

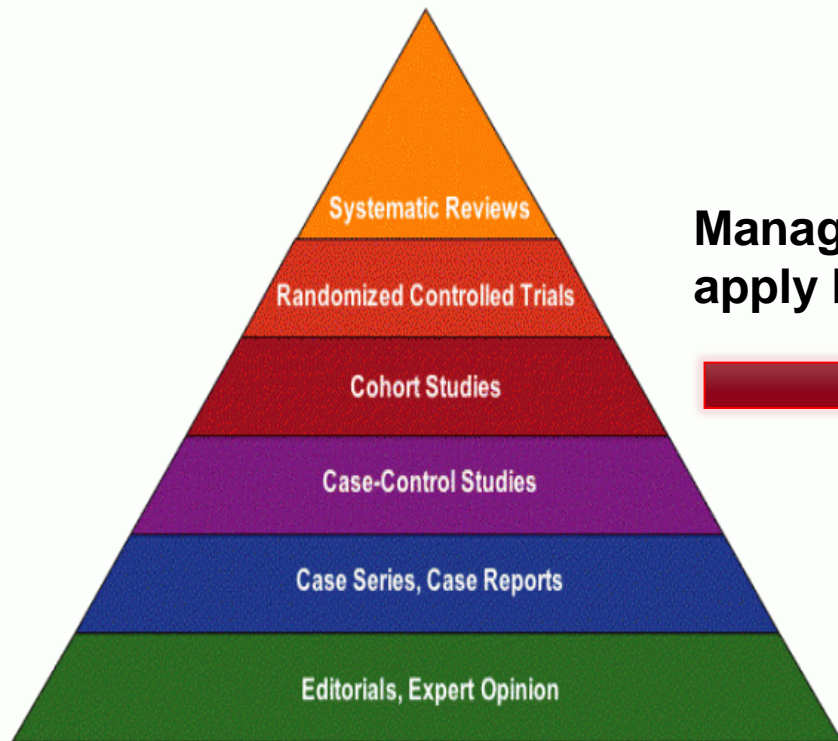
Mind the Gap: The Use of Evidence in Commissioning Decisions

Jacky Swan

Mind the Gap

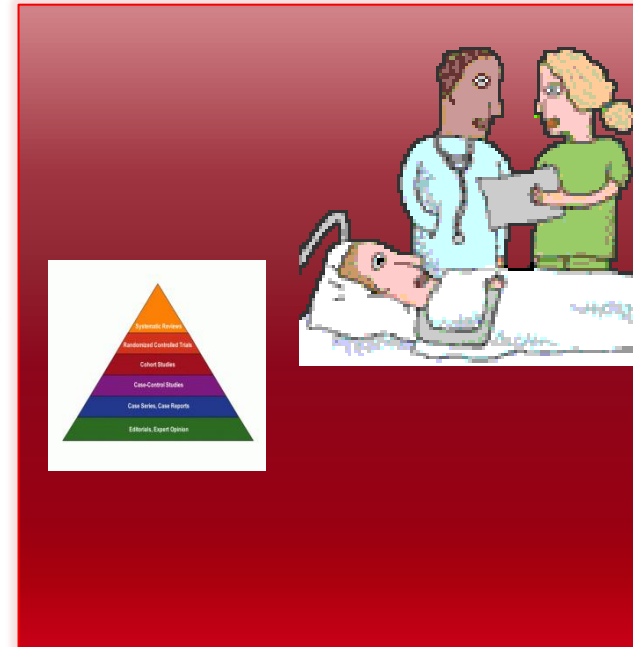
- ◎ The Research-Practice (T2) ‘gap’
- ◎ Unexplained variation in commissioning
- ◎ Rise of ‘Evidence-Based Management’
 - *...translating principles based on best evidence into organizational practices* (Rousseau, 2005)
- ◎ Expanded role of NICE & NHS Commissioning groups to create:
 - *“an objective culture, using evidence to inform the full range of its activities”* (Developing the NHS Commissioning Board, DH, 2011).

