

Health Development Agency

Getting evidence into practice in public health

*Michael P. Kelly, Viv Speller
and Jane Meyrick*

Introduction

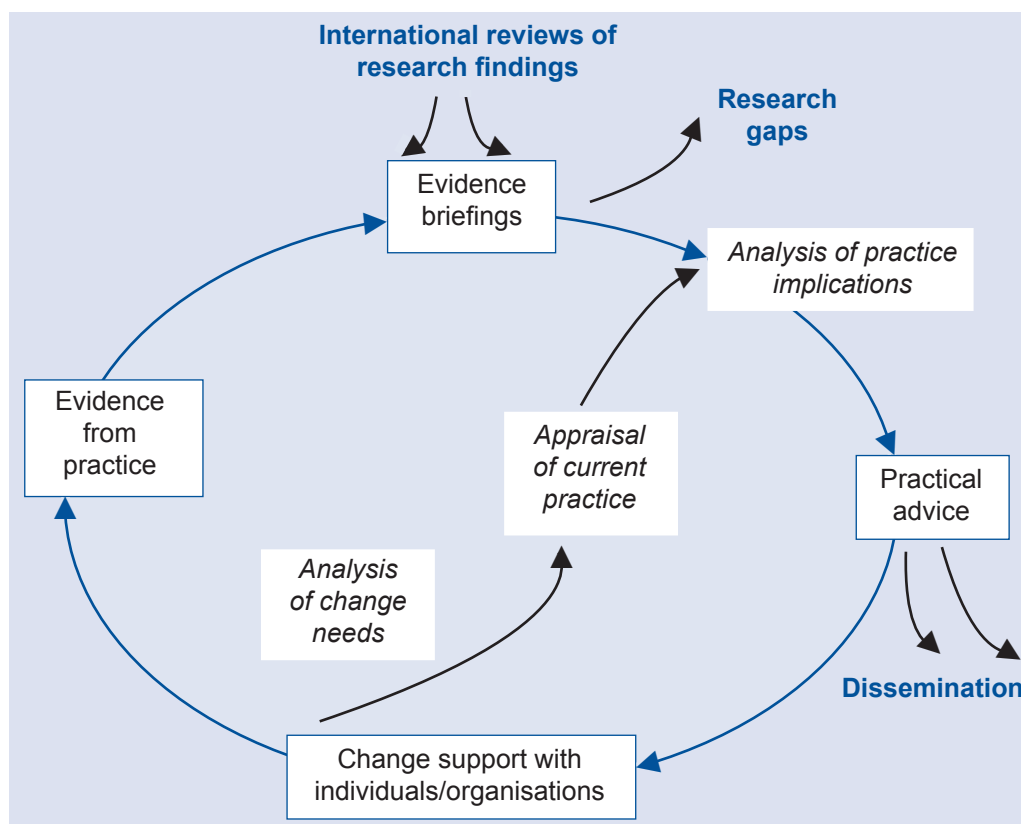
This publication describes how the Health Development Agency (HDA) has established systems and protocols to develop the evidence base in public health and to produce guidance materials based on that evidence. It also outlines the proposed basis for changing public health practice using that evidence and guidance.

Several important questions are raised: What is the best way to develop evidence in public health? What is the definition of evidence? How may evidence best be used

to produce guidance for practice? What are the practicalities involved in putting evidence into practice? And what are the best ways of stimulating change in practice?

This account acknowledges the complexity of the processes. It also describes some of the underlying theory and debates in the fields of producing evidence of effective public health interventions, developing practical guidance, and supporting change within the evidence-into-practice cycle (Figure 1).

Figure 1 The evidence-into-practice cycle



Building the evidence base

Since 1997 the UK government has developed strategies to tackle inequalities in health (Department of Health, 2001a, 2003). There are two overarching, long-term goals: reducing inequalities in infant mortality across all social groups; and raising life expectancy more quickly in the most disadvantaged areas than elsewhere. *The NHS Plan* (Department of Health, 2000) identifies a number of elements that could contribute to reducing health inequalities, including breaking the cycle of inequalities, tackling major killer diseases, improving access to services, strengthening disadvantaged communities, and supporting vulnerable groups. Since 1997 there have been a number of shifts in emphasis, but central to all policy statements has been a commitment to finding ways of reducing health inequalities (Department of Health, 2003). The underlying principles behind this drive to reduce inequalities are twofold: the goal of social justice, and the evidence-based approach needed to reach that goal.

