HS&DR - 12/5002/20: Improving the Capabilities of NHS Organisations to Use Evidence: A Qualitative Study of Redesign Projects in Clinical Commissioning Groups

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The research reported in this 'first look' scientific summary was funded by the HS&DR programme or one of its predecessor programmes (NIHR Service Delivery and Organisation programme, or Health Services Research programme) as project number 12/5002/20. For more information visit https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/12500220/#

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This 'first look' scientific summary presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health.

Scientific Summary

Background

Innovation driven by authoritative evidence is a current and future priority for the National Health Service (NHS). Much of the responsibility for innovation rests with NHS Clinical Commissioning Groups (CCGs), who are tasked with designing services to meet local health needs. Evidence-based products and recommendations are increasingly supplied to assist CCGs in making effective, evidence-based decisions. Yet, uptake of evidence in healthcare contexts is problematic and patchy. A major challenge then for NHS commissioners is to proactively and strategically consider how their organisations can be better equipped to take hold of, and use, evidence in service design and delivery decisions. Alongside evidence users, the supply of authoritative evidence does not always connect closely to demand. Therefore, another consideration is to better match evidence production to the realities of use.

Objectives

Of relevance to these challenges are findings from a rich stream of research on evidence 'pull' (demand) and 'push' (supply) in healthcare settings. In terms of 'pull', the theoretical approach of knowledge mobilisation is particularly relevant. This situates evidence use as a locally situated, social and political process. It shows, for example, that healthcare workers often rely on evidence from a variety of sources, including their peers, in a form that is compatible with their daily activity. For these reasons, equipping NHS organisations for evidence use may begin with identifying what evidence is used and when in decision-making processes; i.e. the 'evidence journey'. This will be the first objective of our project.

In addition to understanding what evidence is used, work is also needed to identify and articulate how NHS organisations can develop and improve their capabilities to use evidence effectively. Some previous research has shown that evidence use may be improved by

certain enabling practices and conditions in the decision-making context. One practice that has an obvious importance in CCG work is to proactively manage relationships among stakeholders to create coalitions. There is, however, a dearth of research on the topic of capabilities for evidence use in healthcare management and so we seek to identify and clearly articulate the practices and organisational conditions that support commissioners in using evidence in their work. This will be the second objective of our project.
Our secondary interest relates to evidence 'push'. Here we gain insights into how evidence producers envision end users, and how this relates to the realities of commissioning work. Research on 'inscribed meanings' provides important insights here. This work encourages us to consider how evidence producers anticipate their research will be used in practice. Understanding the meanings inscribed in evidence products provides further insights into discrepancies between producer expectations and user reality. This will be the third objective of our project.

Method

Building on previous research, we adopt a comparative research strategy to investigate how commissioning organisations use evidence, especially NICE evidence given its importance to health and social care reforms. Based on 8 case studies of CCGs involved in redesigning services, we describe what evidence is used and identify capabilities for evidence use. We compare across the cases to explain how more successful evidence journeys differ from relatively less successful ones. Specifically, we understand evidence use, objectives, and stakeholder experiences in light of capabilities in the CCG for evidence use. We also conducted a small number of interviews and observations with evidence producers in order to better understand evidence 'push'.

Results

Our analysis suggests, first, that, in addition to NICE evidence, CCG stakeholders use a mix of different kinds of evidence to inform decision-making in their redesign work. Applying both inductive and deductive coding, we categorise these evidences as: 'universal', 'local', 'expertise-based', and 'trans-local'. The first two categories (universal and local) were used

in all CCG projects, with stakeholders attempting to understand how authoritative guidelines and standards could be implemented in the local context. Expertise-based evidence was most often used to understand and identify solutions. The latter evidence (trans-local) involved taking and applying local evidence originating from another place in the current context. Trans-local evidence was used to identify new ways of providing services and usually accessed through informal channels.

