Measuring policy impact & Sage Policy Profiles

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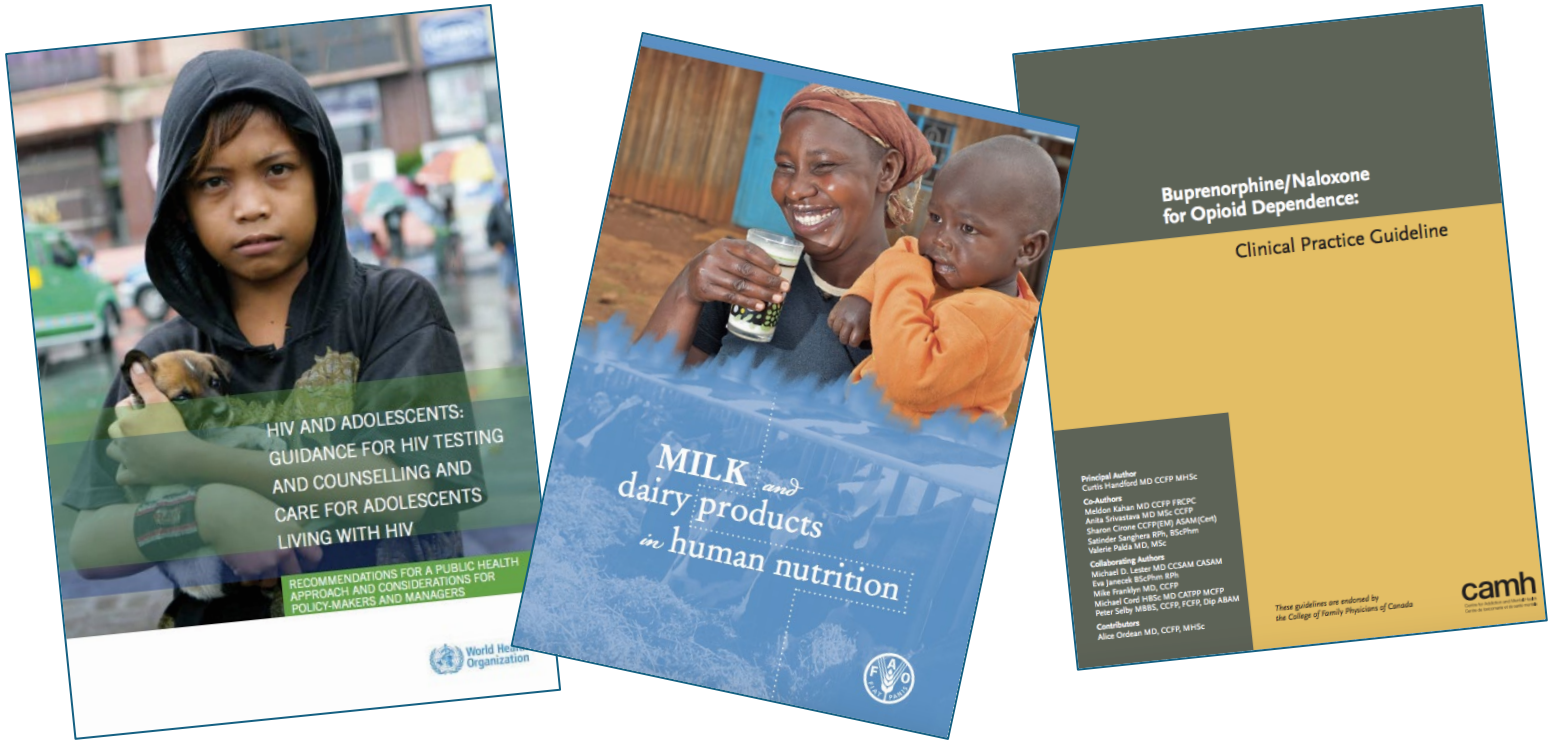
ICRP, 15th May 2024

