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Evidence in Management Decisions (EMD) - Advancing Knowledge Utilization in Healthcare Management

Executive Summary

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Executive Summary

Background

The advent of the evidence-based healthcare movement has focused attention on how healthcare managers can exploit evidence in their decision-making more effectively. Policy makers, practitioners and academics alike, have all sought to understand and improve the translation and use of evidence in practice.

Improvements in the use of evidence have been seen as particularly relevant to commissioning in the English NHS because of the large financial commitments and more complex healthcare management decisions involved. The previous government made improvements in evidence uptake a top priority within a wider ambition to rationalise commissioning as a process of planning and prioritising resource allocation.

While the new coalition government has outlined plans to transform the fabric of NHS commissioning[1], this objective of developing more evidence-based decision making remains an important concern. It has been reaffirmed by recent statements from the NHS commissioning board, which outlined an intention to create, "an objective culture, using evidence to inform the full range of its activities"[2].

Despite the policy emphasis on embracing evidence-based principles and the debate surrounding their application, we still know very little about the ways in which evidence-based (EB) decision-making in commissioning is actually accomplished in the context of the NHS (1). What does evidence utilization actually entail for the process of commissioning? What are the circumstances that underpin or inhibit the uptake of evidence in practice? In the research described below, our main motivation has been to respond to these key and largely unexplored questions.

[1] 'Liberating the NHS' White paper, DH, July 2010
[2] 'Developing the NHS Commissioning Board', DH, July 2011.

Aims

Our study aimed to investigate the utilization of evidence in actual healthcare commissioning decisions. The objectives of our research were:

1. To provide greater understanding of evidence-based healthcare management by analysing the co-production of evidence in commissioning decision making.
2. To explain how and why available evidence-based products, aimed at managers, are synthesized and applied (or not) within the commissioning process.
3. To analyse the ways in which co-producing evidence for commissioning decisions is accomplished, and also identify: (i) patterns of inter-group collaboration, and; (ii) the micro-dynamics of evidence utilization, which characterise local decision-making and which may be framed by broader discourses and policies.
4. To develop a comparative theoretical framework, derived from multiple case contexts, and identify enablers for, and barriers to, using different sources of evidence to decisions being made in the process of commissioning.
5. To develop practical guidance for policy makers and managers on 'evidence-based commissioning' by engaging stakeholder groups in all stages of the research.

Methods

Our study was conducted between September 2009 and May 2011. Our theoretical approach was to view evidence as *co-produced* – i.e. produced *through* interacting practices of collaborating groups, rather than as existing prior to those practices. Our research was designed to build (rather than test) theory by drawing data from multiple methods and contexts. Our research methods (described in detail in chapter 3) were conducted in 2 Phases:

Phase 1: Detailed case studies focusing on commissioning practices in 4 NHS commissioning organisations (PCTs), which were chosen to capture variation in context. Case studies were built upon data collected from observing 79 real commissioning meetings, conducting 57 interviews with NHS commissioning staff, and reviewing local and national policy and other documents. These methods aimed at meeting objectives 1, 2, and 3, while we planned to use key preliminary findings to inform the design of the survey in Phase 2.

Phase 2: A nationally representative survey of individuals involved in commissioning was conducted in order to investigate the following: factors with a potential influence on commissioning decision making; potential sources of evidence and information; and the formal decision making tools available to those working in health care commissioning in England. The survey targeted 444 individuals across 11 PCTs and yielded a response rate of 78% (n=345). Findings here focused on Objective 2.

To meet Objective 4, the findings from Phase 1 and Phase 2 were synthesised, together with feedback from our engagement activities. Practical guidance and implications, as per Objective 5, were developed after having held a national workshop in July 2011.

Results

Through our comparative research study, we have shed new light on evidence-based commissioning as an empirical phenomenon. The key findings can be summarised as follows:

A. ***The evidence used in commissioning decision making, especially on service redesign is co-produced from a wide variety of sources***.

The evidence which commissioning groups found most relevant or influential was not necessarily the more scientific or objectively defined types of 'evidence', but was often more to do with commissioning know how and local knowledge. Our survey respondents identified "examples of best practice from other organisations", closely followed by "local public health intelligence", as the sources of evidence with the strongest influence on commissioning decisions. These were also those identified as lacking.

Here we can distinguish between 'universal' and 'local' types of evidence. The former included: standardised information produced nationally (e.g. secondary, primary care, benchmarking data), public health data, clinical practice standards (e.g. NICE guidelines), and models of care. Local evidence entailed: local knowledge and competences, local public health intelligence, user needs/attitudes/lifestyles, activity/finance information, feedback from knowledgeable colleagues, examples of best practice, contracting models, and monitoring indicators.