The four categories of evidence identified in our study were never used in isolation; instead stakeholders mobilised multiple categories together to inform sense-making across the redesign process. Importantly, and as anticipated, using these evidences was far from straightforward. Personal, social, and political challenges were just some of the barriers stakeholders faced in efforts to conduct evidence-based redesign work.

While there were certainly challenges, there were also clear enablers of evidence use. From our cases, we identified five capabilities that showed to enable and enhance evidence-based decision-making in commissioning organisations. These included: ‘sourcing and evaluating evidence’, ‘engaging experts’, ‘effective framing’, ‘managing roles and expectations’, and ‘managing expert collaboration’. Although the first capability refers to actively gathering, evaluating, and applying relevant evidences, capabilities were largely social, rather than technical, in nature. That is, evidence use was visibly enhanced when CCGs worked to engage stakeholders in contributing and legitimating evidence, often through effective framing, and managing individual’s role expectations and group collaborations.

Comparing across cases provided important insights into relationships between evidence use, capabilities for evidence use, and project outcomes. We considered redesign project outcomes in terms of evidence use (i.e. overcoming challenges), stakeholder experiences (i.e. how satisfied or dissatisfied redesign actors were), and objectives (i.e. whether project objectives were met). We found that CCGs with the fewest capabilities for evidence use also reported the most challenges in their redesign attempts. The frequency of capabilities was not directly proportional to outcomes; that is, more capabilities did not necessarily mean equivalently better outcomes. Instead, applying relevant capabilities as necessary in context seemed to be more beneficial to evidence-based redesign work. We suggest that

commissioning groups should be supported to develop capabilities and understand when and how to apply them.

Importantly, we are keen to ensure that findings become actionable in the real world and so we have developed a toolkit to enable stakeholders to assess their capabilities to use different types of evidence and identify opportunities for improvement. The toolkit documents routes to effective evidence use, accounting for organisational dynamics and complexities. It contains questions intended to help leaders of commissioning organisations and redesign teams to reflect on how well they use evidence and to identify opportunities for improvement. An ESRC Impact Acceleration Grant supported toolkit development (July – December 2016). A secondary set of findings relates to an exploratory study of 'push' by evidence producers (the start of the evidence journey). Specifically, we consider how producers *think* their evidence should, and will, be used by commissioning organizations and how this meaning is inscribed in their work and artefacts (e.g. published guidance). We identify 3 main "discourses of evidence users": "discourse of production", "discourse of audience feedback", and "discourse of implementation consultancy and marketing". The former discourse is more traditional, assuming that the quality of published evidence itself assures its route into practice. The latter two discourses reflect alternative knowledge mobilisation views that see evidence production and use as a socially dynamic process. The co-existence of these three discourses among producers indicate an evolving landscape for the production of evidence, one that may be more aligned with user needs and practices in future years.

Conclusions

In sum, we show that commissioning groups making redesign choices use multiple evidences. Evidence use is often informed by applicability and accessibility rather than by mode of production. Evidence use is a dynamic, sense-making process dependent on the task at hand. It is not completely random or fortuitous however. Instead, certain organisational conditions and practices enable effective evidence mobilisation. These capabilities entail effectively managing social and political issues that arise in redesign work where multiple forms of expertise are needed. We also show, albeit preliminary, a

relationship between evidence use capabilities and project outcomes. We also shed light on the way that the production of evidence-based products might reflect and shape their use.

Our findings provide a tool aimed at supporting commissioning groups to improve evidence use capabilities by understanding the political and social nature of evidence-based redesign work is fundamental. More broadly, identifying, developing, and applying capabilities relevant to each context may be a means of ensuring more effective, evidence-based redesign work in NHS organisations. In identifying these implications, we make a small, but important contribution to evidence-based innovation in England's National Health Service (NHS).

Funding Details

This research was funded under the National Institute for Health Research (NIHR) Health Services and Delivery Research Programme (HS&DR 12/5002/20).