The Ideology: EBMgmt



RESEARCH

Managers source & apply best evidence



PRACTICE

Fixing the gap

- ⦿ Supply more/ better evidence & information
- ⦿ Train managers to acquire/use evidence
- ⦿ Set targets for uptake
- ⦿ Framed as a supply or knowledge transfer problem (push model)
 - i.e. there are right answers but they are not being used

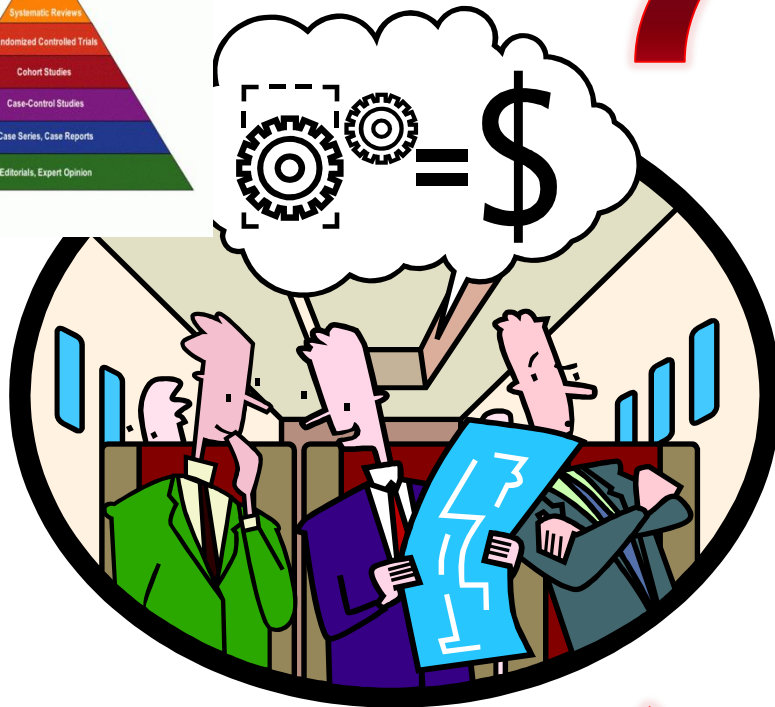
Critics say...

- ◎ It's just not that linear
 - Demand & knowledge translation - pull model (Crilly et al, 2010)
- ◎ Science alone is not the way to effective decision-making (Learmonth, 2008)
 - Management entails **judgement** that also takes account of values, beliefs and social/political interests (Morrell, 2008)
 - E.g. clinical/individual needs vs population needs; what is 'best' vs what is feasible... (Nicolini, 2011)
- ◎ Context matters: The politics of everyday life play a decisive role in **what** evidence is used, **when, how** and **why**

Our Research

- ◎ How are commissioning decisions *actually made* on the ground
 - Service redesign & individual funding requests
- ◎ What influences co-production & to what ends?
- ◎ What sources of knowledge are used *in practice*?
 - Need to make 'informed' commissioning decisions
 - *But how does 'informing' actually happen? Can it be improved and become more evidence-based?*

The Reality (Co-Production)



