

The capacity of health service commissioners to use evidence: a case study

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

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Scientific summary

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Scientific summary

We need to move from 'what we know' to 'what we do' in the commissioning of health service interventions. The commissioning of health service interventions should be underpinned by evidence that is not just about the most effective clinical practice, but that also encompasses pluralist evidence; that is, more than formal research evidence, but also evidence about patient experience, cost efficiency and tacit knowledge held by clinical and managerial practitioners. Health-care commissioners should not just acquire pluralist evidence, but use it to inform decision-making about service interventions. Furthermore, commissioners then need to enact a feedback loop to judge the success of the local service intervention, and so decide whether or not 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 on 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 on interviews with commissioning managers, general practitioners (GPs), patient and public involvement (PPI) representatives and other relevant stakeholders. Our concern lies not with whether or not the interventions work, but with how the commissioners make the decision and what evidence underpins the decision. In essence, we interrogated the critical review capacity of the Clinical Commissioning Group (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'. ACAP has four dimensions: (1) acquisition of knowledge, (2) assimilation of knowledge (combining new knowledge with pre-existing knowledge), (3) transformation of knowledge (applying new knowledge to develop a service intervention) and (4) exploitation (evaluation of the service intervention towards potential scale-up if judged successful). Our study reveals that CCG-led commissioning networks acquired pluralist evidence relatively effectively, but it also shows the way in which 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 CCGs do not effectively use pluralist sources of evidence, 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. Co-ordination 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 ACAP. The interaction of systems and socialisation capabilities stymies ACAP, whereas co-ordination capabilities mediate their effects and thus enhance ACAP. It is clearly important to understand how capabilities combine and, in particular, the positive effect of co-ordination capabilities on ACAP.

Our study reveals that co-ordination 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 co-ordination 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 the needs of commissioners. This, our study suggests, is not a result of 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, as this case relied less on its local CSU, having developed a more sophisticated 'in-house' business intelligence unit that meant that data were provided in a more contextualised and timely manner.

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

Finally, our study highlights the importance of 'social integration mechanisms', specifically to facilitate collaboration between health and social care organisations to support older people so that they do not 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 in which their data and perspectives are subsequently combined with 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. Our study suggests a need to ameliorate the deleterious effect of systems capability on ACAP of CCG-led commission networks. We encourage reflection on the implementation gap around PPI in commissioning, and the potential decoupling of practice-based GPs from commissioning.

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