



HSDR 18/92 Evaluating approaches to health and care services commissioning and provision with the third sector in the UK

## **Commissioning, Co-commissioning and Being Commissioned; the NHS and Third Sector Organisations. Multi-method realist study.**

### **Protocol**

#### **1 Full title of project**

Commissioning, Co-commissioning and Being Commissioned; the NHS and Third Sector Organisations

#### **2 Summary of research**

##### Research Questions

RQ1. How do healthcare commissioners address the task of commissioning voluntary, community and social enterprises (VCSE) as service providers, and what barriers do they face?

RQ2. What are the consequences for VCSEs, of the public bodies commissioning services from them?

RQ3. How are VCSEs involved in CCG, local authority and other (e.g. ACS, NHS England) commissioning decisions?

RQ4. What absorptive capacities do healthcare commissioners and VCSEs respectively need for enabling VCSEs to be commissioned, and for co-commissioning?

Here, 'healthcare commissioners' are defined as all forms of publicly-funded healthcare commissioning organisations (i.e. CCGs, local government etc.).

##### Background

National policies and the [NHS Long Term Plan](#) encourage healthcare commissioners to commission voluntary, community and social enterprises (VCSE) as service providers, and to 'co-commission' services of all kinds collaboratively with VCSEs. Alongside the potentially positive consequences of these policies, previous studies also describe how, in certain circumstances, being commissioned by public bodies may compromise the characteristics of VCSEs which made them potentially valuable to the healthcare commissioners in the first place. What commissioning methods help healthcare commissioners productively commission different kinds of providers (NHS-owned, corporate etc.) is partly understood, but not how commissioning might differ for

different kinds of VCSE. Increasing healthcare commissioners' and VCSEs' capacity to exploit the relevant research is also required.

### Aims and Objectives

Besides answering the above research questions, this study aims to help strengthen commissioners' and VCSE capacity to absorb and exploit evidence relevant to commissioning.

### Methods

Mixed methods evaluation:

1. Systematic comparison of case studies of the commissioning relationships between healthcare commissioners and VCSE providers.
2. Cross-sectional and longitudinal analysis of post-2014 CCG accounts and other routine administrative data to show the extent and profile of commissioning of VCSEs.
3. Systematic comparison of case studies of NHS and VCSE co-commissioning.
4. VCSE and commissioner self-assessment of their current capacity for collaborative healthcare commissioning, leading to design and implementation of development activities for strengthening their capacities. The activities include involving VCSE members as co-researchers in the research project itself.

Purposive maximum-variety sample of sites covering all four quartiles in terms of the extent of VCSE participation in the local health economies. The sample will therefore cover sites likely to have comparatively complex, extensive and diverse commissioning relationships between healthcare commissioners and VCSEs, and those which do not. Three 'tracer' care groups: social prescribing for older people; hospices; and people with learning disability and complex behavioural needs.

### Timelines for delivery

Three years from December 2019. Milestones:

1. 3 months: Elaborated criteria for study site selection.
2. 1 year: Initial profile of CCG commissioning of VCSEs;
3. 1 year: Profile of study organisations' capacity for participating in commissioning.

### Anticipated impact and dissemination

Capacity building in participating (co-researching) VCSEs, as a prototype for dissemination via networks of VCSEs and healthcare commissioners. Evidence based guidelines for the commissioning of, and for co-commissioning with, VCSEs.

### 3 Background and rationale

#### Policy Background

Recently the government's Civil Society Strategy, Innovation in Democracy and Place Based Social Action programmes have re-asserted that service providers should be 'drawn from a broad range of suppliers from the public sector and beyond' (1 p.10) including Voluntary, Community and Social Enterprise (VCSE) organisations, often referred to as 'third sector organisations (TSO)'. VCSE's intended roles include being 'citizen commissioners' 'speaking up on behalf of those they support' (p.14) and helping address 'injustices and entrenched social challenges, such as poverty, obesity, mental ill-health, youth disengagement, reoffending, homelessness, isolation, and loneliness, and the challenges of community integration' (p.18). Consequently government 'plans to reform commissioning in favour of charities and social enterprises' (p.69) through such measures as co-commissioning, 'flexible contracting' (including Innovation Partnership projects) and Social Impact Bonds. These and other policies (e.g. care integration, provider diversification, personal care budgets, the [NHS Long Term Plan](#)) involve commissioning of VCSE providers.

Many VCSEs have developed in parallel with the NHS, initially as advocates both of new kinds of healthcare and of non-healthcare activities which help maintain health and reduce demand on the NHS. Many are long-established service providers, indeed the dominant providers for some services (such as hospices) for patients whom they see as under-served by the NHS including 'hard-to-reach' care groups. They also provide adjunctive services to extend and continue NHS services (e.g. Macmillan nursing (post-acute cancer care). NHS trusts and some non-for-profit providers (e.g. Nuffield's) have volunteering schemes, fund-raising and hospital 'friends' organisations. However cuts in local government budgets have increased the financial and demand pressures on VCSEs at a time when the NHS has been increasingly looking towards them as providers. The introduction of personalised budgets for health appears to threaten some VCSEs' block contracts. Meantime some NHS trusts (providing community and/or mental health services) have been converted into 'social enterprises', which policy-makers increasingly also count as part of the 'third sector'.

NHS policy and the Sustainability and Transformation Partnerships (STP) have also increasingly supported VCSE participation in healthcare commissioning, including the Universalised Personal Care strategy, local authority and NHS joint commissioning, and the New Models of Care for cross-provider 'integration'. Health and social care systems are to 'integrate' services between NHS and local authorities, and VCSEs will provide many of the services to be integrated. The [NHS Long Term Plan](#) states '*The NHS will continue to commission, partner with and champion local charities, social enterprises and community interest companies providing services and support to vulnerable and at-risk groups.*' (§2.37). Examples include stroke rehabilitation services (§3.77), mental health services (sanctuaries, crisis cafes) (§3.98), 'well-designed volunteering initiatives' (§4.54).