B. ***Evidence does not speak for itself, but needs to be mobilized at the right time, and through the right people, to make a difference in decision-making.***

We found that the effective mobilisation of different kinds of evidence was task-, time-, and expertise-dependent. Thus, the demand for diverse sources of evidence differed across redesign initiatives, and reflected different task and problem-solving requirements. Also the timing of evidence utilization was particularly important. In many cases, evidence on contracting models, activity and costing information was brought forward too late. Commissioners recognized that it could and should have been used while a new service was still on the drawing board. Finally, bringing key evidence to the table without involving the relevant experts was often problematic; e.g. using benchmarking data without the input from an information analyst. Our survey results also indicated that commissioners tended to use evidence in different ways depending on their own expertise. For example, "universal" empirical evidence was more likely to be used by those with Public Health training.

C. When evidence was used in commissioning decisions, it always involved collaboration and co-production amongst the different groups involved. The effectiveness of co-production is highly influenced by the way decision-making is organized.

The process of assembling, synthesising and understanding evidence drew on diverse sources of expertise distributed among multiple stakeholders. Co-production was critical not only for developing a technically sound solution, but also for ensuring that this solution was widely accepted. Our survey indicated that practitioners' satisfaction with commissioning decisions was strongly linked to the extent of co-production.

The findings from our qualitative study suggest that key factors affecting the effectiveness of co-production included: (i) recognition and pro-active management of divergent interests (e.g. between commissioners and potential/existing providers), (ii) overcoming the constraints imposed by collaboration with different groups due to the commissioning problem at hand (e.g. large-scale service redesign or routine decision making). In addition, our survey findings identified a number of other *process factors* that contributed to effective co-production; e.g. the availability of information and people at meetings were important and positive factors; a formal and well understood decision-making process was an important condition for effective co-production, while cancelled or poorly attended meetings were a negative factor.

D. ***Decision-making for commissioning does not take place within a vacuum. It is highly interdependent with a shifting array of management and policy arrangements.***

We found that important interdependencies for such decision-making related to features such as clarity of role expectations, governance arrangements, project management, expertise integration, and relationship management. One important dimension of such interdependence was temporal – e.g. the sequencing of activities between the design and contracting stages of commissioning. Another important dimension was found to be the interface between decision-making and the wider policy environment as reflected in the tensions between individual decisions and commissioning policy development, and the alignment between organisational and national priorities. It is notable that our survey respondents regarded budget availability, compliance with national guidelines, and fit with strategic plan as the most important drivers for commissioning.

The interdependencies found in our study help explain the advantages of a more collaborative approach in which the co-production of evidence, across groups, and over time, is central. For example, we found that the highly interdependent activities of service redesign and contracting were frequently not understood as such by decision makers, and consequently were treated as discrete sets of decisions. This meant that relevant contracting evidence was often not utilized in time and decision making faced roadblocks and long delays. Our findings thus suggest that the way evidence is mobilised and used may well depend on forms of collaboration that enable key interdependencies to be identified and managed.

Conclusions

Details of proposed NHS reforms are still emerging at the time of this report, but on present information, while PCTs will be abolished by April 2013, the commissioning of services will not. Indeed, one of the drivers for these reforms was seen as the improvement of commissioning, through a more clinical focus, better responsiveness to the needs of patients, and enhanced capacity to drive quality and innovation. In light of these developments, our research findings become particularly relevant in a number of ways.

Firstly, our research results have implications in relation to the current debate on defining required roles and capabilities for commissioning support

services in the reformed NHS. For example, support for evidence-based commissioning may need to account for the multiple sources of evidence demanded in commissioning decision contexts and not just on the supply of information. This includes reviewing the provision of forms of evidence, such as examples of best practice, which are currently ranked as 'low quality' but which are highly valued by commissioning groups. Importantly, development of commissioning support needs to take into consideration the skills/expertise needed to mobilise and utilize evidence effectively. The skills and expertise of information specialists and Public Health experts are particularly important in this regard.

Secondly, in developing their capabilities, future commissioners may need to place significant emphasis on the implications of different models of co-production. Our research findings identify a number of important factors that may need to be taken into account when large-scale service redesign initiatives are undertaken. These include the recognition and pro-active management of divergent interests, and understanding the benefits of formal decision making processes that better support the co-production and collaboration needed to manage interdependent commissioning activities centred on design, procurement and contracting.

Finally, future research should be undertaken to understand the approach of clinical commissioning consortia to the use and uptake of evidence in the newly reorganised NHS. This would include a focus on the relationships between co-production, decision satisfaction and improvements in health outcomes.