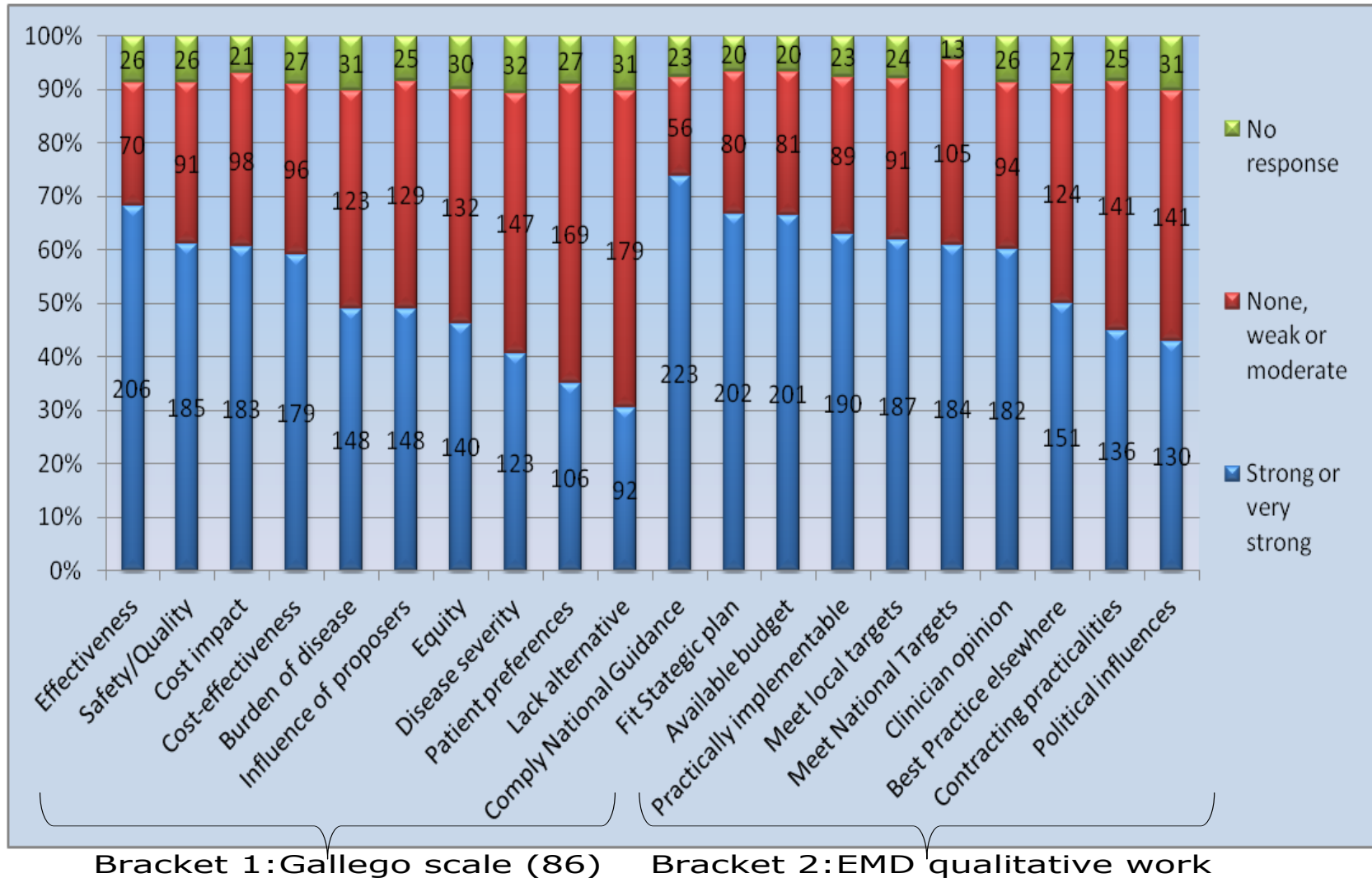
The Research Study

- ⦿ Multidisciplinary research team (WBS & WMS)
- ⦿ 24-month project (NIHR funded)
- ⦿ Phase 1: Observation of commissioning decisions in 4 organizations (79 meetings, 57 interviews, document analysis
 - Identify enablers of/barriers to evidence use in practice
- ⦿ Quantitative survey (345 responses across 11 organizations, 78% response rate)
 - Test findings/generalise results
- ⦿ Scientific & Stakeholder Advisory Panel