Accordingly this study is sponsored by the NIHR Health Services Delivery Research Programme, National Institute for Health Research and managed by their Evaluation, Trials and Studies Coordinating Centre, University of Southampton, Alpha House, Enterprise Road, Southampton SO16 7NS, UK. The sponsor called for bids then selected protocols for funding through open competition and peer review. After agreeing the details stated in this protocol with the researchers, the sponsor played no further part in study design nor had ultimate authority over collection,

management, analysis, and interpretation of data; writing of the report; and the decision to submit the report or materials derived from it for publication.

### Existing Research

Like the call for bids, we define VCSE organisations as “formally organised; non-profit distributing; constitutionally independent from the state; self-governing and benefiting from some form of voluntarism”.<sup>2</sup> Previous studies, including our own<sup>3-5</sup>, suggest that VCSEs have certain distinct characteristics. They tend to be ‘mission-driven’<sup>6</sup> rather than profit-driven<sup>7</sup>; to have user and/or worker representation<sup>4</sup> in, or even democratic control<sup>8</sup> over, their governance structures; to rely heavily (in some cases) on volunteers rather than employees<sup>9</sup>; to have distinctive patterns of innovation<sup>10</sup> and response to market changes<sup>11</sup>; and to have close (structural) ties to particular localities or care groups. VCSEs also have distinctive resource dependencies, for example their balance between help-in-kind, donations, subscriptions, commissions, sponsorship and sales; and between voluntary and paid labour). They have distinctive ways of combining bureaucratic with democratic work-coordination, non-profit and for-profit activities.

Potential positive consequences of commissioning VCSEs as healthcare providers therefore include:

1. Responsiveness: introduction of VCSE expertise about patient activity, experience and needs, especially for (as VCSEs may see it) underserved care groups e.g. the marginalised or vulnerable groups which the call for bids lists.
2. Innovation: inventing new models of care which NHS organisations can later co-fund or adopt in place of less suitable NHS services (e.g. hospice instead of hospital in-patient care), including preventive services.
3. Participation: greater patient, carer and user participation in planning and decision-making, reaching the higher levels of Arnstein’s ‘ladder’ of participation.<sup>12</sup>
4. Advocacy of specific care groups’ interests at both national and commissioner levels (e.g. Lighthouse (for AIDS)).
5. Independence: Health promotion campaigns, including anti-marketing which official bodies cannot so easily undertake (e.g. against tobacco or food firms), and inter-sectoral activities (e.g. dementia-friendly airlines).
6. Complementarity: Supplementary service funding and/or provision by VCSEs themselves, possibly (e.g. by using volunteers) at lower cost than NHS or commercial providers.
7. ‘Social enabling’ i.e. constructing referral networks (e.g. ‘social prescribing’) which enable patients to access health-related services and resources, extending NHS reach and impact.

For commissioners to take advantage of these possibilities requires capacity<sup>13-15</sup> to acquire, assimilate, adapt and apply knowledge from many sources, both knowledge about VCSEs and knowledge provided by them. However commissioners often lack this capacity.<sup>16</sup> They often have limited understanding of the VCSE sector and how best to engage with it. Often they see VCSEs as able to provide low level services but not necessarily clinical care. Conversely, VCSEs also face specific barriers (see below) to using research<sup>2</sup> and need to develop their own capacity to bid for commissions and then supply the commissioned services. That implies correspondingly adapted

forms of volunteering, VCSE management, 'performance', culture and (employed) workforce.<sup>17</sup> In sum, VCSEs still lack embeddedness in the NHS and much of the health system more widely.

Previous studies also describe how, in certain circumstances, VCSEs' mission-driven character, their original mission itself, or their democratic or participatory governance may 'degenerate'.<sup>18</sup> For VCSEs, being commissioned by public bodies may involve restrictions on their advocacy and autonomy and being made 'governable'.<sup>17</sup> It may create pressure to develop structures and managerial practices more like those of for-profit corporations.<sup>19</sup> So there are also risks in commissioning VCSEs, not least to VCSEs themselves. Resource dependency theory<sup>20</sup> implies that heavy dependence on NHS income also risks making VCSE providers become more like NHS providers because:

1. Commissioners' demand specific 'innovations' (e.g. service models). VCSEs then have to accumulate profits to finance them, making VCSEs in that sense more 'corporate'<sup>21</sup>.
2. External payments enable, and their contracts compel, VCSEs to use paid rather than volunteer labour<sup>22</sup>, accentuating the gap<sup>23</sup> between patient and professional discourses.
3. Competition for commissions motivates 'commercial-in-confidence' secrecy about VCSEs' distinctive inventions or working methods, and more generally the 'commercialisation' of VCSEs' internal managerial practices and regimes.<sup>19</sup>
4. VCSEs become more accountable to healthcare commissioners than to their members, volunteers, care group or community. That inhibits their campaigning about what they see as policy or service shortcomings.<sup>17,19</sup>
5. VCSEs experience managerial 'capture'<sup>24</sup>, immersion in an 'audit culture'<sup>25,25</sup> or 'cultural take-over by stealth'<sup>26</sup>, which 'block' their original institutional logic.<sup>27</sup> They become more bureaucratic and the transaction costs of commissioning them increase. Charities with multiple income streams may become large enough to sustain teams who specialise in seeking funding, but smaller charities who cannot may struggle to survive.
6. VCSEs become so dependent on healthcare commissions that they respond to budget cuts much as public bodies do, for instance by defending their vested interests or block contracts against, say, more personalised forms of contracting. Conversely, large VCSEs, or those mainly funded from non-NHS sources, may be in a stronger bargaining position than local healthcare commissioners.
7. Commissioners' focus on cost-savings results in VCSEs receiving less income or resources than they need to sustain both themselves, their workers and informal carers.

