has been the subject of significant activity resulting from the World Health Organisation's St Vincent Declaration in 1989. Three boards specifically identified decisions about diabetes services as evidence-based: the provision of a primary care-based diabetic register; support for fundoscopy screening by optometrists; and a large scale diabetic services investment programme.

Infertility treatment criteria

Two boards mentioned this as an area where evidence played a major role in decisions about the number of cycles of treatment to fund and the age limit for treatment. However, two other boards felt that the evidence for assisted conception played a lesser role to that of cost and political imperative. One board's decision to fund in vitro fertilisation (IVF) and not intra-cytoplasmic sperm injection (ICSI), despite good evidence of success for both treatments in certain age and diagnostic groups, was made on cost grounds alone.

Other case studies

Several boards identified case studies where new services have been introduced without recourse to evidence because they are considered 'a good thing', or because the cost of evaluation far exceeds the costs of providing the service. Examples included the provision of small units for NHS continuing care of elderly people, introduction of a 24-hour community nursing service, and additional community nursing posts.

Despite evidence that mass media health promotion campaigns do not impact on behaviour unless they include a 'call to action', one health board continues to support these in order to increase visibility and raise awareness of health issues.

A health board examined the evidence for hydrotherapy for arthritis but found it to be inadequate. However, the board agreed to fund the service because it was not costly (£4 per treatment) and had a strong placebo effect.

Summary

- The influence of evidence on the decision-making process is felt to have increased in recent years. Problems arise where evidence is not available or is contradictory. Decision-making is pragmatic and reflects a number of different influences.
- The most commonly cited areas where decisions were made on the basis of evidence was where new services were being proposed. Examples included new drugs, cancer services, infertility treatment criteria, and diabetes initiatives. Few case studies were given about reconfiguration of current service provision, reflecting the lack of evidence in this area. There were very few case studies which related specifically to primary care.
- Some decisions are still made on the basis of a general perception that a treatment is 'a good thing', rather than on evidence of health benefit.

The way forward

Boards were asked to suggest the way forward for EBHC at national and local levels. The establishment of SHTAC was mentioned by eleven boards. It was considered to have the potential to increase the use of evidence in decision-making, providing its work is co-ordinated with other national initiatives and its recommendations and resource implications are endorsed nationally. The importance of basing future policies and priorities on evidence was mentioned by nine boards (Exhibit 11).

Exhibit 11: The way forward for EBHC at a national level

	Number of boards
SHTAC	11
Evidence-based policy-making and prioritisation	9
Strategies to increase understanding of EBHC	5
Amendments to SIGN process and remit to take account of resource implications	4
Improved quality and accessibility of research evidence	4
Production of national clinical effectiveness strategy	4
National standardised data collection and prospective audit	4
Managed clinical networks	3

Boards were also asked what could take place at a local level to progress EBHC. The most common response by boards was the development of a more focused approach for EBHC (Exhibit 12).

Exhibit 12: The way forward for EBHC at a local level

	Number of boards
More focused approach	8
Raise awareness of EBHC and its uses; engage clinicians	5
Develop explicit prioritisation / decision making process	4
Use of IT to access information	4
Managed clinical networks	3
Trust reorganisation / clinical governance	3

Specific issues relating to small boards were highlighted (Exhibit 13). Large boards face different problems.

Exhibit 13: Issues for small boards

- Increased cost of training, both travel costs and opportunity costs.
- Small numbers of staff, each taking on a number of roles and responsibilities, can lead to conflicting priorities and lack of time.
- Small numbers of clinicians mean it is easier to get debate underway, but clinician resistance may have greater impact.
- Out-of-area treatments can mean the resident population receives care on the basis of decisions made by other boards.
- Applicability of evidence to rural settings.

Boards' overall impressions

When boards were asked if they believe their planning is evidence-based, only two boards were able to agree fully, while another four felt that new developments and strategies are now based on evidence. The remaining nine boards considered that evidence influences planning up to a point, but that other influences, particularly political ones, are important. One board specifically said that evidence can only ever partially inform the planning process. The majority of boards felt that evidence would have an increasing influence on the planning process over time.

'Evidence-based healthcare is about getting the best for your population but it should not be seen as a panacea for the ills of the NHS.'

Study methodology

All health board general managers in Scotland were asked to nominate individuals within the board who should be part of the study. Those identified were then interviewed using a semi-structured questionnaire and prompt cards for Exhibit 3. Interviews were face-to-face and took place in the period June to December 1998. All 15 health boards participated in the study.

Advisory panel

Dr A Carver	Researcher, Scottish Association of Health Councils
Mr T Divers	General Manager, Lanarkshire Health Board
Dr P Hanlon	Chairman, Scottish Needs Assessment Programme
Professor R Lorimer	Director, Scottish Clinical Audit and Resource Centre
Dr C Loughlan	R&D and Teaching Manager, Addenbrooke's Hospital
Professor J Petrie	Chairman, Scottish Intercollegiate Guidelines Network
Dr N Waugh	Consultant in Public Health Medicine, Grampian Health Board
Dr H Zealley	Director of Public Health, Lothian Health

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- ⁴ *Designed to Care: Renewing the NHS in Scotland*, The Scottish Office Department of Health, 1997.
- ⁵ See, for instance, *Status Report*, the Centre for Evidence Based Medicine, 1997.
- ⁶ *The Bitterest Pill: Decision Making for New Drugs*, Accounts Commission for Scotland, 1997.

The Accounts Commission is a statutory, independent body which, through the audit process, assists the NHS and local authorities in Scotland to achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources.

The Commission has five main responsibilities:

- securing the statutory external audit
- following up issues of concern identified through the audit to ensure a satisfactory resolution
- reviewing the management arrangements which audited bodies have in place to achieve value for money
- carrying out national value for money studies to improve economy, efficiency and effectiveness in the NHS and local authorities
- issuing an annual direction to local authorities setting out the range of performance information which they have to publish.

The Commission secures the audit of 32 councils, 34 joint boards (including police and fire services), 15 health boards, 28 NHS trusts and six other NHS bodies. Local authorities spend over £9 billion of public funds a year and the NHS in Scotland spends over £4 billion .

The Commission assists the NHS in achieving value for money by highlighting good practice, providing comparative information, and supporting auditors in reviewing performance locally. Its Health and Social Work Studies Directorate is responsible for managing a national programme of value for money studies.

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Responsibility for the contents and conclusions rests solely with the Accounts Commission.



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