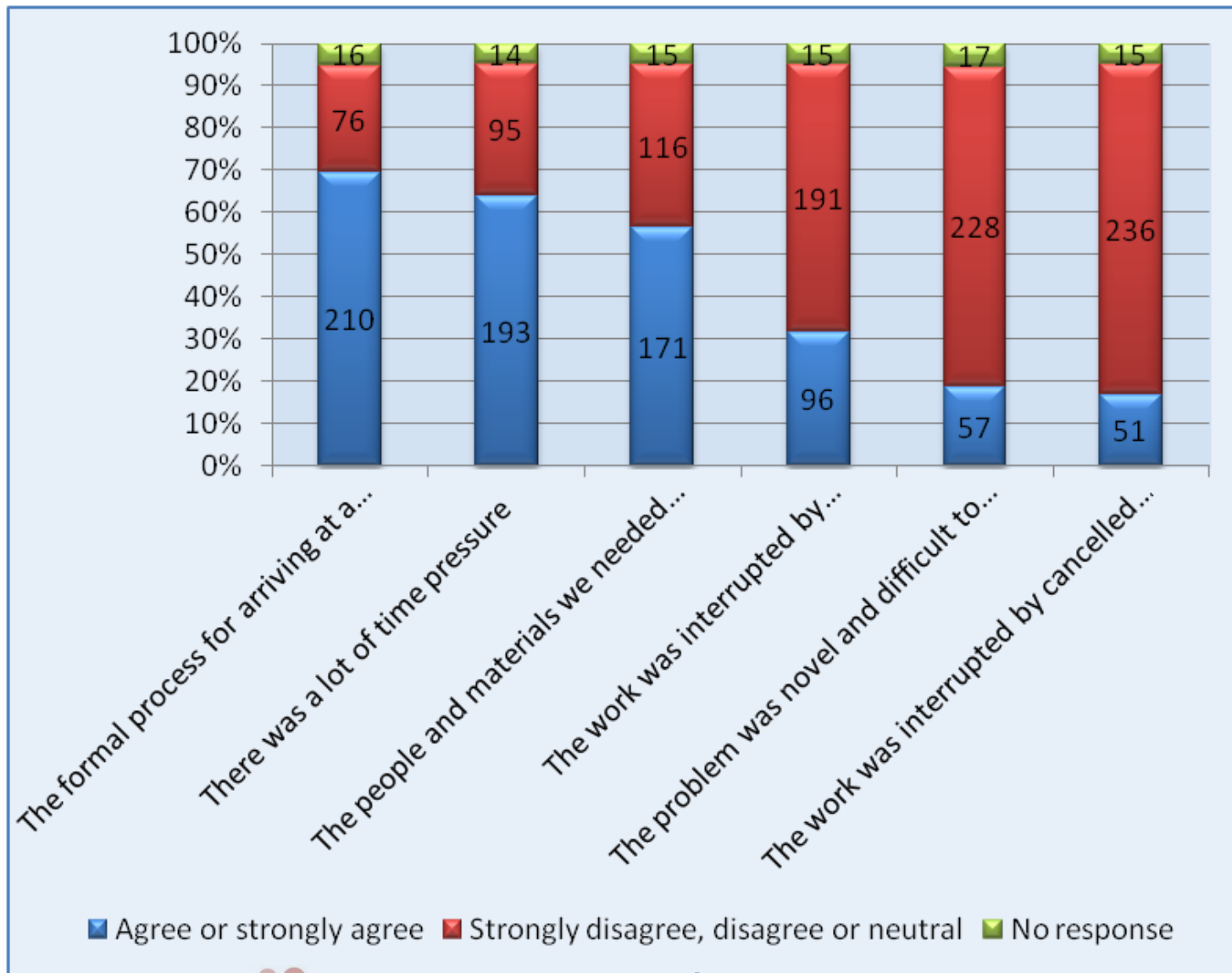
Commissioning

- ◎ *...the process of specifying, securing & monitoring services to meet individuals needs at a strategic level (Audit Commission)*
- ◎ One of the most significant management roles in the NHS
- ◎ New Landscape: 211 CCGs under NHS England (NHS Commissioning Board)
- ◎ Deliver on quality improvement + (unprecedented) efficiency/cost savings

Decisions are Messy - *Perceived importance of different factors in the decision making process*



And Pressured - *Participants views of the decision making process*



Case Example: Redesigning Diabetes Services

- ◎ Project: 'Whole System' approach to redesigning diabetes services – moving services 'closer to home'
- ◎ Motivation: improve performance in line with national benchmarks
- ◎ People: Diabetes project group (led by public health), with external (GPs, hospital consultants, practice-based commissioners, nurses, librarian, Local Involvement Network) & internal (contracting, finance) party involvement.
- ◎ Governance: Prof Exec Committee (focussed on general clinical model)
- ◎ Process: monthly meetings to review evidence (NICE guidelines, Map of Medicine pathways, models of care...) & develop tiered care plan in line with national guidance