The HDA was established to support the effort towards tackling health inequalities. After publication of the white paper *Saving*

lives: our healthier nation (Department of Health, 1999), the HDA was set up to ensure that 'organisations and individual practitioners base their work on the highest standards and over time raise the quality of the public health function in England.' Subsequently, the research and development strategy for public health (Department of Health, 2001b) has endorsed the HDA's role in this endeavour by identifying its task as 'maintaining an up to date map of the evidence base for public health and health improvement ... and effective and authoritative dissemination of advice to practitioners.'

The approach outlined for the HDA and specified in the research and development strategy (Department of Health, 2001b) took its cue from evidence-based clinical medicine. Evidence-based medicine and evidence-based healthcare have received considerable impetus in the past decade (Egger *et al.*, 2001). Evidence-based medicine is defined by Sackett *et al.* (1996) as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.' Explicit guidelines were produced

to derive evidence of effectiveness from primary research through systematic review (secondary research) (NHS Centre for Reviews and Dissemination, 2001). This led to a bias towards synthesis of primary research based on randomised controlled trials, which are the most appropriate method to determine the effectiveness of treatments and drug interventions. However, the inclusion of studies in systematic reviews based on the methodology employed created a *de facto* hierarchy of research design. This hierarchy places experimental studies, especially randomised controlled trials, at the top, and observational and other qualitative studies lower down – although some systematic reviews take a more catholic approach and include evidence drawn from investigations which were not randomised controlled trials (Dixon-Woods *et al.*, 2004).

The extension of an analogous approach to answering questions about the effectiveness of public health interventions led to a vigorous debate. A number of reviews from the NHS Centre for Reviews and Dissemination, and the Health Education Authority's series of effectiveness reviews (eg Riddoch *et al.*, 1998), sparked considerable controversy. Questions were raised about both the nature of the research used to evaluate public health, and the complexity of interventions (Black, 1996; Speller *et al.*, 1997; Davies and MacDonald, 1998; Nutbeam, 1998; Scott and Weston, 1998). The main argument was that randomised controlled trials are an inappropriate research method for evaluating complex community-based public health interventions where target groups cannot be randomised to provide controls, and where multiple interventions are operating simultaneously on individual, community and system levels. Additionally it was argued that, in certain situations, randomised controlled trials might be unnecessary, inappropriate, impossible or inadequate to provide evidence of effectiveness (Black, 1996). The alternative view was also argued – that, notwithstanding the difficulties, it was of vital importance to develop public health policy and practice on a sound evidence base of the best possible information, and that randomised controlled

trials could usefully be deployed to that effect (Oakley, 1998; MacIntyre *et al.*, 2001).

Another line of argument was that systematic review was itself problematic. Inclusion criteria for some reviews pay insufficient attention to the quality of the interventions being evaluated, so that poorly designed interventions might be included in reviews, while carefully implemented interventions might be excluded on the basis of the research design. It was also noted that, even where interventions may have been of good quality, 'Given the lack of attention in many research studies to process evaluation, important features of the intervention design may not be known ... thereby reducing the ability of practitioners to adopt the methods' (Speller, 1998). At the same time, concerns were voiced about the scope of the evidence base, including the need to incorporate qualitative research and other methods in evidence-based clinical practice (Black, 1996; Green and Britten, 1998). In addition, there were also concerns expressed about its limitations in answering questions and dealing with complex public health interventions, and those relevant to addressing cross-cutting issues, eg reducing health inequalities. The implications of these issues were debated at a workshop on the contribution of reviews to evidence-based health promotion (Meyrick, 1997).

Against this background of controversy about the type of evidence that might be used to evaluate public health, the HDA began its work. At the outset it had to be acknowledged not only that the definition and type of evidence is controversial, but also that bringing about change based on evidence is not straightforward. Collecting and appraising evidence, the conversion of the evidence into advice and guidance, and supporting change within complex systems are all complicated processes based on quite different practical methods and philosophical assumptions. The HDA's challenge since then has been to integrate the conduct of each of the disparate processes of evidence generation, developing guidance and changing practice, to clarify their underlying assumptions and to make them as transparent and auditable as possible. As