At worst, unsuitable modes of commissioning would then undermine the very characteristics which made VCSEs valuable to the health system in the first place.<sup>28</sup>

Our previous studies<sup>5,29</sup> developed a typology of commissioning models. To exercise power or control over providers, healthcare commissioner use a range of methods: managerial techniques (planning, evaluation), persuasion, financial incentives, provider competition, relationship-building, and contracts or regulation. Commissioners tend to find different combinations of methods (i.e. different 'modes of commissioning') effective in influencing different kinds of providers (NHS-owned, corporate, VCSE etc.). However it is not yet well understood how the effective combinations of methods might differ for different kinds of VCSE. Neither is it known which

combinations of methods are more likely to produce the positive, or the negative, consequences listed above. It is not known, either, whether these combinations methods work differently when VSCEs participate in commissioning (i.e. in co-commissioning). It also remains to be seen how VSCEs will respond, both as service providers and as co-commissioners, to the new strategic environment of STPs, integrated care and public health.

#### Rationale: Evidence explaining why this research is needed now

VSCE contributions to healthcare commissioning currently include:

1. Advocating inclusion and service 'co-design' for specific care groups. VCSE activities range from outside campaigner or pressure group to consultee or advocate (e.g. National Osteoporosis Society) to actively participating within healthcare commissioning.
2. Acting as 'social enablers' of 'social prescribing'.
3. Co-funding services in parallel with public commissioners (as do e.g. Alzheimers Society, British Heart Foundation), whether at care group level through large contracts or at individual level through personal budgets or grants.
4. Funding research, including making their own independent evaluations of service accessibility and quality. (This research is often linked to their advocacy.)

The term 'co-commissioning' covers any of the above. Indeed the above list is an initial typology of co-commissioning variants. As noted, the [NHS Long Term Plan](#) continues these policies. Scotland, Wales and NI have similar policies. Yet as the call for bids notes, policy makers consider VCSE input to the health system as 'too often restricted in scope and in funding and that they [VCSEs] face difficulties of expertise and funding to evidence their impact and value'; and so do the practitioners whom this research is intended to support.

The rationale for the present research is therefore to discover which commissioning methods can harness for the NHS these positive characteristics of VCSEs whilst preventing the potential adverse consequences noted above. That is, to discover what:

1. Benefits that healthcare commissioners currently gain, and in future might reasonably seek, by commissioning VCSEs as providers and by co-commissioning with them.
2. Commissioning methods (including co-design<sup>30</sup>) appear best adapted for these purposes, and best able to avoid the potential adverse consequences noted above.
3. Practical capacities VCSEs and healthcare commissioners currently need (both in their own perceptions and according to research evidence) so that VCSEs can bid credibly for healthcare commissions and so that once they are commissioned, both parties can sustain mutually beneficial roles.
4. Methods can be devised for developing these practical, absorptive capacities, especially for VCSEs.

#### **4 Research Aims and Objectives**

Hence the reason (aim) for this study is to produce knowledge which will help strengthen collaboration between healthcare commissioners and VSCEs in commissioning all kinds of

healthcare providers, and make commissioning relationships between the NHS and VCSEs more productive for both. Such changes may be expected to make NHS-funded services more responsive to patients' and carers' needs. Our research aims are therefore to:

1. Strengthen the evidence-base for guidance to commissioners on how:
  - (a) VCSE contributions can strengthen healthcare commissioning
  - (b) VCSEs should use research to inform their activities, to encourage and enable them to produce evidence in their own cause.
  - (c) Commissioners and VCSEs can gain knowledge of each other's needs.
2. Produce evidence about how, and under what conditions, healthcare commissioning of VCSEs and co-commissioning with them tends to produce the potential positive or the potential negative consequences listed above.
3. Develop the typology of commissioning methods<sup>29</sup> relevant commissioning VCSE providers and to co-commissioning with VCSEs,

Additional study aims are to develop:

4. Commissioners' capacity for co-commissioning with VCSEs, and the training and knowledge mobilisation methods required.
5. Practice guides for VCSEs about service commissioning at the scale of CCGs (including merged CCG), local authorities, and local communities.

Lack of published administrative data (see below) prevent this study being a cost-effectiveness, cost-efficiency or cost-utility analysis of the costs and outcomes of commissioning VCSEs.

### Research Questions

Accordingly this proposal addresses questions 1,5,6 in the call for bids. It will also contribute to answering questions 2, 3 and 4.

The two explanatory frameworks outlined above (potential positive and negative consequences of commissioning VCSEs; distinctive commissioning methods) both suggest a making VCSE-commissioner interactions the focus of this research and (as explained below) the route to mobilising the resulting knowledge with evidence users. We therefore propose to address four over-arching research questions. One of them (RQ1) therefore concerns what the organisations commissioning VCSEs bring to, and take from, those interactions; RQ2 addresses the same issues for the VCSEs who are commissioned; and RQ3 addresses them in regard to co-commissioning.

RQ1. How do healthcare commissioners address the task of commissioning voluntary, community and social enterprises (VCSE) as service providers, and what barriers do they face?

RQ2. What are the consequences for VCSEs, of the public bodies commissioning services from them?

