

Knowledge exchange in health-care commissioning: case studies of the use of commercial, not-for-profit and public sector agencies, 2011–14

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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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Background

Recent history suggests that there will always be some mix of public sector, clinician and commercial involvement in health-care commissioning in the English NHS, even if the balance shifts under successive governments. As a result of new legislation in 2012, the NHS landscape has changed remarkably. Several functions that were formerly considered 'internal' in health-care commissioning structures now have external status. For example, public health departments moved to local authorities and analytics (i.e. data production, management and analysis) became the remit of external organisations known as commissioning support units (CSUs). These 'external' organisations want to influence and work with commissioners, along with commercial and not-for-profit agencies, freelance consultants and the voluntary sector. The aim of this research was to study knowledge exchange between these external agencies and health-care commissioners. Our research questions were:

1. How do health-care commissioners access research evidence and other sources of knowledge to aid their commissioning decisions?
2. What is the nature and role of agencies that provide commissioning expertise from the public (e.g. Public Health), private (e.g. commercial providers) and other sectors (e.g. not-for-profit)?
3. What are the processes by which health-care commissioners transform information provided by other agencies into useable knowledge that is embedded in commissioning decisions?
4. What are the benefits and disadvantages?

In addition to these research questions, given the timing of this study, another objective was to learn more about the types of commissioning in operation. This study took place from 2011 to 2014.

Methods

Using a case study design and ethnographic techniques, we collected data through interviews, observations and documentation from early 2011 to mid-2013. Because our interest was in knowledge flows between health-care commissioners and external providers, cases were selected only where commercial or not-for-profit agencies had been contracted. All cases were given pseudonyms. Four were cases of commercial and not-for-profit providers working across multiple commissioning organisations. These included:

- Heron – a multinational commercial company with a suite of tools and mixed UK/non-UK staff, offering analytics and project management.
- Jackdaw – a small, international, not-for-profit offering one tool.
- Swallow – a national commercial company with a suite of tools, staffed largely by ex-NHS personnel, offering analytical and commissioning expertise.
- Swallow Tool – an exemplar of Swallow and NHS clients [primary care trust (PCT), acute and community providers] working together to audit best place of patient care using an electronic tool.

We also independently recruited four commissioning organisations located in areas where our commercial and not-for-profit providers were contracted. These four cases were geographically bounded commissioning agencies [former PCTs, now Clinical Commissioning Groups (CCGs)] and included:

- Carnford CCG – struggling financially, highly collaborative with its health-care providers and reliant on the use of tools and the data produced from those tools to influence commissioning decisions.
- Deanshire CCG – relatively confident as a commissioning organisation, focused on governance, carrying out some innovative projects in partnership with commercial providers.
- Norchester CCG – financially challenged, emphasis on (ideally academic research) evidence-based policy-making, piloting new ways of commissioning contracts, with substantial aid from commercial and not-for-profit providers.
- Penborough CCG – creating an integrated network of health and social care provision with a heavy emphasis on public involvement, historically extensive use of commercial and not-for-profit providers and freelance consultants.

Data sources included 92 interviews with commercial and not-for-profit providers ($n = 36$), their clients ($n = 47$) and others such as freelance consultants, lay representatives and local authority professionals ($n = 9$). We conducted 25 observations of training events and meetings and collected various documentation including meeting minutes, reports, websites, marketing material, press releases and e-mails. Using a constant comparison method, data were analysed thematically through the application of a coding framework and summaries of entire case sites. Cross-case analysis was conducted. Emerging findings were continually discussed and refined in regular team meetings throughout the study.

Results

Models of commissioning

Three functional types, or models, of commissioning were identified from the data: 'clinical', 'integrated health and social care' and 'commercial provider'. Different kinds of knowledge were privileged in the different commissioning models. Local clinical knowledge from general practitioners (GPs) about service provision was prioritised in clinical commissioning, service user experiences of care were key in integrated health and social care, and commercial providers prized high-quality process and outcome data to 'drive decision-making'. Nonetheless, every CCG case site had its own unique blend of commissioning models.

