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Knowledge exchange in healthcare commissioning: clinicians, PCTs and external private providers

Chief investigator	Dr Lesley Wye
Sponsor	University of Bristol
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Research questions

1. How do healthcare commissioners access, integrate and use 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. Primary Care Trusts) and private sectors (e.g. external providers)?

3. What are the processes by which healthcare commissioners transform information provided by other agencies into useable knowledge that is embedded in commissioning decisions, particularly in light of the current economically challenging climate?

4. What are the benefits (and disadvantages) of these processes?

Aims and objectives

- To describe at least three distinct models of commissioning expertise, including private sector (i.e. external providers), Primary Care Trust (PCT), specialist commissioning, clinical consortia and/ or local authority commissioning (if possible).
- To elucidate how external private providers and healthcare commissioners access, assimilate, integrate and utilize managerial and clinical research.
- To establish how existing professionals with expertise in commissioning from the public (i.e. PCT managers) and private sector (i.e. private management consultants) transform and market their managerial and clinical knowledge.
- To examine how knowledge is exchanged between private sector agencies and public sector bodies and how that knowledge is applied and embedded in the commissioning process.
- To gauge the benefits and disbenefits of these exchanges in terms of healthcare commissioners' increased understanding and application of research based knowledge and their ability to meet their performance targets.
- To identify actionable messages and disseminate them to commissioners, policy-makers and external providers using effective knowledge exchange strategies in light of the proposed changes to commissioning structures and the current challenging economic context.

Background

Evolution of this project

We want to understand more about the processes by which healthcare commissioners access, integrate and use clinical and managerial research evidence and other sources of knowledge to inform their commissioning decisions. We use the term 'knowledge exchange' (rather than 'knowledge transfer' or 'research implementation') for these processes, since informati research evidence and innovations are all forms of 'knowledge', and 'exchange' best describes how knowledge is transformed through the interaction of two or more parties.

Our chief interest is in exploring the knowledge exchange processes betwe healthcare commissioners in the public and the private sector with particul focus on the role of research based information and innovations in knowle exchange. The recent proposed re-structuring of the NHS (*Liberating the NHS,* 2010) will bring about significant changes in the commissioning landscape. Commissioning responsibilities have been re-allocated to clinic commissioning consortia and local authorities. Thus there are now several players on the commissioning stage: specialist commissioners, clinical commissioners, the private sector, local authorities and PCT staff. Moreov PCT managers will be changing roles, as they move from actively commissioning services themselves to offering commissioning expertise to others - just like private sector organisations. Hence, once clinical consorti are up and running, they will have the choice of utilizing the expertise of pu sector commissioners from former PCTs as well as that of private sector agencies. How healthcare commissioners negotiate this new terrain, the sources of knowledge they access and the ways in which they interweave knowledge into commissioning decisions is key to the success of the curre NHS reforms. Moreover, all this is set against an extremely challenging financial backdrop.

Commissioning led by clinicians, such as GPs, is not new. Most recently, t Labour Government has attempted to implement practice based commissioning. But this has struggled in its engagement of clinicians [1], perhaps partly because no real funding followed decision making. Much earlier in the 1990's, the Conservative government brought in GP fundhold Fundholding practices negotiated their own secondary care contracts, mac decisions about which providers and services they would use and often deployed surpluses to develop innovative new services. Abolished by the Labour Government in 1998, amidst accusations of creating a two tier NHS some critics claim that fundholding was never properly evaluated.[2]

Total purchasing pilots were another variation of GP commissioning that al operated in the 1990's. This scheme was evaluated.[3] The results showed that the level of achievement varied widely between pilots and included reductions in the length of stay and emergency admissions. However, tota purchasing pilots were also associated with higher direct management cos