RQ3. How are VCSEs involved in CCG, local authority and other (e.g. ACS, NHS England) commissioning decisions?

RQ4. What absorptive capacities do healthcare commissioners and VCSEs respectively need for enabling VCSEs to be commissioned, and for co-commissioning?

Here, 'healthcare commissioners' are defined as all forms of publicly-funded healthcare commissioning organisations (i.e. CCGs, local government etc.).

## 5 Research Plan and Methods

### Design and theoretical/conceptual framework

To answer these research questions we propose a mixed methods research design applying realist methodology (the applicants have published several such studies<sup>5,29,31</sup>) but in a two-sided way: a methodological innovation. From the commissioners' standpoint, commissioning VCSEs can be understood as a means of achieving the positive outcomes noted above (responsiveness, innovation etc.). As the mechanism for achieving them, the commissioners will use some selection of the commissioning methods listed above. From the VCSEs' standpoint, making these contracts is implicitly a mechanism for achieving the outcomes that *they* seek. (What specific outcomes those are, will be one finding from this study.) As the mechanisms for doing so, VCSEs will rely on their own distinctive governance structures, external and network relationships, and working practices. We therefore require a study design that will identify the respective intended outcomes, the mechanisms which either party thinks will achieve them, their actual effects and what contexts these effects depend upon, the most important context being (we assume) what the other party to the commissioning relationship does. Similar reasoning applies to co-commissioning.

This reasoning suggests making the *relationship* and interactions between VCSE and commissioner, rather than organisational structures, the research focus and the unit of analysis or 'case'. In practice this unit of analysis may vary considerably in size between local health economies ('commissioning networks'), a factor which may itself impact upon commissioning and co-commissioning relationships. Accordingly we propose four work-packages (WP) and, to get them started, some preliminary work. Two WPs (WP1, WP3 below) use predominantly qualitative methods, supplemented with a quantitative study (WP2) of England-wide patterns of VCSE commissioning by the NHS. WP2 will also help us assess the likely generalisability of the findings from WP1 and WP3. WP4 uses surveys of absorptive capacity to ground action learning methods which (as explained below) are also a means of mobilising knowledge more widely.

### Preliminary Work

The preliminary work will be to make a more specific preliminary classification of the kinds of VCSE commissioning and co-commissioning relationships likely to be found. The findings will be used to specify more exactly the sampling criteria for the following work packages and contribute to developing the project's analytic frameworks (see below). This preliminary work will draw on advice from the PPI Steering Committee (see below), large VCSEs and approximately 10 individual key informants from VCSEs, an initial review of the provider lists in published CCG accounts, existing research studies<sup>32</sup>, other published sources (e.g. Carers Support Centre, NHS Choices provider lists, NCVO Almanac), national and professional press rapportage, VCSE networks and national bodies.

## VSCE-commissioner relationships (WP1)

WP1 addresses **RQ1** (how the NHS currently commissions VCSEs) and **RQ2** (consequences for VCSEs) by systematically comparing case studies of the commissioning relationships between commissioners and VCSEs providers. We will observe and analyse these relationships from both the commissioner and VCSE sides. Involving service users and (where applicable) volunteers, these case studies will trace down to service delivery level the consequences of commissioning VCSEs; and examine user involvement in VCSE governance (about which little research yet exists). Outputs from WP1 include the pithy evidence-based guidance for the use of VCSEs and the corresponding social marketing materials (see 'Outputs' below).

### *WP1 Sample*

At study site level WP1 will use a purposive maximum-variety qualitative sample of local health economies (commissioning 'patches'), the variety being in terms of patterns of commissioning relationship with VCSEs. The preliminary work findings will differentiate the types of commissioning relationship more concretely, but as a first approximation we expect them to vary in terms of :

1. The size of VCSEs involved, ranging through (for example) national VCSEs with local branches (e.g. Macmillan); local VCSEs which already have contracts with healthcare commissioners (e.g. a single free-standing hospice); and VCSEs which struggle to win contracts at all. One would expect all these VCSEs to differ in bargaining power and resources, especially access to specialised bidding expertise, and absorptive capacity.
2. How large a proportion of services VCSEs provide in each CCG, which is likely be an proxy for the extent, complexity and variety of commissioning relationships between healthcare commissioners and VCSEs.
3. How long-standing the commissioning relationships are, because mutual trust and working relationships, and the concomitant skills, on either side take time to develop.

Elaborating the preliminary work findings, we will assemble a list of publicly-commissioned VCSE providers (a method we used in an earlier study<sup>5</sup>). It will be the sampling frame for the maximum-variety sample. We will sample one site (CCG) in each quartile for proportion of services provided by VCSEs. This sampling strategy will guarantee at least two sites in the middle quartiles, i.e. which are middle-range in terms of the proportion of VCSE-provided services. It is also likely to include sites which approximately cover the variety of local commissioning relationships with VCSEs, on the assumption (explained above) that the development of commissioning relationships with VCSEs partly reflects the proportion of commissioning that involves VCSEs. In addition the preparatory work (see above) will identify between two and four further sites which have comparatively well-developed commissioning relationships with VCSEs. From these 'positively deviant'<sup>33</sup> sites will select (if available) one for each of the above quartiles. This sampling strategy is also likely to maximise the social diversity of sites studied. It is likely to include inner-city, suburban and rural<sup>34</sup> VCSEs, and populations that differ in socio-economic terms, because a locality's population size affects the availability and size of its VCSEs, and its socio-economic profile their range and character<sup>35</sup>. Similarly we anticipate that such a sample will include sites with high and low percentages of volunteers in the resident population. As explained below (see 'Analysis'), WP1 will use systematic qualitative comparisons, not statistical generalisation, to detect patterns and differences across VCSE-commissioner relationships.