these processes have evolved, they have had to confront the fact that knowledge transfer does not happen according to a simple cause-and-effect model. Making information available to practitioners does not necessarily or automatically lead to its application to practice (NHS Centre for Reviews and Dissemination, 1999). The collection of data and its systematic review, through to the production of summaries or syntheses of the state of the evidence, is an iterative but ultimately linear and rational empirical process, and the way the HDA has built the evidence base has been linear, rational and empirical. Although the process is not simple, the logic is, and while scientists may debate the methodological and philosophical bases, biases, meanings and definitions of evidence, the principles are relatively well defined and the issues and disputes well rehearsed (Egger *et al.*, 2001). In contrast, the ways in which deliverers of service engage with and change practice in line with the evidence is most certainly not linear (Green and Kreuter, 1991; NHS Centre for Reviews and Dissemination, 1999; Ollerearnshaw and King, 2000; Greenhalgh, 2001; NHS Confederation, 2001).

Pragmatically, a sequential approach was adopted towards building a map of the evidence for public health interventions. Initially this involved collating and synthesising evidence from an accumulating number of systematic reviews on public health topics, making this accessible and highlighting limitations of both methodology and reach. This task was defined as the beginning of a process of evidence building. The intention was subsequently to enhance the evidence base by incorporating forms of evidence drawn from research traditions other than experimental and randomised controlled trials.

Evidence briefings

The process began by devising a method, then preparing a series of evidence briefings (Kelly *et al.*, 2002). Evidence briefings consist of summaries and syntheses of review-level evidence on a range of topics. A detailed protocol was constructed for searching databases, conducting a critical appraisal

of the reviews and writing the documents (Kelly *et al.*, 2002; Swann *et al.*, 2002). The earlier editions of evidence briefings consist of tertiary level research – reviews and syntheses of existing systematic reviews and meta-analyses. The evidence briefings describe in detail strengths and weaknesses in the review-level evidence, and identify the gaps, analyse future primary and secondary research needs, and discuss the implications of the review-level evidence for policy and practice. Each document has a freestanding summary. The documents are supported by the HDA website www.hda.nhs.uk/evidence, which also provides electronic copies of the original systematic reviews on which the evidence briefings draw, along with full bibliographic information about primary sources. The documents are designed to be accessed by a variety of users including those simply looking for headline findings, those wanting complete detailed synthesis, and those who need to track back to original primary or secondary sources. There is an audit trail from primary research source to policy and practice implications.

The next stage of evidence generation will involve extending the gathering of evidence to include data drawn from sources other than reviews – observational epidemiology, social scientific investigations (including those using qualitative designs), grey literature, and eventually data from practice (see Dixon-Woods *et al.*, 2004). So different types of evidence from different methodological traditions will be drawn together.

The evidence briefings provide a comprehensive, systematic, up-to-date map of the available review-level evidence base for public health and health improvement, focusing on issues that may have an impact on reducing inequalities in health. They are a resource that can be used by a variety of audiences. They are source documents that will contribute to a range of other products that may be developed. However, they are a passive resource. For the evidence to be directly applicable in the field, an active approach to the evidence to make it accessible, contextualised, usable and implemented is required.

Developing and disseminating guidance

The development of the evidence briefings, and especially critically appraising the evidence itself, have demonstrated that while evidence derived from scientific studies is important and vital, it is best understood as providing scientifically plausible frameworks for intervention, rather than guides to detailed action at local level. The HDA makes an assessment of the strength of scientific plausibility using critical appraisal processes (Kelly *et al.*, 2003). But, while necessary, this kind of scientific plausibility is not sufficient for a successful intervention in the field. The evidence on its own does not provide a complete recipe for success, or an imperative for action. The evidence needs further refinement if it is to be useful in everyday practice. To determine whether an intervention, even one well founded in the evidence, is likely to be successful requires an understanding of local contexts and circumstances, of local professionals' knowledge bases, commitment and engagement, and detailed assessment of the particular population at whom the intervention is aimed.

Effective action briefings

The HDA has produced guidance to support the development of aspects of effective public health practice (West *et al.*, 2000; HDA, 2001, 2002a). These earlier documents were based on an evaluation of the evidence and the policy and practice context, along with consultation with stakeholders and target audiences. They also drew on examples of good practice. The HDA is now developing a more integrated, systematic and empirical way of involving practitioners in producing guidance. The new guidance documents will be called effective action briefings. Flexible and evolving mechanisms are being established to draw out the expertise of such groups as health visitors, school nurses, teachers, medical and related practitioners, managers, and civil and other public servants, for each topic under consideration.

