Evidence-based policy-making and the ‘art’ of commissioning

What researchers need to know to make a difference

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PenCLARHC 21 Sept 2015

In collaboration with

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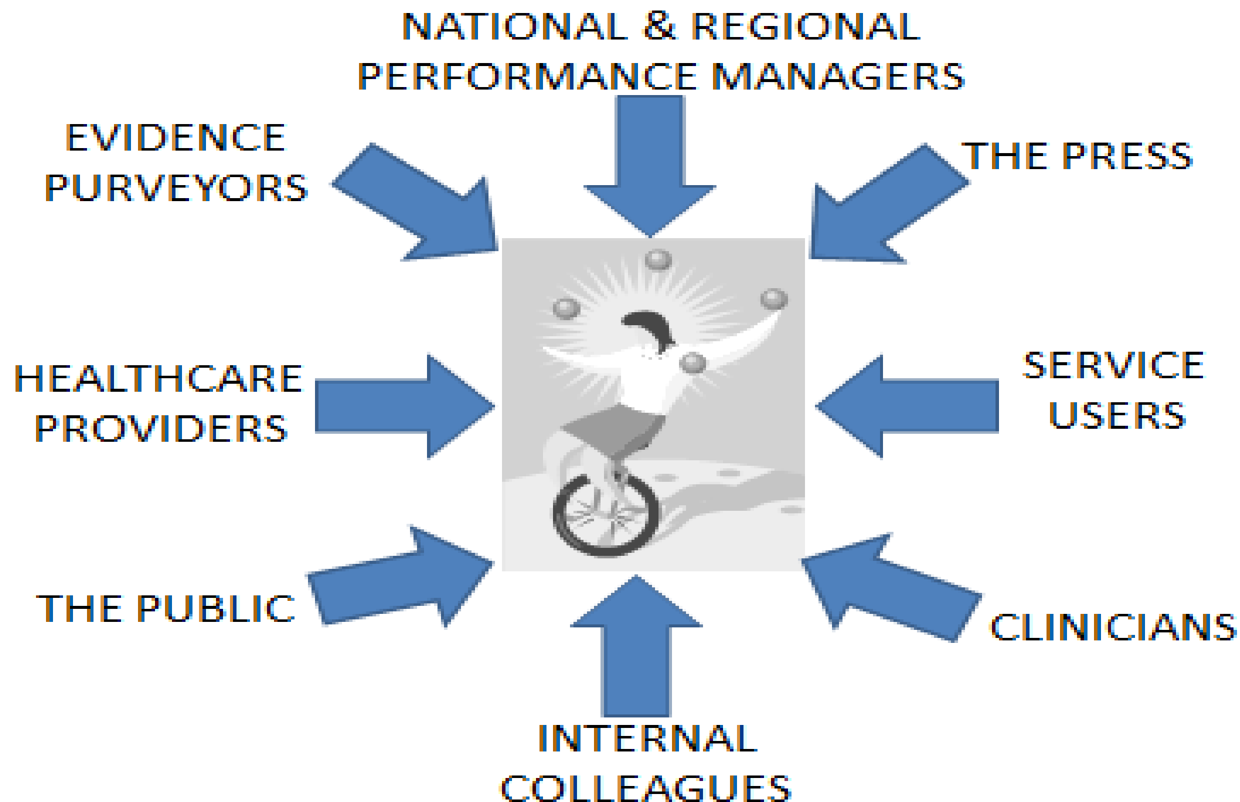
What's the problem?

- Commissioners from Clinical Commissioning Groups (CCGs) plan services with an annual budget of about £95 billion
- Academic research not informing local commissioning decisions much
- Researchers need to know more about commissioning and how commissioners access and use information to better influence them

The study (2010-2014)

- Funded by NIHR HS&DR
- Aim: to understand how commissioners access and use information including research evidence
- Methods: 8 case studies of contracts between commissioners and external providers
  - 4 CCGs + 3 external providers (2 commercial 1 NFP)
  - 92 interviews of commissioners, analysts, external consultants, public health
  - 24 observations of commissioning meetings & training events
  - Hundreds of documents (e.g. board papers, minutes)
  - Thematic coding, summaries, constant comparison

The ‘art’ of commissioning



What is evidence-based commissioning?