Diabetes project chronology

Kick off
Dec 07

New project lead
Mar 08

Care planning
model adopted
Mar 08

PEC workshop
and initial approval
Apr 08

Interim Service
Specs

Diabetologist on board
May 08

Final Specifications
approved by PEC
Oct 08

Final Service
Specs

Procurement challenges
identified
Jan 09

Contracts Director
leaves
Jul 09

Additional legal
challenges emerged
& CEO involvement
Jun 09

Contracts and Finance
experts involved
Aug 09

Contract Advert for an
intermediate,
community-based service
Nov 09

Final service
specs

Contract Award
Jul 10

Developing model of care for the entire geographical area

Considering contracting options

Procurement Process

Activity/
Process

Events

Outcome

Diabetes Project: Challenges

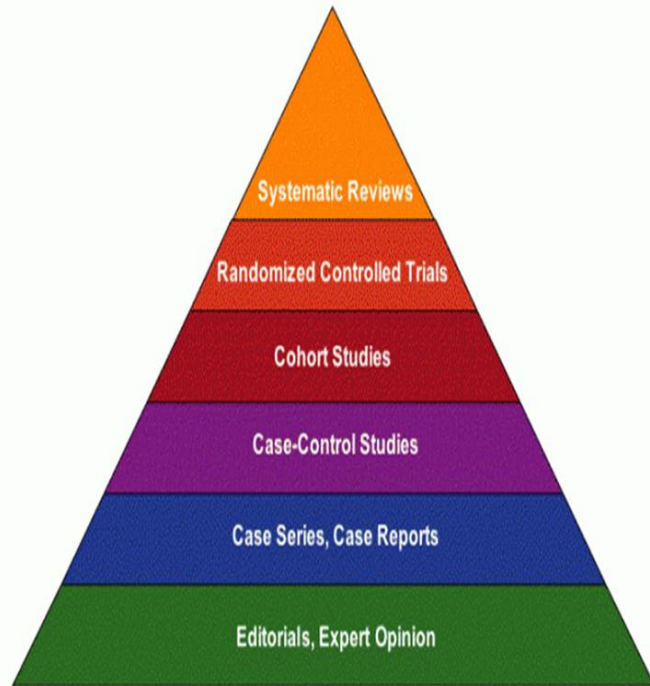
- ⦿ Lack of role clarity & ‘moving goalposts’ of national commissioning framework & budget
- ⦿ Severe problems with community nurse contracts (key to new service) in move from secondary care to primary care
- ⦿ Little support from contracting team in design phase
- ⦿ Difficult relationships with Practice-Based Consortium – PBCs seen as acting in own interests
- ⦿ Problems with legal compliance
- ⦿ Result: ‘descoped’ (cheaper) Local Enhanced Service but upskilling of primary care

Findings: What Evidence is Used?

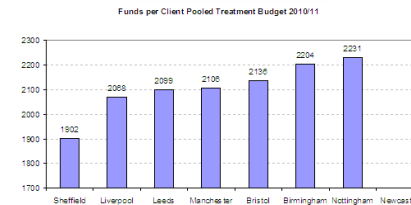
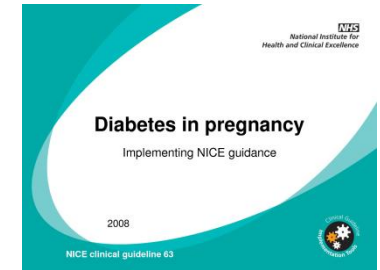
Hierarchy