The process involves testing the strength of the research messages (validity and reliability),

paying attention to how far these messages can be generalised and transferred, and to the means of turning findings into action. Evidence briefings are assessed to identify the most significant findings. These are then tested for their robustness in scientific terms, and the potential for implementation assessed. It may be necessary to return to the primary research to drill down to the detail needed to determine both the scientific strength of findings, and how practical implementation in non-experimental conditions might be achieved. Once the best, most reliable, valid and potentially useful findings have been identified, they are tested with practitioners.

Groups of relevant practitioners and agents involved in delivery of the service assess the findings in the light of an appraisal of existing practice and organisation. Practitioner groups are convened. These groups are asked to consider the question of how to get the evidence working at local level, given all the issues and problems they are familiar with in their day-to-day practice. The practitioner groups also consider current organisational and professional barriers to change, in order to identify drivers, triggers, opportunities and pressure points relevant to making the evidence work on the ground. This phase is critical in informing where and how the evidence can be used, and the type of activities that are likely to be effective in changing practice (NHS Centre for Reviews and Dissemination, 1999; Kelly *et al.*, 2003).

The process of meeting practitioners involves fieldwork in various parts of the country with different groups. Using qualitative data-gathering techniques, a systematic account is built up of patterns of local issues and problems identified by the practitioners. Case studies arising from the fieldwork demonstrating good (or bad) practice will also be made available. Experience of conducting pilot studies of this process suggests that about six fieldwork meetings are needed to obtain sufficient data coverage, before the ideas from the groups become

overly repetitive. Although there is local variation, it is not infinite, and certain patterns or themes recur in the meetings. Sufficient saturation of the data seems to occur around the fifth meeting. The technical reports of these meetings will

form the basis of effective action briefings, containing clear recommendations of effective and implementable public health interventions to improve health and reduce health inequalities, and aimed at particular research audiences.

Supporting change in public health

The guidance element of the above process will then be disseminated through HDA publications and regional activities, to raise awareness of effective action. Regional HDA staff will be in an influential position to support this phase in local policy implementation and planning through regional public health networks.

The HDA provides four main routes to supporting the development of effective public health practice and systems: the nine regional development arms of the HDA; a central practice development team; specific national coordination programmes eg the National Healthy School Standard; and practice development collaborating centres which will be established during 2004. Each of these strands will contribute to the dissemination and adoption of effective practice. It will be through these routes that effective action briefings will be disseminated and practice development supported. Where indicated, new tools, resources and educational materials will be produced and disseminated to support these efforts. National level coordination of regional delivery will facilitate learning from practice and sharing between regions. The central features of the delivery and development functions of the HDA will be that they aim to implement effective public health actions, using evidence-based methods that build on what is known about best practice in improvement techniques and, critically, engage with the field to support local implementation.

At national level the HDA supports real and electronic networks for dissemination of the evidence base and continued learning among players in the field. The HDA also has a role in working with the Department of Health, National Institute for Clinical Excellence, strategic health authorities, the Commission

for Health Audit and Inspection, the Local Government Improvement Programme and professional bodies to ensure that effective practice is incorporated in policy, performance management systems and occupational standards.

The HDA's approach to practice development and change stems from key findings about getting evidence into practice, drawn from reviews of the evidence and understood within a wider theoretical framework.

Principles for changing individual practice are described by the NHS Centre for Reviews and Dissemination (1999) and in the Cabinet Office's review of spreading good practice (Ollerearnshaw and King, 2000). These suggest, as a first step, a diagnostic analysis of the factors likely to influence change in the user group, including internal factors such as preparedness to change and any external barriers. These principles are being assimilated into the appraisal of practice work described above. Involving peers at all stages of defining and disseminating best practice is vital, as is the need to involve learning from others' experiences, to identify what will work in local circumstances. Successful strategies are likely to be broadly based and multi-faceted, and to include effective elements such as use of reminders and educational outreach, within a wider coordinated strategy with contact through networks, benchmarking or other interactive systems. Appropriate training is necessary, and strategies should be coordinated by those with the skills and knowledge across all stages of dissemination to implementation. Instructions from 'the centre' should be avoided, and people need to trust the source of data. Finally, approaches should include means of monitoring and evaluating how far proposed changes are achieved, and of reinforcing the maintenance of change.

Stacey's agreement certainty matrix (Figure 2) has been loosely applied as a first-stage decision-making model to guide judgements about the general types of activities likely to be effective under particular circumstances. This has helped the HDA to understand when to use evidence, when to concentrate on policy changes, and when to use practice development approaches.