With the commercial provider model, the provider won an outsourced contract to take over all commissioning responsibilities for a NHS team. Along with high-quality data, accountability and tight performance management of providers was stressed ('no data, no payment'). Without mechanisms to transfer commercial provider skills into the NHS/CSU, the NHS clients effectively became completely reliant on the commercial provider, as the contract was expected to run for at least 10 years.

Knowledge acquisition

Commissioners sought out information to build a cohesive, persuasive case for commissioning decisions. Commissioners purposefully looked for information to identify which course to take and navigate a way through. Knowledge was acquired, modified and transformed in manoeuvring it through the system. They juggled competing agendas, priorities, power relationships, demands and their own inclinations – to make the 'best' decision circumstances allowed. Just as there is an 'art of medicine', this was the 'art of commissioning'.

Sources of information for commissioners included people (such as clinicians, commissioning managers, analysts, patients and the public, commercial and not-for-profit providers, and freelance consultants) and organisations [such as local public health departments, CSUs, health-care providers, Department of Health, the National Institute for Health and Care Excellence (NICE) and think-tanks such as The King's Fund and the Nuffield Trust]. Tool-based information came from software tools from commercial providers, national benchmarking and local dashboards. Academic research was occasionally explicitly sought, but usually this was present in a form that was already digested, transformed and embedded into NICE guidance, software tools, the clinical knowledge of GPs and local briefings. Disinvestment opportunities highlighted by academic research did not appear to trigger debate or influence commissioners' thinking.

Local data often trumped national or research-based information in persuading commissioners on a course of action. Conversations and stories were important, as oral methods were fast and flexible, which suited the changing world of commissioning. Unsolicited documentation was ubiquitous and often sent electronically. Commissioners used internet search engines such as Google™ (www.google.com) and Google Scholar™ (www.scholar.google.com) to find required information. Once acquired, indeed in the very act of its acquisition, information went through many transformation cycles to be rejected, filtered and/or modified before further dissemination.

Knowledge acquisition was interwoven with knowledge transformation in multilayered, multifaceted and nested ways. The five main conduits through which knowledge flowed were:

- *interpersonal relationships*, whereby commissioners sought information held by others with whom they had ongoing relationships
- *people placement*, whereby commissioners accessed information embodied by external consultants, who were placed among them with particular skills and experiences
- *governance*, whereby commissioners were expected to act on information from elsewhere (e.g. Department of Health, NHS England teams) or set up internal structures and processes in their role as publicly accountable, statutory organisations
- *copy, adapt and paste*, whereby commissioners accessed information from initiatives elsewhere which might be locally applicable
- *product deployment*, whereby commissioners accessed information held in electronic or non-electronic tools and methods.

Commissioners employed the knowledge transformation processes of *contextualisation* to apply a local lens and *engagement* to refine the knowledge and ensure that the right people were involved and on board.

Face-to-face encounters were important in facilitating interpersonal relationships. People placement and product deployment implicitly relied on creating interpersonal relationships. Of all the conduits, interpersonal relationships appeared most crucial in influencing commissioning decisions. Without this comingling of conduits, commissioners struggled to interpret data outputs without interpreters on hand.

External providers

External providers were contracted for their knowledge, skills and expertise in many areas including project management, forecast modelling, event management, pathway development, software tool development, analytics and stakeholder engagement. Commercial providers could bring a specialist 'big picture' view, offered an independent view to challenge local stakeholders, drew in knowledge from international and national sources and sometimes just filled capacity gaps.