- Researchers define evidence as research while commissioners have a much broader definition of ‘evidence’
- Influence and collaborate with external and internal interested parties to build a cohesive, **compelling** case for taking a particular course of action
- Commissioners highly pragmatic – if info not helpful they will not use it

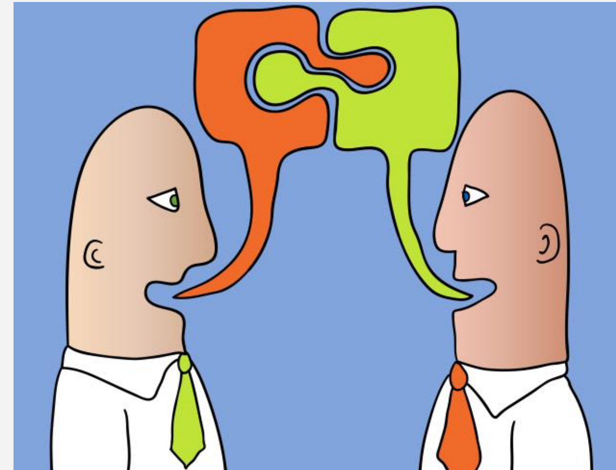
Sources of information

- Who?
  - Local clinicians, commissioning managers, analysts, patients & the public, freelance consultants
- What organisations?
  - Department of Health, NICE, NHS Improving Quality, Public Health (England & local), CSU, Think tanks e.g. King's Fund, Royal Colleges, local healthcare providers, other CCGs/CSUs/ providers, commercial & not-for-profits

Sources of information (2)

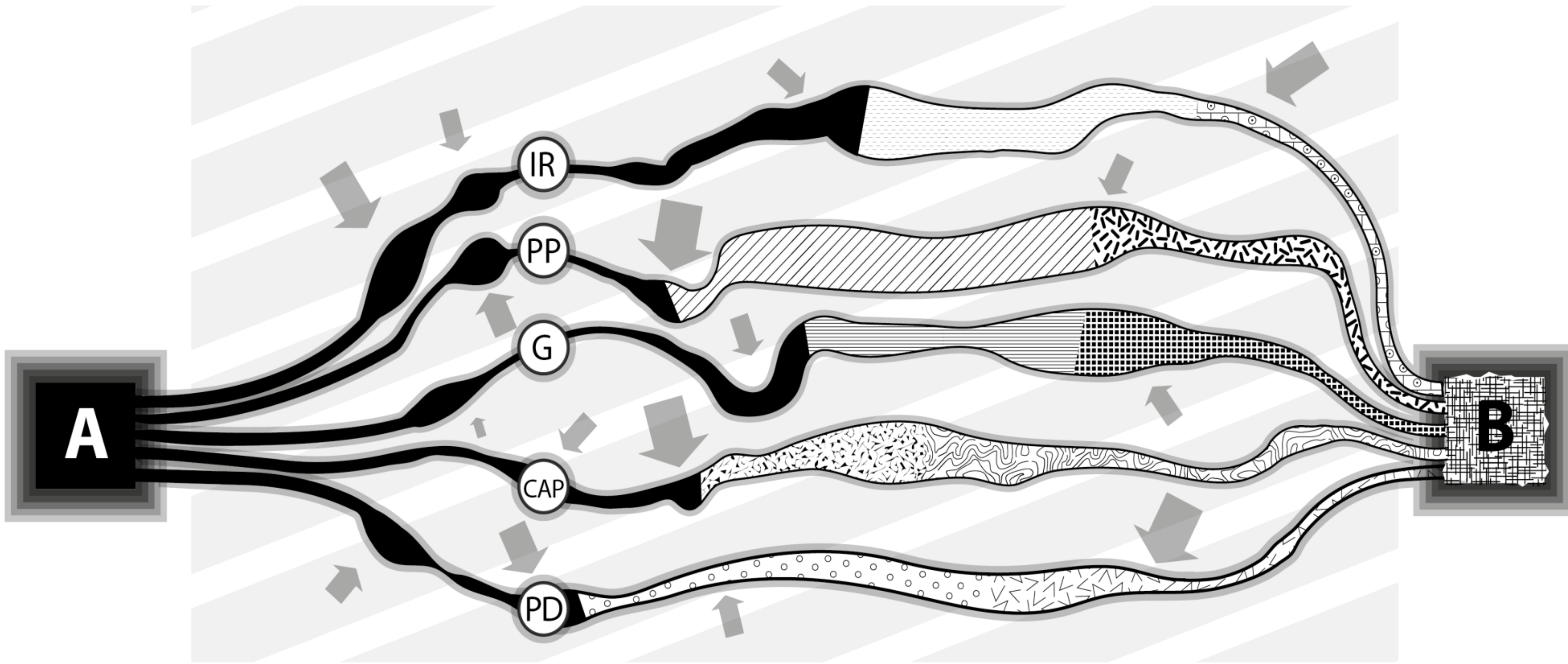
- What info sought/ received?
  - Best practice guidance, Department of Health commissioning guidance, service & population data, improvement tools, 'horizon scanning', clinical guidelines, how services operate, 'whole picture view', hospital/ primary/ community data, condition specific expertise, contracting, procurement, finance, budgets, benchmarking