Within each study organisation, our criteria for sampling key individual informants will be:

1. Recent, preferably current, first-hand knowledge of the VCSE-commissioner interface(s).
2. Balanced inclusion of VCSE and commissioner informants
3. Informants whose work includes the three tracer groups listed below.

Inclusion: WP1 will focus on commissioning of VCSEs serving three tracer care groups and their corresponding communities.

1. Social prescribing for older people, for which NHSE has recently funded 23 projects and about which some outcome data already exist at CCG level. VCSEs are main providers of such 'integration' activities, which appear to improve patients' quality of life and reduce unnecessary demands on hospitals.<sup>16</sup> VCSEs providing social prescribing are mostly quite newly commissioned, indeed quite new organisations, hence probably less accomplished than older, larger VCSEs in monitoring, evaluation and research. Given the policy context and research call priorities we will seek study sites with social prescribing projects serving more deprived and/or excluded communities.
2. Hospices, whose models of care the NHS subsequently adopted and who provide end-of-life services which the NHS traditionally delivered in very different ways.
3. People with a learning disability and complex behavioural needs, sampling sites where healthcare commissioners have worked with the VCSEs, both large and small, to develop more individualised packages of support, and building on previous studies.<sup>36,37</sup>

These tracer groups provide opportunities to contrast VCSEs of different sizes, ages, health system function (prevention, self-management, formal care); and different mixes of contracts and funding sources, hence different degrees of dependence on commissioners. Some organisations and services (e.g. for LD) which cater for children and young people *among others* are likely to be included, but not children or young people as a separate care group. Commissioning for all these groups raises questions, which cut across many care groups, of equal access to care.

In each study site we will study at least two of these tracer groups. Hence the setting for WP1 is VCSEs concerned with these three tracer groups. Since our proposed unit of analysis is the commissioner-VCSE relationship, the set of these relationships is (so to speak) our 'target population'. To avoid overlapping other studies the exclusions will be VCSEs concerned predominantly with gender identity<sup>34</sup>, mental health crisis care, child mental health, the on-going evaluations of personal budgets (e.g. for people with learning disabilities).

#### *WP1: Data collection*

Data for WP1 will be collected by key informant interview, content-analysis of documents (including unpublished managerial documents) and the observation of commissioning and/or monitoring meetings. We will recruit key informants by 'snowballing' from an initial contact (either indicated by the PPI group, already known to the researchers, or the CEO or equivalent) to those responsible for commissioning. We will collect data from commissioners who negotiate, monitor and revise contracts; from VCSE employees and/or volunteers working in publicly-commissioned services; and members of patient fora (or the equivalent) who can report how patients are involved commissioning and the implications for services of provision by VCSEs. We will be guided by all

these informants as to which meetings to observe and which managerial documents to content-analyse.

From these sources we will collect data on:

- ◆ What outcomes commissioners sought; what mechanisms, including commissioning methods, they assumed would produce these outcomes; and what contexts they took into account.
- ◆ Conversely, what outcomes the VCSEs sought to produce; through what commissioning or contract mechanisms; and what contexts they took into account.
- ◆ What commissioning methods commissioners used in relation to VCSE providers.
- ◆ What kinds of evidence commissioners expected from VCSEs when deciding whether to commission them as providers, and what kinds of evidence the commissioners in fact got.
- ◆ Barriers to VCSE involvement and development.
- ◆ Whether any of the aforementioned potential positive and/or negative consequences of commissioning VCSEs materialised, and if so under what conditions.
- ◆ How VCSEs relate to their patients in terms of advocacy, accountability, representation etc.
- ◆ Whether VCSE services appeared more acceptable to users, produced different service outcomes for them, and had different innovation patterns and lower long-term overall costs for commissioners than non-VCSE services.
- ◆ Contracting, payment, monitoring and dispute-resolution; how trust and working relationships; associated transaction costs; any differences between the different types of VCSE mentioned above.
- ◆ How commissioning changes (e.g. CCG re-alignment with ICSs, budget cuts ) affected the commissioned VCSEs.

These data will cover the range of VCSE providers, including those on contracts valued below £25000.

### *WP1: Analysis*

Since we will use framework analysis<sup>38</sup> to analyse data from WP1 and simultaneously synthesise them with the data from WP2, WP3 and WP4, we outline it below after describing them.

### Profile of healthcare commissioning of VCSEs (WP2)

WP2 also addresses **RQ1** (how the NHS currently commissions VCSEs) and **RQ2** (the consequences for VCSEs). WP2 will analyse routine administrative data about the commissioning of VCSEs. Since 2014 CCG accounts have published all expenditures of £25k or more, sub-classifying 'Clinical & Medical' providers as 'Commercial', 'Independent' or 'Other Public' & 'Voluntary Sector', assigning each item of expenditure to an 'expense area' (e.g. 'Hospices' or 'Learning Difficulties') and to a particular organisation (e.g. a named hospice). These data provide a census of CCG contracts valued above £25k.

WP2 will be a cross-sectional and longitudinal analysis of the extent (proportion of contracts and of contract value) and profile (variety of VCSEs) of CCG commissioning of VCSEs as providers. We will use established automated 'web scraping' methods to establish the geographic and temporal spread of >£25k contracts in the years since 2014 in terms of proportion of contracts, contract value, types of VCSEs involved and expense types. The first use of these findings will be as a sampling frame for study sites. Patterns of CCG commissioning of VCSEs as providers will be tested against various CCG characteristics to identify correlates with the commissioning of VCSE providers. This is a stand-alone objective, but will also help place the study sites in a broader context vis-à-vis the use made of VCSEs to provide services.