Well, maybe not measuring impact…

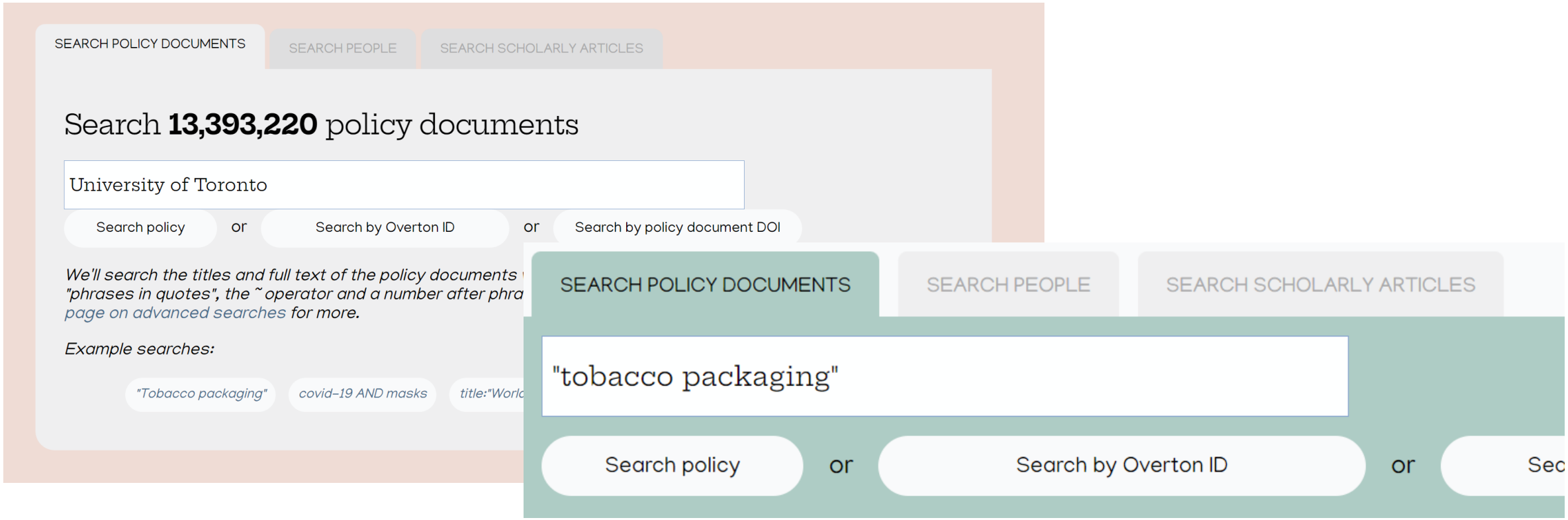
- Specifically impact in health policy and guidelines
- Will talk a little bit about what we mean
- …and at a high level, what we've learned
- Then will show you Sage Policy Profiles, a free tool that makes this data available to individual researchers

Overton

- Overton is a full text grey literature search & indexing database that focuses on government policy
- ~13.5M documents, from governments, IGOs, think tanks &policy orientated NGOs in 180+ countries
- We identify the scholarly researchers and outputs being cited or acknowledged by policy documents

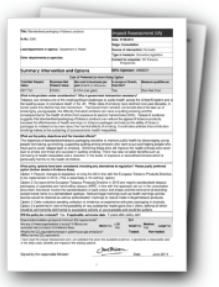


- White papers from government departments
- Draft bills, reports and guidance
- Legislative transcripts from committees or parliaments
- Clinical guidelines



Policy citation indexes map references, name mentions etc. in policy documents to research outputs (and from there to universities, funders etc.)

Policy document



Standardised packaging of tobacco products: draft regulations

Department of Health and Social Care from The UK Government on February 17th 2015 Publication

Seeks views on the proposed draft regulations for standardised packaging on tobacco products.

Cited by 6 other policy documents (inc. same source)

Tobacco smoking | Cigarette | Plain tobacco packaging

Tag this | Download PDF (#1 of 2) | Rights & permissions: Open Government Licence

> Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America
>
> Prabhat Jha et al. (2006) The Lancet
>
> Author from University of Toronto is Prabhat Jha

Jha, P., Peto, R., Zatonski, W., Boreham, J., Jarvis, M. and Lopez, A. 2006. Social inequalities in male mortality, and in male mortality from smoking: Indirect estimation from national death rates in England and Wales, and North America in The Lancet. 368, pp.367–370.