Commissioners tend to seek information from trusted colleagues via conversations



Interpersonal relationships were the most crucial in influencing commissioning decisions

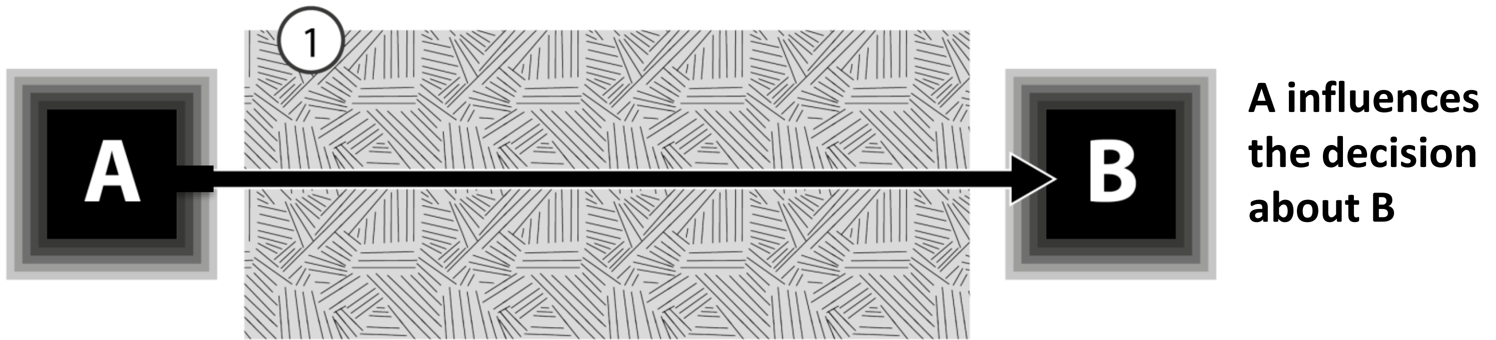
Conduits of information



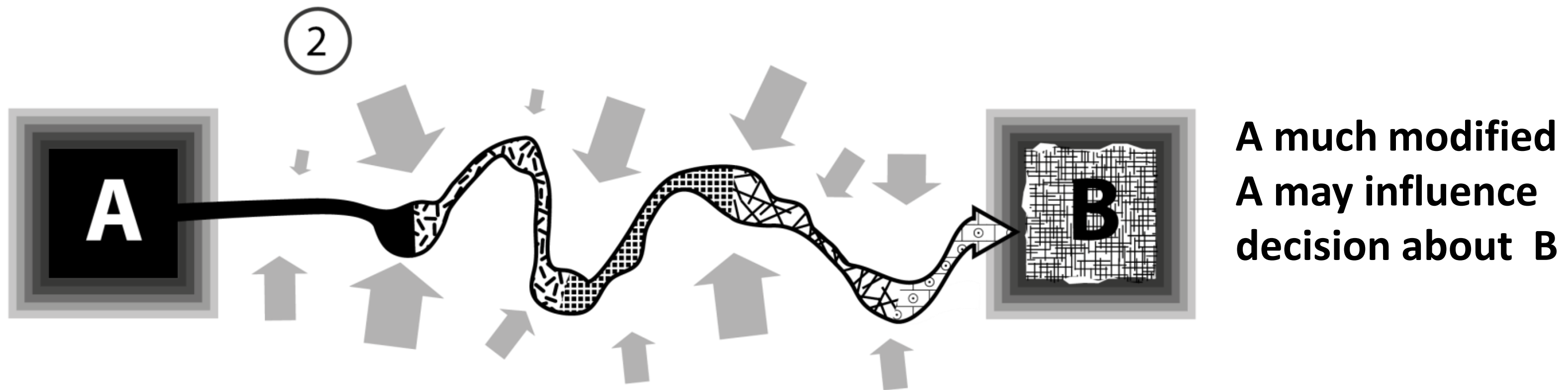
Conduits: IR = Interpersonal Relationships; PP = People Placement; G = Governance; CAP = Copy, Adapt and Paste; PD = Product Deployment

= Engagement & Contextualisation

= Organisational Pressures and Tensions


1
A
B
A influences
the decision
about B

= Organisational
Processes


2
A
B
A much modified
A may influence
decision about B

=
Pressures, tensions, demands &
implications to be negotiated
before A influences the decision
about B

Role of academic research

- Commissioners predisposed to using research but found it difficult to access, understand & apply
- Commissioners rely on public health departments to supply & interpret research
- Evidence reviews difficult to incorporate into decision-making
- Local evaluations more helpful than academic research because evaluations include useful contextual information

Role of academic research (2)

- Negative research findings did not inform disinvestment plans

I've had conversations [with colleagues] about, "Well, we shouldn't be putting that down to say it will make savings because there's no evidence that it will," versus me saying, "But actually we've still got a statutory responsibility to deliver a balanced plan, and if I take those savings out they need to come from somewhere else." (Carla, NHS commissioning manager)

Actionable messages from this study

1. Personal contact is key to research uptake with local policymakers so researchers need to generate/ look for opportunities to meet commissioners.
2. Verbal communication has more impact than written communication so researchers need to find ways to maximise oral communication.
3. Embedding researchers might be a way to meet commissioners and maximise oral communication.
4. Offering to conduct evaluations of commissioners' initiatives might demonstrate researchers' value and increase chances of becoming 'trusted colleagues'.