Whilst providing an important overview on patterns of VCSE commissioning, this analysis has unavoidable evidential limitations. Our preliminary investigation of the data reveals some variation in the classification of organisations as VCSEs (so WP2 will involve cleaning these data), the accounts do not include VCSEs that are subcontracted via another provider, and do not always cover contracts valued <£25k. The automated web-scrapers will detect those contracts <£25k whose details are published online, although those data will probably not be exhaustive because CCGs themselves vary in how much they publish on-line about contracts <£25k. We will also use Charity Commission and further sources of published data on contracts <£25k. As noted, WP1 and WP3 would cover contracts of all values, including <£25k. Taking care not to over-interpret the data, we will include a profile of those contracts <£25k for which data are available for the most recent financial year in the analysis. Even combined, however, these sources are less comprehensive and uniform than data on the larger contracts and there appears to be no realistic means of obtaining complete national-level data on contracts <£25k short of making multiple FOI requests which would be a huge dataset and entail large FOI costs, time and labour for data-cleaning. Given the size and timescale of this project we cannot feasibly extend the primary data collection required to fill these gaps beyond the case study sites to the rest of England.

In the WP1 and WP3 sites we will also investigate through the case studies what biases the omissions and mis-classifications of data mentioned above might introduce. In these ways we will review the availability, usefulness and limitations of currently published data for supporting VCSE self-evaluation, VCSE bidding for commissions, and identify ways in which the routine data might be made more valid and reliable.

### *WP2 Sample*

WP2 will be a census of CCGs.

### *WP2 Data Collection*

Data will be extracted from CCG websites, NHS Digital, NCVO and others describing what kinds, numbers and sizes of VCSEs are being commissioned (including co-commissioned), where, and with what spending. Data held by CCGs are suitable for automated web scraping, with additional use of *Tabula* to extract data from PDF files. Personally-identifiable or pseudonymised personal data are not involved or required.

### *WP2 Analysis*

The data collected for WP2 will be analysed cross-sectionally, longitudinally with a view to providing (mostly descriptive) statistics detailing the geographical distribution and penetration of different kinds of VCSE, including the extent to which they are concentrated in economically deprived areas and areas with large ethnic minority populations. Because CCGs are currently undergoing extensive mergers, the longitudinal analyses are likely to be on the basis of post-merger CCG configurations.

We will compare the study site sample with other English CCGs in respect of those characteristics of VCSE commissioning which the routine data cover, thereby adding to our understanding of the extent to which the findings of WP1, WP3 and WP4 may be generalisable. We will also make any necessary recommendations for making the routinely collected data more consistently coded and reliable, and more useful for commissioning VCSEs.

### Co-commissioning (WP3)

This WP addresses **RQ3** (about VCSE involvement in co-commissioning). It will systematically compare case studies of co-commissioning with VCSEs, contrasting different types of co-commissioning relationship, again with the VCSE-commissioner relationship as the unit of analysis. In doing so, we will investigate what research evidence VCSEs use, and how, in designing and evaluating services; their capacity to use the evidence, and that of their NHS and local government commissioning partners. WP3 will be the main source of the pithy evidence-based guidance, for VCSE and commissioner use, on co-commissioning; and of the corresponding social marketing materials.

### *WP3 Sample*

WP3 study sites will be sampled in the same way as for WP1, except that if co-commissioning is absent in any of the WP1 sites, we will for WP3 replace that site with one where co-commissioning does occur (otherwise maintaining as similar a pattern of VCSEs as possible) where co-commissioning does occur. We would prefer, however, to sample the same sites as for WP1 because that will enable us to investigate any interactions between the consequences of being a commissioned VCSE and those of being a co-commissioning VCSE (and simplify fieldwork).

### *WP3 Data Collection*

Data collection methods will be as for WP1 but different data will be collected i.e:

- ◆ How VCSEs participate in CCG, local authority and other (e.g. ACS, NHSE) commissioning decisions; ways in which this involves *co-design* of services.
- ◆ Acceptability to service users, overall costs for commissioners of co-commissioned services compared with other services.
- ◆ What distinctive mode(s) of commissioning commissioners use when co-commissioning with VCSEs
- ◆ Barriers to VCSE involvement and development.

As for WP1 these data will cover the range of VCSE providers, including those on contracts valued below £25000.

### *WP3: Analysis*

The same framework analysis as for WP1 will also synthesise data from WP3 with data from the other work packages and is therefore described below.

### Absorptive capacity and action learning (WP4)

WP4 will seek to generate insights on how the commissioning process with VSCEs can be practically improved, addressing **RQ4** (practical methods for improving VCSE and healthcare commissioners' capacity to use evidence for commissioning purposes<sup>16</sup> and improving VCSE ability to bid credibly for healthcare commissions). Using action learning methods<sup>39,40</sup>, the VCSE and NHS participants in WP4 will develop, apply and refine through practice a set of learning opportunities and resources tailored to the requirements of commissioning VCSEs as providers, and co-commissioning with them. In addition we will directly help some of the study VCSEs build their capacity in these areas. We will recruit VCSE members to the project work (details below), giving them practical organisational research experience and mentoring whilst they contribute to project design and implementation. In this way WP4 will provide an extended case method<sup>41</sup> for WP1 and WP3. Interim outputs from this WP will be

1. A profile of the values, skills and behaviours that enhance commissioners and VSCEs' absorptive capacity, including capacity to use, or produce, the kinds of evidence relevant to bidding, commissioning and co-commissioning.
2. Co-designed work-based learning opportunities to develop and consolidate these competences.