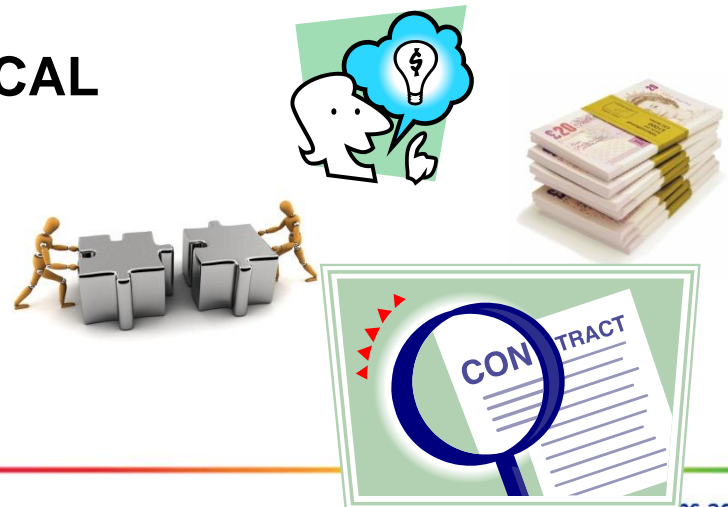
Heterarchy



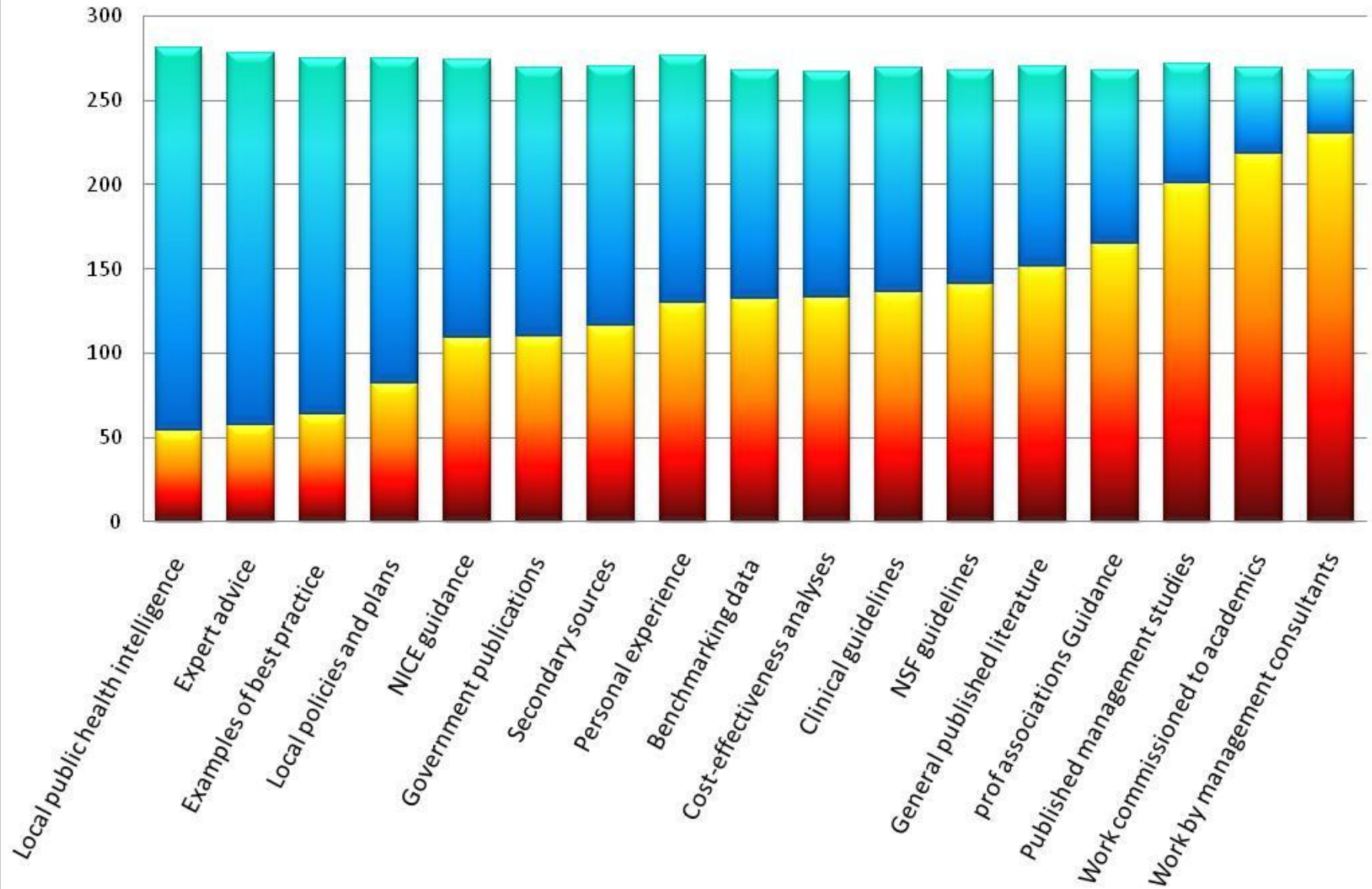
UNIVERSAL



LOCAL



Importance of different sources of evidence



Key Enablers/Constraints

- ◎ Evidence *use* depends on *what* but also *when*, *who* and *how*
 - Timing of information e.g. on contracting
 - Availability of experts to interpret/advocate evidence
 - Presentation of information in line with stakeholder experience/values
- ◎ Pro-active management of co-production
 - For reaching workable solution and having it accepted
 - Biggest predictor of satisfaction with decision outcomes

Co-Production Practices

⦿ Social e.g.

- Variety of knowledge/experience at right time
- Diverse interests/values acknowledged
- Conflicts practically managed
- Involvement incentivised

⦿ Technical e.g.

- Heterarchy of evidence available/ shared/ able to be used
- Clear terminology/ meaning of concepts explained

Key Enablers/Constraints (contd)

- ◎ Management of interdependencies crucial
 - E.g. between design & contracting phases; between local and national priorities; between established & new providers
- ◎ Entails
 - Clarification of roles/ responsibilities/ accountabilities
 - Clear governance arrangements, decision & project mgmt processes
 - Recognition of scope of redesign & local contingencies

*‘Management is a craft that can only be learned
through practice and experience’*

AND

*‘Healthcare managers should use evidence derived
from well-conducted research wherever possible’
...Pfeffer & Sutton, 2006*

- ◎ <http://www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1808-244>
- ◎ New Project: Improving the capabilities of NHS organisations to use evidence
 - Focussing on use of NICE (DO and DO NOT) guidelines by CCGs to improve capabilities
 - Contact jacky.swan@wbs.ac.uk;
emmanouil.gkeredakis@wbs.ac.uk

THANK YOU. QUESTIONS??

Mind the Gap: The Use of Evidence in Commissioning Decisions

Dr Jacky Swan, Professor in Organisational Behaviour, Warwick Business School, University of Warwick, and Director of the *Innovation Knowledge and Organisational Networks (IKON)* research centre

Thursday 13th June, 2013

These are summary notes to accompany the presentation made by Dr Jacky Swan as one of the knowledge exchange seminar series organised by the Fuse knowledge exchange group and is to be read in conjunction with the slide set.

