Title: NIHR HS&DR 12/5002/01 Improving the Capacity of Commissioners to Use Evidence: Reducing Potentially Avoidable Elderly Care Admissions into Acute Hospitals

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Important

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SCIENTIFIC SUMMARY:

We need to move 'from what we know to what we do' in the commissioning of health service intervention. Commissioning of health service intervention should be underpinned by evidence, not just about most effective clinical practice, but encompassing pluralist evidence; i.e. more than formal research evidence, but also evidence about patient experience, cost efficiency, and tacit knowledge held by clinical and managerial practitioners. Healthcare commissioners should not just merely acquire pluralist evidence, but use it to inform decision making about service interventions. Further, commissioners then need to enact a feedback loop to judge the success of the local service intervention, and so decide whether to scale it up. Our study, however, reveals that commissioners have insufficient critical review capacity to use evidence to inform decisions.

To inform our more general concerns, our empirical study focuses upon service interventions designed to reduce potentially avoidable elderly care admissions into acute hospitals. Our empirical analysis derives from 13 comparative cases of representative (region, size, urban/rural) commissioning networks in England, to acquire and use different types of evidence to inform their decisions about service interventions. We draw upon interviews with commissioning managers, GPs, PPI representatives, and other relevant stakeholders. Our concern lies not with whether the interventions work, but how the commissioners made the decision and what evidence underpinned the decision. In essence, we interrogated the critical review capacity of the CCG led commissioning network to acquire and use pluralist evidence.

Theoretically, we apply a concept from organisation science, that of absorptive capacity (ACAP). ACAP is synonymous with the term, 'critical review capacity'. Absorptive capacity has

four dimensions: acquisition of knowledge; assimilation of knowledge (combining new knowledge with pre-existing knowledge); transformation of knowledge (applying new knowledge to develop a service intervention); exploitation (evaluation of the service intervention towards potential scale up if judged successful). Our study reveals CCG led commissioning networks acquired pluralist evidence relatively effectively, but shows the way this informed decision making was weaker, particularly when considering any decision to scale up promising local innovation. We also highlight certain types of evidence that were of marginal concern for commissioners, specifically as to how patient experience informed service development.

In analysing why this was so, and as a springboard for offering research informed suggestions for enhancing the ACAP of CCG led commissioning networks, we applied the notion of combinative capabilities. Combinative capabilities are an important antecedent to realising ACAP. There are three combinative capabilities: (1) systems, (2) socialisation, and (3) co-ordination capabilities. Systems capabilities refer to formal knowledge exchange mechanisms, such as written policies, procedures and manuals designed to facilitate transfer of codified knowledge, but also to environmental incentives that shape priorities. Socialisation capabilities refer to cultural mechanisms that promote shared ideology and collective interpretations of reality within organisations. Coordination capabilities refer to lateral forms of communication such as education and training, job rotation, cross-functional interfaces and distinct liaison roles. Different combinations of combinative capabilities have different impacts on absorptive capacity. The interaction of systems and socialisation capabilities stymie absorptive capacity, whilst coordination capabilities mediate their effects, and so enhance ACAP. It is clearly important to understand how capabilities combine, particularly the positive effect of coordination capabilities upon ACAP.

Our study reveals coordination capabilities are offered, first, by including GPs and PPI Representatives when commissioners make decisions. The extent of such inclusion varies across our cases. Some GPs become embedded in their commissioning roles to the detriment of drawing in local knowledge about patient needs from their practice based peers. Meanwhile, CCG led commissioning networks may not use PPI Representatives effectively, and so patient experience evidence might be acquired but is less likely to be used to inform service development.

Second, external organisations, specifically Commissioning Support Units (CSUs) offer coordination capability to provide data about population needs and existing services. However, the relationship of CCG led commissioning networks with CSUs is a transactional one, with data insufficiently contextualised to meet needs of commissioners. This, our study suggests, is not due to weaknesses of the CSU, but more because each side lacks understanding of the other's expertise and needs that might derive from more relational interactions. In this respect, one of our empirical cases is of interest, since this case relied less on their local CSU, having developed a more sophisticated 'in house' business intelligence unit that meant data was provided in a more contextualised and timely manner.

For older persons' care, third, voluntary sector organisations can provide local knowledge about individual patients and their needs across different providers, and so enhance capacity of commissioners to use a wide range of evidence.

Finally, our study highlights the importance of 'social integration mechanisms', specifically to support collaboration between health and social care organisations to support older people so

that they don't experience potentially avoidable admissions to acute hospitals. Our study thus shows a need for health and social care organisations to develop joint plans and strategies, where their data and perspectives are combined, with subsequent more effective use of evidence to inform decision making around service intervention.

Developing our study further, we offer a psychometric tool for CCG led commissioning networks to use to assess their ACAP, which can be benchmarked against other CCGs. The intention is not that it is used to 'measure' performance, but that it is used as an organisation development tool. We also offer research informed suggestions for policy makers, specifically around how they might ameliorate the deleterious effect of systems capability upon ACAP of CCG led commission networks. We encourage policymakers to reflect upon the implementation gap around patient and public involvement in commissioning, and potential decoupling of practice-based GPs from commissioning.