On page 6 of PDF #1

Policy document

Policy options for extending standardized tobacco packaging

World Health Organization on March 26th 2018 Publication

Smoking | Habits | Herbal and fungal stimulants

Tag this | Download PDF

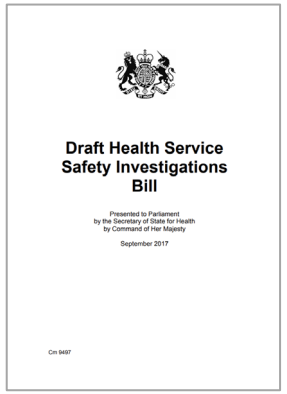
> Global Effects of Smoking, of Quitting, and of Taxing Tobacco
>
> Prabhat Jha et al. (2014) New England Journal of Medicine
>
> Author from University of Toronto is Prabhat Jha

1. Jha P, Peto R. Global effects of smoking, of quitting, and of taxing tobacco. N Engl J Med. 2014 Jan 2;3701:608. doi: http://dx.doi.org/10.1056/NEJMra1308383PMID:24382066

On page 2

At what point does a citation become impact?

Step 1 - citation


Draft Health Service Safety Investigations Bill

Presented to Parliament by the Secretary of State for Health by Command of Her Majesty

September 2017

Cm 9497

Step 2 - impact?

Step 2 – impact?

Step 2 - impact?

Impact is subjective, focus is generally on qualitative analysis &narratives

- …. we agree with this approach
- But hard data &numbers are useful to
  - Evidence claims
  - Track change (success?) over time
  - Indicate where qualitative expert time is best spent

Conceptually it's not a million miles away from citations in journals…

- But in practice very different.
- Three differences to bear in mind:
  - There is no comprehensive public record of policy
  - Knowledge brokers and intermediaries are very important
  - Policymakers cite local

Publicly available documents

Direct relationships with research do exist

Essay

Journal of the Royal Society of Medicine, 2014, Vol. 107(11) 439–443
DOI: 10.1177/0141076814555939

Learning from failure: the need for independent safety investigation in healthcare

Carl Macrae[1] and Charles Vincent[2]
[1]Centre for Patient Safety and Service Quality, Imperial College London, London W2 1PG, UK
[2]Department of Experimental Psychology, University of Oxford, Oxford OX1 3UD, UK
Corresponding author: Carl Macrae. Email: carlmacrae@mac.com

Tragedies are powerful motivators for learning and improvement. The only honourable response to the victims is to try to ensure that similar tragedies are not repeated in the future. In the NHS the report that led to the National Reporting and Learning System was entitled 'An Organisation with a Memory' precisely because of the ambition to capture the learning inherent in tragic incidents.[1] The recent Berwick review into patient safety in the NHS similarly speaks of 'A Promise to Learn' but also, tellingly, of a 'Commitment to Act'.[2] We clearly need a capacity for intelligent, thoughtful reflection on the causes of tragic events and, still more, a capacity for using this hard won knowledge to build a safer healthcare system. In this paper we suggest that this would be most effectively achieved by the creation of a small, permanent independent agency charged with coordinating major inquiries and safety investigations in the NHS. Such a model, if successful, could be applied in other healthcare systems.

Safety investigation in the NHS

The NHS currently has no consistent approach to investigating and learning from safety issues. There is a smorgasbord of approaches to investigate and address systemic safety issues at various levels of the healthcare system with little apparent consistency, logic or strategy underlying their design or execution. These span locally managed independent investigations, commissioning and regulatory investigations, rapid reviews, service reviews and independent and public inquiries (see online supplemental file for details and examples).

Individual NHS trusts conduct large numbers of occasional exceptions,[3] local investigations rarely encompass the wider systemic factors that can contribute to serious failures of care, such as ambiguous regulatory requirements or inappropriate commissioning.