Dr Swan explained the background to the main subject of her presentation which was a project entitled "Evidence in Management Decisions – advancing knowledge utilisation in healthcare management", funded by the SDO (Service Delivery & Organisation Network), based on a collaboration between Warwick Medical and Business Schools. The web-link for this project is: <http://www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1808-244>

The stimulus for the research was the 'research-practice' gap, and variations in spending on commissioning of up to a four-fold difference. The solution was conventionally held to be evidence based management, from the same intellectual stable of thinking as evidence based medicine. The meaning of evidence based management was explained in relation to the expanded role of NICE and NHS commissioning groups (slide 2). Slide 3 illustrates the hierarchy of evidence, from which the theory was that managers would source their needs from the hierarchy and apply to practice. Fixing the gap (slide 4) was seen to be to improve and supply more evidence, train managers, set targets for uptake on the basis that this was a supply problem – that the right answers exist but are not being used. In addition commissioning managers already received a lot of information, so overload was a real possibility.

Critics of this approach commented that the idea of a linear model of the supply of research into practice did not match with reality. Apart from supply, there was also a demand side to the model from practice itself, leading on to the concept of a pull model, ie; practitioners acting to draw out research evidence from academia to serve their needs. In addition other factors, such as judgement, values and context also played a part in the application of research to practice. In practice the reality is more 'messy', for example the difficulty of defining what commissioning actually is, and other factors, such as the influence of the way existing services are set up. The basis for the project Dr Swan described was around knowledge situated in practice and commissioning as a practical accomplishment. So, how are commissioning decisions actually made? What influences co-production? What forms of knowledge are used in practice? (The main parameters of the project are set out in slide 8).

