Rulemaking is informed by scientific knowledge, practical knowledge drawn from experience and value-led knowledge (Flyvbjerg, 2001; Ehrenberg, 1999). Our six-part series on the lifecycle of a research project uses the Creating Learning Environments for Compassionate Care (CLECC) study to illustrate how research evidence shapes policy and practice. This final article discusses what makes a piece of research likely to influence policymakers.

Strength of the evidence
Scientific, or research, evidence required for good policy governance needs to be rigorous and reliable, but choosing research to influence policy involves more than this alone. One single study never ‘proves’ anything; at best, it demonstrates a strong probability of a particular outcome following a given intervention (see parts 3, 4 and 5). The findings of a single study are unlikely to provide a strong enough case for policymaking, so developing a body of evidence around a policy area is essential.

Some nursing research is simply descriptive or falls into the ‘promising-but-not-proven’ category (findings are interesting but evidence weak, often due to a small sample). Some studies have a large-enough sample and strong evidence of a difference between the intervention and control groups, but that difference (effect size) is small, so the upheaval of a policy change might not be justified in terms of the gain. Where there is strong evidence of a large difference, the findings may not be generalisable – much of nurses’ work is highly context-dependent and a single study cannot cover all the differences (variables). This raises the question of how best to implement such evidence.

Agenda and readiness
Research may meet policymakers’ needs, but does not, on its own, lead to policy change. Many other factors are considered, including competing arguments and the relationship to current policy initiatives. There will be myriad evidence on countless topics – policymakers must determine priorities, in nursing and
Guidance rather than legislation

New legislation is often seen as the pinnacle of policymaking but does not always create the desired change. ‘Softer’ initiatives, such as national guidance, can be more successful, as with the work on healthcare-acquired pressure ulcers initiated by East of England Strategic Health Authority and continued by NHS Improvement (Box 1).

Another example is the response to the Francis report recommendation that the National Institute for Health and Care Excellence (NICE) draw up guidance on staffing. NICE concluded that the existing studies on nurse staffing were observational rather than intervention studies. Intervention studies would test different staffing models in controlled environments to be sure it was staffing, rather than anything else, that was responsible for different outcomes. NICE also noted a lack of research evidence on the reliability of tools and approaches used by hospital managers to decide nursing staff establishments and skill mix at individual ward level, despite the population level associations between nurse numbers and patient harms. Without robust evidence of a significant effect obtained while controlling other variables, legislation is not possible.

In the meantime, services still needed advice on staffing numbers so, in 2013, the National Quality Board also served as a call to action: ‘do something’ to ensure compassionate care in inpatient wards. Its authors note the need to test the intervention more widely, but the study is promising. The findings will inform future NHS Improvement plans to support trusts in improving care for older people living with frailty. NT

References

National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe, sustainable and productive staffing. Bit.ly/DHRightStaff2016.

Achievability and affordability

A study like CLECC – which describes the conditions that make good care possible and ways of creating those conditions in different workplaces – is very useful for policymakers, as it moves the discussion on from what individual staff can do to what managers and organisations can do.

To have an impact, policy needs to be practical and achievable. Interventions must be affordable and offer a good return on investment compared with other demands, including clinical interventions. Research that describes an ideal service without considering the availability of resources and the feasibility of integration is unlikely to be chosen by policymakers, however enticing its outcomes.

Call to action

What is striking in these two examples is the existence of a narrative that creates an imperative for policymakers to act. The

**Box 1: How research evidence guided pressure ulcer prevention**

Research on how to prevent pressure ulcers had been around for some time when The Patients Association (2011) published first-hand accounts of poor care in hospitals in England and Wales. This accelerated the thinking of one of its authors, Ruth May, (then chief nurse of a strategic health authority) about how to measure nursing care and substantively improve it by making changes in nursing practice.

Ms May and her team reviewed existing research and concluded that pressure ulcer prevalence could be used as an indicator of overall nursing care quality. They used evidence to develop a set of actions and measures nurses could adopt in all areas using an established quality-improvement methodology. The Stop the Pressure campaign was launched and research evidence used to raise awareness of the causes of pressure ulcers, early warning signs and preventative measures. Within a year, care providers in the Midlands and East of England almost halved the number of pressure ulcers.

The campaign created enthusiasm and belief among nurses that pressure ulcers could be prevented. It reached other regions and improvements were sustained. In 2016, it was rolled out across England and is now managed by NHS Improvement which, in 2018, issued new guidance on pressure ulcer definition and measurement in England, which will come into effect in April 2019 (Fletcher and Hall, 2018).

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