Regulators, commissioners, and other NHS and professional bodies all conduct their own different forms of safety investigation. These provide important insights into patient safety from the perspective of the agency involved.[4] However, these investigations are necessarily conducted by organisations that may themselves inadvertently contribute to the emergence of system-wide safety issues and recommendations from these inquiries tend to focus on punitive sanctions, regulatory enforcement and performance management.

At a national level efforts to learn from major tragedies take a variety of forms. The most high-profile approaches are independent or public inquiries, such as those into the failures of care at Mid Staffordshire NHS Foundation Trust.[5,6] Inquiries can have considerable impact and provide much-needed public explanation after terrible events.[7] However, each one starts afresh and determines its own unique approach rather than building on systematic and established methods of safety investigation.[8,9] Inquiry teams are short-lived and are dissolved once the report is complete; they therefore have no capacity to independently review progress against recommendations. And the legal orientation of independent and public inquiries is not well suited to developing strategies for improving safety. In practice the question of building a safer system may only be given serious consideration late in the process. Public inquiries appear to spend 90% of the time examining what happened and 10% of the time considering the future; arguably this allocation of time

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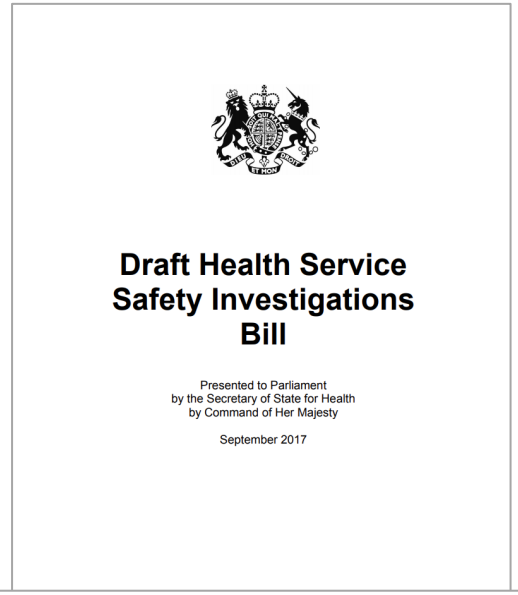

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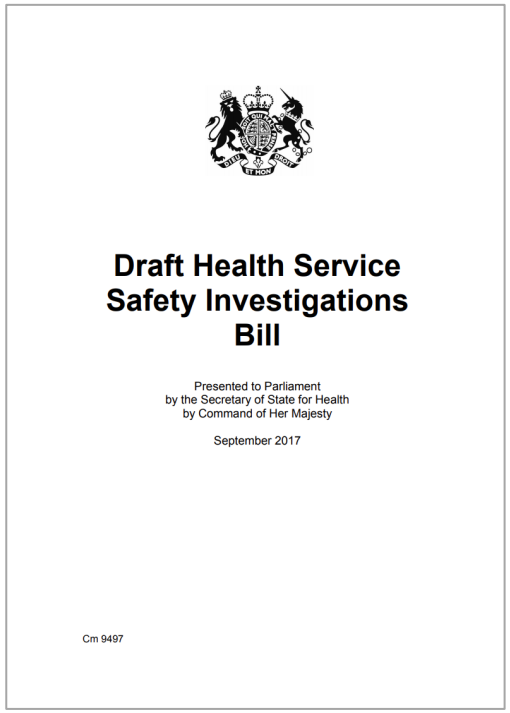
for using this hard won knowledge to build a safer healthcare system. In this paper we suggest that this would be most effectively achieved by the creation of a small, permanent independent agency charged with coordinating major inquiries and safety investigations in the NHS. Such a model, if successful, could be applied in other healthcare systems.

The Government has stated the main objectives of the Health Service Safety Investigations Bill [HL] 2019-20 are to:

- establish the Health Service Safety Investigations Body (HSSIB) as a new independent arm's-length body with powers to conduct investigations into patient safety incidents that occur during the provision of NHS-funded services;

But second order citations more common

"translation" steps



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Carl Macrae[1] **and Charles Vincent**[2]
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Individual NHS trusts conduct large numbers of investigations into serious safety incidents, sometimes with the assistance of external advisers. These investigations can lead to important local safety improvements, particularly when linked to a broader safety strategy. However, the scope of these investigations is necessarily focused on a specific trust. With occasional exceptions,[3] local investigations rarely encompass the wider systemic factors that can contribute to serious failures of care, such as ambiguous regulatory requirements or inappropriate commissioning.