Its eventual outputs will be a cohort of VCSE members with enhanced capacities for engaging in commissioning and co-commissioning; a tested suite of developmental activities for strengthening those capacities; and formal, published outputs about how to achieve these things. To that extent WP4 itself provides a route to knowledge mobilisation by certain key evidence users.

### *WP4 Sample*

WP4 will take place in the same study sites as WP1 and WP3. Subject to the self-assessment findings, we anticipate that the WP4 participants will include key informants from WP1 and WP3. A maximum variety sample gives scope for evaluating different models (e.g. training, evaluation of pilot innovations, social marketing, knowledge mobilisation) for developing the practical skills that WP4 focuses on.

### *WP4 Data Collection*

In year 1 of the study we will use an established knowledge mobilisation tool<sup>16</sup> to profile VCSEs' and the commissioners' current ability to gather and deploy information regarding the services concerned. This will ground self-assessment by the commissioners and the VCSEs, gaining the perspectives of both. The commissioners and VSCEs will reflect upon the findings for their site to identify the key enablers and barriers to gaining and understanding of the knowledge relevant to commissioning, focusing in particular on the values, skills and behaviours that commissioners and the VSCEs need to adopt. The participants and the researchers will co-design work-based learning opportunities to develop and consolidate these competences. WP4, and to some extent WP1 and WP3, will also identify the routes to mobilising the knowledge so produced with evidence users.

By these methods WP4 will collect data on:

- ◆ What capacities commissioners require for constructive collaboration with VCSE providers and, reciprocally, what capacities VCSEs require.
- ◆ What kinds of evidence and competences co-commissioning requires.
- ◆ What competences, capacities and other support VCSEs have to acquire, in order to bid for NHS-funded care, then evidence their contributions to it.
- ◆ How VCSEs use research evidence in designing, delivering and evaluating services.
- ◆ The practical consequences of WP4 participants trying to apply their existing absorptive capacities, and those developed through this action learning work package.

#### *WP4 Analysis*

Within WP4, commissioners' competences in commissioning VCSEs and in co-commissioning with VCSEs first will be evaluated normatively against a framework derived from the concepts of absorptive capacity mentioned above, Anheier's theory of VCSE management<sup>42</sup>, and current health policy objectives. Then, following practical application of the co-designed learning activities, the participants will (applying action learning methods<sup>39,40</sup>) again reflect on their learning needs, adapting or extending the learning activities as needed.

#### Data Analysis (all work packages)

##### *Combining the findings*

To combine the findings from WP1, WP3 and WP4 we will make a systematic comparison of the case studies, comparing them through a framework analysis based on the explanatory frameworks noted above. We will explore any cross-site patterns or differences in terms of:

1. Which commissioning methods the commissioners used, including:
  - (a) whether they used different methods with different kinds of VCSEs (helping to answer **RQ1,RQ3**).
  - (b) Whether the possible positive and negative observed consequences noted above were associated with any specific commissioning methods (helping answer **RQ1, RQ2**).
2. Which of the aforementioned potential benefits and/or disbenefits materialised, and if so under what conditions (helping answer **RQ2**).
3. Whether, and if so through what mechanisms and in what contexts did:
  - (a) commissioning VCSEs as providers yielded the policy and services outcomes that the commissioners had initially sought (helping to answer **RQ1, RQ4**).
  - (b) Obtaining healthcare commissions led to the outcomes that VCSEs had initially sought. (helping to answer **RQ2, RQ4**).

We will also consider whether the outcomes that VCSEs and commissioners each sought, the mechanisms that each used, and the contexts required, were mutually compatible (addressing **all four RQs**).

We will analyse any data which do not fit into the above frameworks inductively to reveal any additional patterns with which to supplement or revise those frameworks. As noted, WP2 will compare the study sample with other English CCGs in respect of the characteristics of VCSE commissioning which the routine data cover. On that basis we will assess how far the findings from the systematic comparisons may be generalisable.

Insofar as our sample includes examples of good practice in VCSE-commissioning relationships, it will yield evidence above when, why and in what contexts, any of the potential benefits of VCSE commissioning and co-commissioning occur. That will identify mechanisms and contexts for commissioning VCSEs as providers and for co-commissioning with VCSEs successfully, in terms of current policy and VCSEs' own aims.

By combining the framework and the inductive analyses across the policy outcomes mentioned above, we will formulate thematic findings in ways that are generalisable, both empirically (with due caution) and practically, across other sites. That is, we will use the methods of qualitative generalisation.<sup>43</sup>

### *Critical distance*

WP1 and WP3 would involve VCSE co-researchers and outpost research team members to VCSEs. As precautions against lacking or losing critical distance from the commissioning relationships that we study we propose that:

1. For each study site the WP leads will review and triangulate the co-researcher and outposted researchers' initial findings (in effect, a 'clean room' review).
2. Similarly we will invite co-researchers from other VCSEs to check the emerging findings from each site for face-validity in respect of objectivity and critical distance.
3. We will as far as practicable rotate the RF out-postings. Each RF will spend a period in each of several organisations to reduce the likelihood of 'going native' in just one.
4. In mentoring co-researchers we will include falsificationist methods<sup>44</sup> (including explicitly re-checking data for evidence *against* their initial interpretations and conclusions); fieldwork techniques such as probe questioning; and explanations of cognitive biases known<sup>45</sup> to affect analysis (e.g. availability, confirmation and reporting biases).