As a general principle, within commissioning, a contrasting emphasis was found on contracting as opposed to service design/specification. Lots of factors were involved and it

was very time pressured, slides 10 and 11 illustrate these points and the relative weight of different factors. Dr Swan showed a case study relating to the re-design of a diabetes service. The main idea behind the re-design was to create a whole system approach, which entailed moving services into the community “closer to home” (see slide 12). From the outset the re-design was about a new pathway, based upon and similar to national guidelines. The task was led by a public health consultant with the aim of the re-designed pathway being signed off by the PEC (Professional Executive Committee of the Primary Care Trust). Many meetings were held and at an early stage dwelt on the research evidence from many sources (as listed on slide 12). Slide 13 illustrates the project chronology, which started to become problematic in the implementation phase, for example, it entailed specialist nurses moving from the hospital to the community and there was an issue about how to contract for this, generating a number of legal and financial issues. It took two and a half years to effect change, and the outcome was a locally enhanced service at Tier 2 level. Slide 14 lists some of the challenges to the project, including ‘moving goalposts’, the question of community nurse contracts (as described above), little support from the contracting team in the design, difficult relationships with the practice-based consortium (concerning the legitimacy of a new service model) and issues with legal compliance. The outcome was a ‘de-scoped’ Local Enhanced Service with upskilling of primary care.

Slide 15 takes a step back from the case study to consider what evidence is used in practice compared with the hierarchy of evidence introduced earlier in the presentation. This was divided between universal evidence used at the start of the process (for example from NICE or national benchmarking) and local evidence used much later on, including debates about cost, local feasibility, whether acknowledged experts were involved and what other PCTs were doing. It was proposed that the universal and local sources of evidence used in the case of the diabetes were not brought together early enough in the process as a whole. Slide 16 is a bar chart depicting the relative importance of different sources of evidence and it was noted that local public health intelligence, expert advice and examples of best practice were at the top of the scale, and at the bottom work commissioned to academics and management consultants. (Note to reader: in addition a considerable number of other factors are also shown on this slide between the two extremes).

Slides 17-19 list the key enablers and constraints. Evidence use depends very much on what it is, when it appears, who is involved and how. Timing is critical, for example, to the commissioning cycle, and the availability of experts to interpret evidence and be advocates for particular ways forward. Within the project one finding was that some meetings missed the relevant expertise and this influenced the outcome. In addition, the presentation of information needed to be in line with stakeholder experience and values, so, people with different backgrounds expected evidence in different forms. Pro-active management of co-production of research ensured the best of outcomes and the biggest predictor of satisfaction with the decisions reached. Within the conclusion, the main point stressed was to start from practice narratives and build from there by working in other sources of evidence. (Note to reader – key contact information for the project and Dr Swan and her main academic collaborator appears on the final slide no 21.)

Discussion

A number of questions were asked around the following topics:

- How to approach some key opinion formers, for example, local Councillors. In response Dr Swan suggested that it was mainly a question of pitching appropriately to the audience, and building alliances to generate a persuasive case. So, for example, work out ahead of time what the concerns of a group are – such as finance and cost/value.
- There was a general debate about the value of open-access journals in helping to make work more accessible, with the main conclusion that this would have some impact over time as it became more widespread. However, open access journals did not necessarily contribute to the REF within Universities and publishing in journals read by the management ‘trades’ could have more influence.
- In discussion it was noted that the landscape had changed with recent government led reforms, so that multiple commissioners were now in play. In consequence, it was necessary to think differently about research and commissioning as it has become more fragmented and there were more boundaries to consider.
- A question was put about co-production challenging Dr Swan about her model of co-production which concentrated on academics and clinicians. The point was put that a consequence of the government reforms was that the public had been encouraged to think that GPs hold the budget which raised a point about what evidence was convincing to the public. Dr Swan commented that the patients had been considered but not directly involved in her work.
- A question was put about the training of academics and whether this needed to change to accommodate client needs for research. Dr Swan commented that training would be useful, provided a sense of specialism was retained. There were other approaches such as employing more intermediaries and improving the relevance of research.

AR – FINAL as at 18th June 2013