The Bristol KM team

- Sept 2013 set up with 2 commissioners seconded into Centre for Academic Primary Care
- Sept 2014 2 further commissioners seconded + 2 ‘researchers-in-residence’ seconded into Bristol CCG + addition of academic based communications manager
- Commissioners attached to research teams; researchers attached to commissioning sub-committees
- Secondments 12 months WTE – most part-time
- Funded by Research Capacity Funding from Avon Primary Care Research Collaborative
- Part of wider KM initiative i.e. clinical evidence fellows, ‘Head of effectiveness and evidence’, evaluation assistants

Purpose of the KM team

To encourage researchers, commissioners and clinicians to work together to promote research-informed commissioning and commissioning-informed research.

What do we do?

- Design & conduct co-produced evaluations
- Set up contacts between researchers & commissioners
- Advise & carry out dissemination activities
- Explain health and social care landscape
- Develop new skills
  - Research & evaluation for commissioners
  - Project management & communication for researchers
- [Develop co-produced NIHR bids]

What works well?

- Co-location on CCG/ university premises
- Dedicated time
- LW as broker/ manager
- Creating a team approach
- Choosing proactive fellows with the right skills
- Start small
- Cultivate an experimental mindset
- Make it evidence based by reading the literature
- Model the change you want to see

Challenges

1. Lack of levers in academia
   a. Progression/ promotion
   b. Research funding stops with final report
2. Commissioners' don't understand evaluation
   a. Insufficient resources
   b. "Just do it for me!"
3. Governance is a minefield
4. Limited skills in collaboration in both communities

What difference are we making to commissioners?

Better understanding of:

- control groups
- the value of qualitative research and qualitative research skills
- developing patient information leaflets for research
- topic guides for interviews
- interview skills with both staff and patients
- the benefits of using recording and transcriptions for interviews
- the diversity and variation of research skills
- information governance
- the different ways in which research evidence is developed and interpreted

What difference are we making to researchers?

- increased understanding of the commissioning world
- learnt specific facilitation and workshop techniques
- developed project management skills
- developed new co-produced evaluations beyond the two evaluations considered here
- developed new grant applications and collaborations with commissioners
- learnt and developed different knowledge mobilisation techniques

It's probably something that both sides for years have kind of been saying we should really link up, but never have. And just having somebody to facilitate that…has been really good. (Commissioner, 12)

What can researchers do to make a difference?

We need to change our ways of reaching commissioners

1. Start talking & rely on written communication less (F2F)
2. Produce what they want
   a. Focus more on context
   b. Tell stories
3. Consider employing people placement strategies e.g. researchers seconded into commissioning organisations (co-location)
4. Learn about your local CCG to find out areas of commonality
   a. Check out CCG websites to identify priorities (plan on a page) & key managers
   b. Attend public governing board meetings
5. Carry out local evaluations to build relationships & demonstrate that researchers have something worthwhile to offer
6. Develop relationships with your local public health department

Collaboration, it turns out, is not a gift from the gods, but a skill that requires effort and practice.

Reeves quoted in Hincliffe et al, International Journal for Quality in Health Care 2014

Further information

KM team website: http://www.bristol.ac.uk/primaryhealthcare/km/

Publications:

1. Wye L, Brangan E, Cameron A, Gabbay J, Klein J, Pope C. Knowledge exchange in health-care commissioning: case studies of the use of commercial, not-for-profit and public sector agencies, 2011–14. Health Service Delivery Research 2015;3(19).
2. Marshall M, Pagel C, French C, Utley M, Allwood D, Fulop N, et al. Moving improvement research closer to practice: the Researcher-in-Residence model. BMJ Quality and Safety 2014;23(10):801-5.

Evaluations: (on request)

1. Farr, M. Independent review of Lesley Wye's work on the NIHR Knowledge Mobilisation Fellowship. July 2015
2. Wye L & Baxter H. NHS fellows evaluation 2013-2014. Nov 2014

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Acknowledgments

- NIHR HS&DR and APCRC for funding
- All participants in the study and working with the KM team
- Chris Salisbury (Univ of Bristol), Alison Moon & Peter Goyder (Bristol CCG) for supporting the initiative