Stacey is helpful in that he identifies appropriate management mechanisms dependent on the balance of agreement and certainty about particular actions. Where levels of both agreement and certainty are high, the field is ready for the development of planning and control mechanisms such as guidance, application of standards of practice, and performance management. In complex systems where either dimension is low, changes in practice will follow from other approaches such as experimentation and local innovation. The HDA's activities in producing evidence briefings and effective action briefings will, for the first time, provide assessments of both certainty (availability and strength of the evidence) and the level of agreement in the field about the nature of and capacity for changed practice in public health (appraisal of current practice). This will lead to the ability to design appropriate implementation programmes. An important conclusion from Stacey's work is that central guidance and standards are a tool for change only where both agreement and certainty are high.

Implementing changes in the broad arena of public health, which includes many other partners and sectors in addition to the NHS, brings its own challenges. A framework the HDA has found useful in understanding the different categories of intervention is a capacity-building framework specifically for this broader field of health improvement, developed in Australia (NSW Health, 2001). This provides a helpful, tested model of change and capacity-building in public health for conceptualising the range of change activities the HDA and practice development collaborating centres will deliver. Capacity-building is defined as 'an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors.' (Hawe *et al.*, 2000). The framework identifies five central dimensions for change actions: organisational development; workforce development; resource allocation; partnerships; and leadership.

Returning to the evidence for effective change approaches, we can see that the distinction between organisational development and workforce development (or individual professional behaviour change) underscores the need for different, complementary approaches. Building effective partnerships is also an area for HDA support programmes. The HDA can influence resource allocation at regional and local levels. Thus the processes and systems in place attempt

Figure 2 Stacey's agreement certainty matrix (Stacey, 1999)

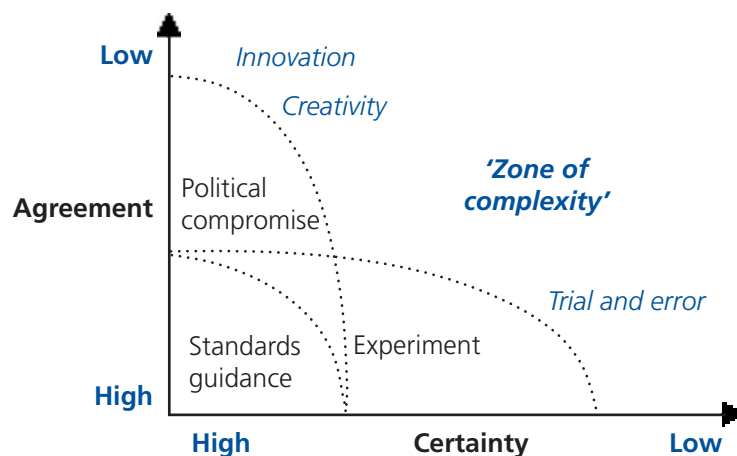


Table 1 Types of impact – where and when are they measurable?

Types of practice development activities (NSW Health, 2001)	Diffusion of innovations (Rogers, 1995)			
	Dissemination	Adoption	Implementation	Maintenance
Resource allocation		✓		✓
Organisational development			✓	
Workforce development			✓	✓
Partnerships		✓	✓	✓
Leadership		✓	✓	✓
HDA				
Evidence briefings	✓	✓		
Effective action briefings	✓	✓		

to influence not just the dissemination phase of diffusion of innovations (Rogers, 1995), but also the adoption and implementation phases.

It is important to note a number of distinctions between different types of potential impacts of public health interventions, eg the distinctions between process evaluation, which measures the activities of the programme and its quality and reach; impact evaluation, measuring the immediate effect of the programme (has it met its objectives?); and outcome evaluation, which measures the long-term health effect of the programme (Hawe *et al.*, 1990). The planning framework described above favours a ‘theories of change’ approach to evaluating work, with an emphasis on developing the theoretical understanding of how work will lead to change, then the theory-driven selection of outcome indicators to demonstrate this. The HDA also runs national evaluations that require more sophisticated, ‘realistic’ approaches to understanding what works, where and for whom (Bowers *et al.*, 2003). Our understanding of combining such approaches with complexity theory is, like that of others (Barnes *et al.*, 2003), at an early stage.