Trust and usability (i.e. ease of use) influenced clients' views on the usefulness of external output. The motivations of Public Health and CSUs were more trusted, but the usefulness of their output was variable; for example, some thought that Public Health overstressed the inequalities agenda at the expense of more valuable outputs such as service evaluations and evidence reviews (high trust + variable usability). Freelance consultants were perceived as less threatening than commercial providers. Their output was well contextualised to their client, as often freelance consultants were former employees of their clients and so had useful local knowledge (high trust + high usability). In contrast, although commercial consultants often had ex-NHS or public sector backgrounds, they were sometimes viewed as threats, either to the stability of the NHS or professionally by particular individuals. The usefulness of their contribution was variable and they lacked local knowledge (low trust + variable usability). Not-for-profit providers encountered less hostility than commercial companies. Sometimes commercial and not-for-profit agencies were subcontracted by other commercial/not-for-profit suppliers and client trust was further challenged if clients were not allowed direct access to the subcontractors.

Benefits and disadvantages

The definition of 'successful' contracts was largely based on client satisfaction that the objectives had been met, although some contracts stipulated cash savings (e.g. one contract required savings of £200M over 4 years). Other signs of a successful partnership were that the outputs were still in use, contracts were extended or the external provider was recontracted for other work.

The long-standing schism between analytics and commissioning in the NHS was particularly notable in this study. Participating commercial and not-for-profit providers tended to deploy software tools for better data generation. In assessing impact, commissioners often could not identify benefits because the work of external organisations targeted and benefited health-care analysts more than commissioners. External providers had difficulty persuading, either directly or indirectly, the decision-makers to make use of the new knowledge. In addition, those supplying software tools sometimes offered 'solutions looking for a problem' rather than developing solutions in response to real problems identified and experienced by their clients.

Within this study, overall impact by commercial and not-for-profit providers on commissioning decision-making was patchy. In one contract, NHS clients generally thought the contribution of the external provider was comparable with public sector input and added little of extra value. This contract ended early with the commercial provider payments docked for poor performance. In another, the relationship was better, but at the time of fieldwork (2012) the benefits were more notional than actual, as it was early days. With a third external provider, clients were quite impressed with some examples of excellent work, but a minority questioned if the benefits justified the expense. This external provider was recontracted by two commissioning organisations, which suggested good levels of client satisfaction, although with one contract we were unable to obtain enough NHS client views to form a firm conclusion.

A primary reason for unsuccessful contracts was that clients did not want to work with external providers. Contractual relationships were sometimes 'forced' because of concerns around NHS performance and sometimes procured without their involvement. At other times, frontline operational staff did not identify the same need for assistance as their colleagues or external providers were contracted in response to Department of Health directives. Another hindrance was lack of clarity around the brief, often because the client was not entirely clear about the problem or the desired outcome. The rapidly changing nature of the commissioning environment made it difficult to keep the brief relevant; successful external providers continually reconfigured objectives.

External providers who really understood the health-care market and could add extra value were more appreciated, as were those who incorporated a way of transferring knowledge so that clients were not dependent long term. Good relationships between the external provider and client also facilitated better knowledge exchange. Knowledge exchange was possible only if both sides were receptive.

Conclusions

By easing the way for greater competition between commercial, not-for-profit and other external provider involvement in the NHS, new legislation in 2012 led to the creation of a number of new 'external' organisations that were intended to aid commissioning. These included CSUs, and public health departments within local authorities, as well as commercial and not-for-profit agencies and freelance consultants. One consequence of this proliferation of competing organisations among our case studies was to curtail freely exchanged knowledge transfer. The growing multiplicity of organisational boundaries not only frustrated knowledge exchange but also established substantial barriers to the NHS clients' scope for strengthening commissioning skills within the NHS by learning from these external providers.

Where knowledge exchange occurred, external providers who maximised their use of the different conduits and produced something of value beyond what was locally available appeared more successful. The long-standing schism between NHS information producers (analysts) and users (commissioners) blunted the impact of some contracts on commissioners' decision-making. To capitalise on the expertise of external providers and consider legacy planning, external providers and their NHS clients should include explicit knowledge transfer components within the contract, where possible.

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