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Investigation in safety-critical industries

Safety-critical industries such as aviation, shipping and the railways all face the risk of major failures

Governments tend to cite local

In government policy from…




The three most cited universities are…

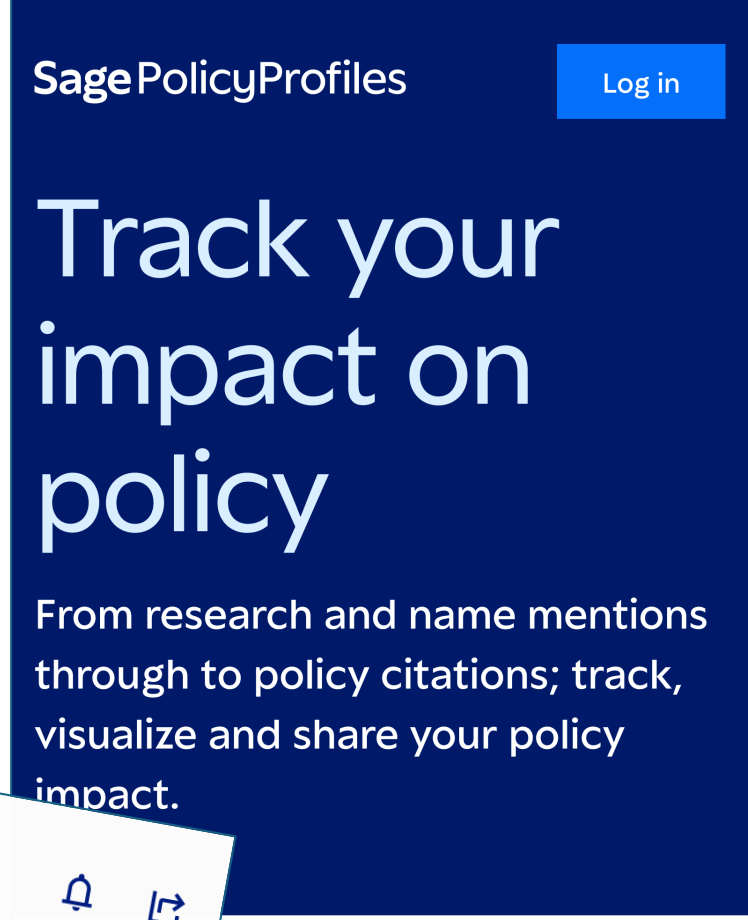
University of Melbourne University of Sydney Australian National University	Harvard Stanford University of Washington	Stockholm University Uppsala University Lund University	University of Sao Paolo University of Brasilia University of Minas Gerais