Within this context it is useful to categorise areas of activity to help understand the types of impact they may have. If we consider the four stages of diffusion of innovations (Rogers, 1995); the distinct steps of the HDA’s evidence into practice approach via evidence briefings and effective action briefings; and the support to changing public health systems and practice as described by the five dimensions of capacity-building (NSW Health, 2001), it can be seen where and when different types of impact may be measurable (Table 1).

The HDA will assess impacts through a variety of processes. This assessment will include routine surveys of awareness and use of HDA products; regional collation of local impacts of uptake and application in local planning and service delivery; and formal evaluations of the impact of specific programmes on organisational and workforce development and partnerships. Currently the HDA uses some of these mechanisms, including routine impact surveys, National Healthy School Standard monitoring data and national evaluation, website use, the evaluation of the pre-retirement pilots (Bowers *et al.*, 2003), and evaluation of specific areas of work where resources permit. These have

included guidance on the impact of smoking cessation services on resource allocation and maintenance of services (HDA, 2004); organisational and workforce development impacts on leaders in public health nursing (Latchem *et al.*, 2003); and the impact of improvements to support services for teenage parents (HDA, 2002b). The theory-driven planning framework has resulted in impact data being collected routinely, and specific programmes will be identified for increased funding for external evaluation.

Undoubtedly this is an ambitious project. It seeks to close an important loop in thinking about evidence-based service innovation and development in public health. The mechanisms and structures described here provide an initial attempt to improve precision both in the scientific basis of

attempts to reduce health inequalities, and in the effectiveness of the methods used to support innovation and development. As the programmes of evidence, guidance and practice development continue to grow, the HDA will be better placed to pose questions to the evidence base, based on practice. Sharper focus is also needed on the interaction or crossover between the different types of activities and supporting theoretical frameworks inherent in creating the evidence base, in comparison to those associated with supporting change in practice. The HDA now needs to ensure that work in each of the phases of the evidence-into-practice cycle is coordinated in a systematic way, so that evidence continues to support practice and vice versa, to improve the delivery of public health.

References

- Barnes, M., Matka, E. and Sullivan, H. (2003). Evidence, understanding and complexity: evaluation in non-linear systems. *Evaluation* 9 (3): 265-84.
- Black, N. (1996). Why we need observational studies to evaluate the effectiveness of health care. *British Medical Journal* 312: 1215-8.
- Bowers, H., Secker, J., Llanes, M. and Webb, D. (2003). *The gap years: rediscovering mid-life as the route to healthy, active ageing*. London: Health Development Agency.
- Davies, J. K. and MacDonald, G. (eds) (1998). *Quality, evidence and effectiveness in health promotion*. London: Routledge.
- Department of Health (1999). *Saving lives: our healthier nation*. London: The Stationery Office.
- Department of Health (2000). *The NHS Plan*. London: The Stationery Office.
- Department of Health (2001a). *Tackling health inequalities: consultation for a plan for delivery*. London: The Stationery Office.
- Department of Health (2001b). *A research and development strategy for public health*. London: Department of Health.
- Department of Health (2003). *Tackling health inequalities: a programme for action*. London: Health Development Agency.
- Dixon-Woods, M., Agarwal, S., Young, B., Jones, D. and Sutton, A. (2004). *Integrative approaches to qualitative and quantitative evidence*. London: Health Development Agency.
- Egger, M., Davey Smith, G. and Altman, B. G. (2001). *Systematic reviews in health care: meta-analysis in context*. London: BMJ Books.
- Green, J. and Britten, N. (1998). Qualitative research and evidence based medicine. *British Medical Journal* 316: 1230-2.
- Green, L. and Kreuter, M. (1991). *Health promotion planning: an educational and environmental approach*. Palo Alto, CA, USA: Mayfield.
- Greenhalgh, T. (2001). *How to read a paper: the basics of evidence based medicine*. London: BMJ Books.
- Hawe, P., Degeling, D. and Hall, J. (1990). *Evaluating health promotion. A health worker's guide*. Sydney: MacLennan and Petty.
- Hawe, P., King, L., Noort, M., Jordens, C. and Lloyd, B. (2000). *Indicators to help with capacity building in health promotion*. Sydney: New South Wales Health Department.
- HDA (2001). *Coronary heart disease: guidance for implementing the preventive aspects of the National Service Frameworks* (2nd edn). London: Health Development Agency.
- HDA (2002a). *Cancer prevention: a resource to support local action in delivering the NHS Cancer Plan*. London: Health Development Agency.
- HDA (2002b). 'Promising practice'. Teenage Pregnancy Survey Report. London: Health Development Agency (unpublished).
- HDA (2004). Evaluation of the document 'Meeting Department of Health smoking cessation targets: recommendations for primary care trusts and practitioners. Report to the Health Development Agency (unpublished).
- Kelly, M. P., Swann, C., Morgan, A., Killoran, A., Naidoo, B. and Barnett-Paige, E. (2002). *Methodological problems in constructing the evidence base in public health*. London: Health Development Agency. www.hda-online.org.uk/evidence/key.html#meth
- Kelly, M. P., Chambers, J., Huntley, J. and Millward, L. (2003). *Method 1 for the production of effective action briefings and related materials*. London: Health development Agency. www.hda.nhs.uk/evidence/EIP_Protocol_july03.pdf