Source: Overton.io database, July 2022

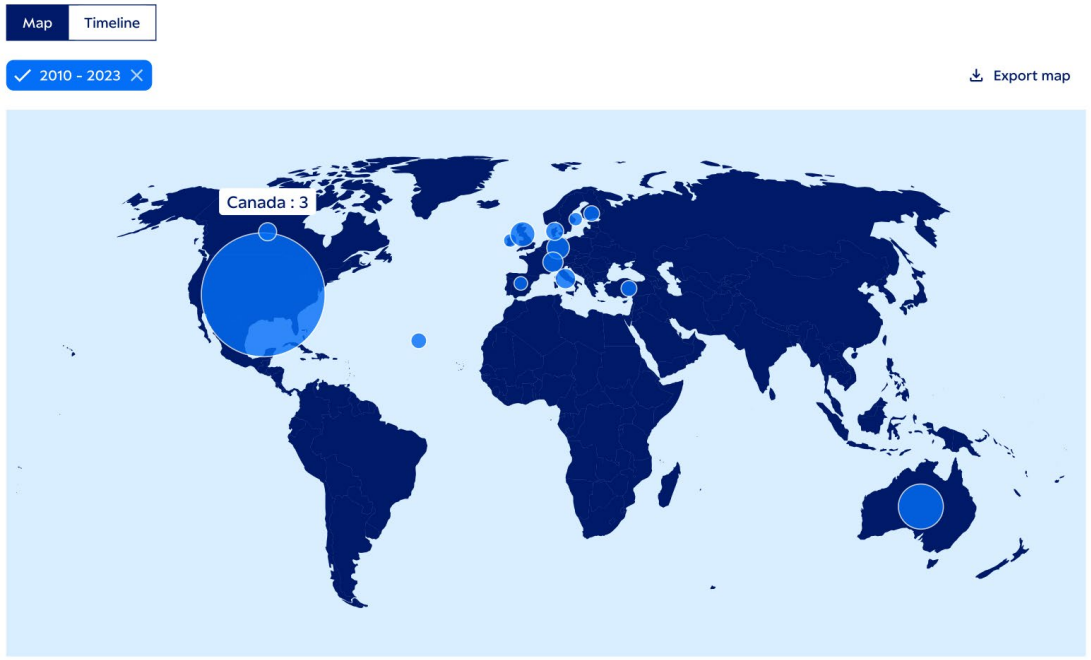
Sage Policy Profiles

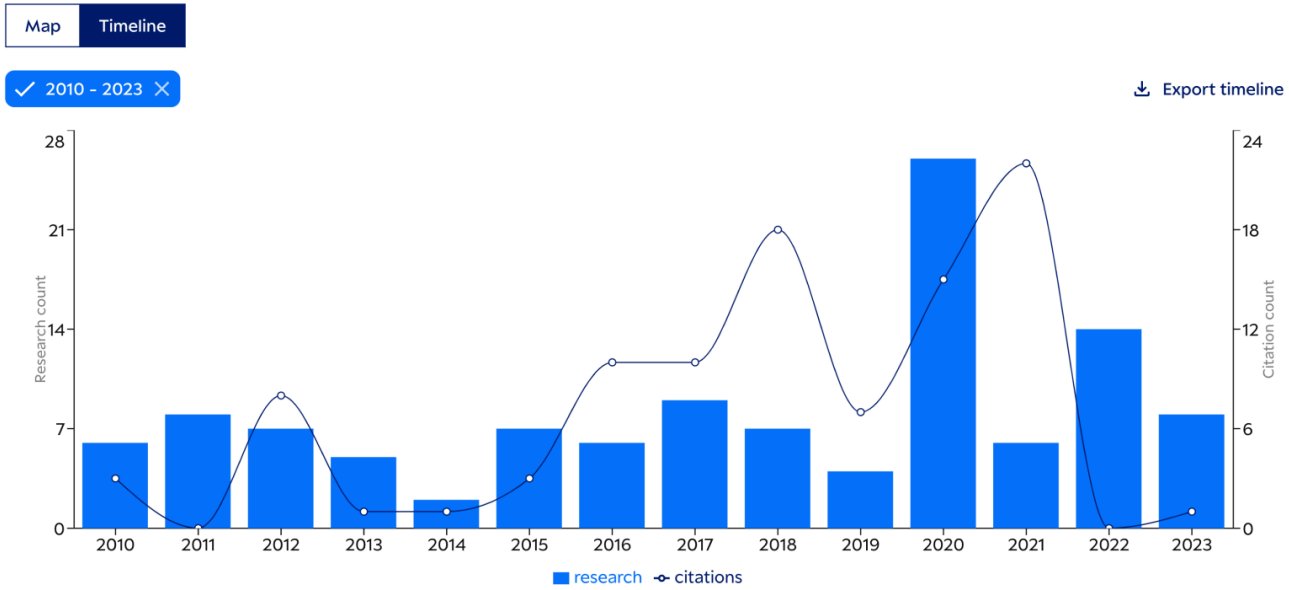
https://policyprofiles.sagepub.com/

- Sign up and select your publications (or use ORCID)
- See policy citations and mentions to your work
- Free to use



Dashboards change based on volume of data





Thank you!

Happy to take questions….

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