Latchem, S., Iskander, R., Meyrick, J. and Duggan, M. (2003). *Supporting PCT nurse leads in working with complexity: leading with emergence, innovation and adaptation*. www.hda.nhs.uk/documents/support_pct_nurse_leads.pdf

Meyrick, J. (ed.) (1997). *Reviews of effectiveness: their contribution to evidence based practice and purchasing in health promotion*. London: Health Education Authority.

MacIntyre, S., Chalmers, I., Horton, R. and Smith, R. (2001). Using evidence to inform health policy: case study. *British Medical Journal* 322: 222-5.

NHS Centre for Reviews and Dissemination (1999). Getting evidence into practice. *Effective Health Care* 5 (1).

NHS Centre for Reviews and Dissemination (2001). *Undertaking systematic reviews of research on effectiveness: CRD's guidance for those carrying out or commissioning reviews*. CRD Report No. 4 (2nd edn). London: NHS Centre for Reviews and Dissemination.

NHS Confederation (2001). Why won't the NHS do as it is told – and what we might do about it? *Leading Edge* 1 (October).

NSW Health (2001). *A framework for building capacity to improve health*. Sydney: New South Wales Health Department.

Nutbeam, D. (1998). Evaluating health promotion – progress, problems and solutions. *Health Promotion International* 13 (1): 27-44.

Oakley, A. (1998). Experimentation and social interventions: a forgotten but important history. *British Medical Journal* 317: 1239-42.

Ollerearnshaw, S. and King, E. (2000). *The effectiveness of different mechanisms for spreading best practice*. London: Cabinet Office.

Riddoch, C. et al. (1998). *Effectiveness of physical activity promotion schemes in primary care: a review*. Health Promotion Effectiveness Review No. 14. London: Health Education Authority.

Rogers, E. M. (1995). *Diffusion of innovation* (4th edn). New York: Free Press.

Sackett, D. L., Rosenberg, W. M. C. and Gray, J. A. M. (1996). Evidence based medicine, what it is and what it isn't. *British Medical Journal* 312: 71-2.

Scott, D. and Weston, R. (eds) (1998). *Evaluating health promotion*. Cheltenham: Stanley Thornes.

Speller, V. (1998). Quality assurance programmes: their development and contribution to improving effectiveness in health promotion. In: Scott, D. and Weston, R. (eds) *Evaluating health promotion*. Cheltenham: Stanley Thornes, pp. 75-91.

Speller, V., Learmonth, A. and Harrison, D. (1997). The search for evidence of effective health promotion. *British Medical Journal* 315: 361-3.

Stacey, R. D. (1999). *Strategic management and organisational dynamics: the challenge of complexity*. New York: Financial Times/Prentice Hall.

Swann, C., Falce, C., Morgan, A. and Kelly, M. (2002). *HDA evidence base: process and quality standards. Manual for evidence briefings*. London: Health Development Agency. <http://www.hda-online.org.uk/evidence/key.html#meth>

West, R., McNeill, A. and Raw, M. (2000). Smoking cessation guidelines for professionals: an update. *Thorax* 55: 987-99.

Copies of this publication are available to download from the HDA website (www.hda.nhs.uk).

Health Development Agency
Holborn Gate
330 High Holborn
London
WC1V 7BA

Email: communications@hda-online.org.uk

URL: www.hda.nhs.uk

© Health Development Agency 2004

ISBN 1-84279-267-9

About the Health Development Agency

The Health Development Agency (www.hda.nhs.uk) is the national authority and information resource on what works to improve people's health and reduce health inequalities in England. It gathers evidence and produces advice for policy makers, professionals and practitioners, working alongside them to get evidence into practice.