## **6 Dissemination, outputs and anticipated impact**

Subject to the PPI Steering Committee's advice we envisage as interim (year 1) outputs:

1. A profile of the practical capacities that commissioners and VCSE members require, and of the key enablers and barriers to the gaining and applying the relevant knowledge.
2. Co-designed work-based learning opportunities, so far as possible to include activities that can be implemented in the study sites during years 2 and 3, and through annual cross-site action learning set workshops. These are routes to implementation and knowledge mobilisation.
3. The evidence base for a paper on patterns of VCSE commissioning in the NHS (WP2).

As whole-project outputs we envisage:

1. Capacity-building by recruiting VCSE members as co-researchers for WP1 and WP3; and by co-designing development intervention to increase VCSE and commissioners' capacity to use evidence (WP4); learning set and annual workshops (WP4).
2. Pithy evidence-based guidance how VCSEs might:
  - (a) Assemble and present evidence likely to help them win and then implement commissions, e.g. by demonstrating their unique contributions as providers.
  - (b) Evaluate their own and other services.
  - (c) Influence and participate in healthcare commissioning.
  - (d) Sustain and develop their distinctive attributes and therefore contributions to the health system, especially in respect of integrated care.
  - (e) Develop social marketing materials to encourage new VCSEs to bid, explaining the benefits and consequences (including risks) of being publicly-commissioned.
3. Final report and consequent academic outputs (conferences; papers; book chapters).
4. Seek joint dissemination (knowledge management, knowledge transfer) activities with other relevant concurrent projects.
5. Any other feasible dissemination activity devised by the PPI Steering Committee.

Authorship and dissemination of the findings will be undertaken only by the researchers themselves.

#### Knowledge mobilisation to NHS, patients and wide population

In ascending order of reach, the routes to knowledge mobilisation to key (i.e. VCSE, commissioner) evidence users will include:

1. Action learning cycles (WP4) have local knowledge mobilisation and implementation built into them. The participants identify 'actions' for practical application (implementation) of existing research findings. Such cycles can continue after the project end.
2. A national feedback and study day organised by the PPI Steering Committee, and open to all VCSEs and other interested organisations.
3. We will offer presentations and discussions of the findings to NHSE and CSUs, focusing on the pithy evidence-based schemas; and national networks of VCSEs

#### *Further funding or support if this research is successful*

Of itself this financially self-contained project will not necessitate further post-project funding. Should healthcare commissioners or VCSEs wish to replicate the developmental component (WP4), we assume that they do so because of the practical and/or financial payback they expect in their particular case.

*Possible barriers for further research, development, adoption and implementation?*

This study does not rely on existing intellectual property. We will publish the project outputs as Creative Commons or similar IP to minimise IP barriers to accessing to our outputs. WP4 will include checking the acceptability and feasibility of the development activity for VCSEs and healthcare commissioners to implement. One possible barrier to uptake of this work is VCSEs' modest resources, although our chosen form of IP will mitigate that. Another is organisational turbulence in healthcare commissioning. Insofar as this study confirms that stable working relationships between healthcare commissioners and VCSEs facilitates the commissioning of, and co-commissioning with, VCSEs, this project may help mitigate the consequences of that turbulence.

*Anticipated Impacts*

1. Impact on practice through implementation in the study sites themselves (see above).
2. Informing healthcare commissioners' selection and commissioning of VCSE providers, e.g. by indicating which methods of commissioning VCSEs are mutually productive.
3. Informing provider development policy, by contributing evidence about (e.g.) which kinds VCSEs appear best qualified for which roles in local health economies.
4. Informing policy for the organisational development of healthcare commissioning.
5. Informing VCSE policy and practice for their own organisational development.

*Dissemination Plan*

There will be three coordinated parallel dissemination streams.

Action learning. This stream disseminates emerging findings from the action learning (WP4) directly to the participating commissioners and VCSEs, and builds their skills and knowledge relevant to commissioning. The final action learning workshop will be used also to devise ongoing activities for disseminating project findings into the wider health system. Milestones:

1. Complete of initial profile of VCSE and commissioner participants (July 2020)
2. First action learning conference (September 2020).
3. First round of development activities (October 2020-September 2021).
4. Second action learning conference (September 2021).
5. Second round of development activities (October 2021-September 2021).
6. Third action learning conference and development of wider dissemination activities (September 2021).

Wider health system. We will offer presentations and discussion meetings via at least the following channels:

1. VCSE conferences and networks, in particular NCVO, Social Care Institute for Excellence, local VCSE guilds (or equivalents), and via the Centre for Health and Social Care Leadership (of which Miller is director.)
2. Local government, including the Local Government Association conference
3. NHS researchers-in-residence (R-in-R) have come forward to participate in the project, and the R-in-R network gives a dissemination route into NHS bodies in many localities (at the time of writing including Manchester, Salford, South Devon)
4. Knowledge translation networks (the AHSNs and ARCs for the study localities, HSR-UK). In the past, NIHR has also organised dissemination events and activities.

Dissemination to the wider health system will be on-going for the duration of project. As milestones we will there ask the PPI Steering Committee to review and advise on this dissemination activity at its relevant meetings i.e:

1. October 2020 meeting (on development work)
2. September 2021 meeting (progress report)
3. August 2022 (findings, dissemination)

We will offer each study site a 'sharing conference' at which the researchers, VCSEs and commissioners can share their findings about best practice, both from this project and from other concurrent activities. (Miller has considerable experience at this.)

Academic and Scientific We will focus on dissemination via journals and conferences which focus on health systems, healthcare organisational research, and third sector research. Conference 'milestones' are set by the conference organisers and (unforeseen Special Issues apart) the relevant journals have no fixed submission deadlines. Aiming to achieve two presentations, we will submit oral presentations in 2022 for the following conferences in the following order of preference:

1. European Health Management Association
2. International Conference on Integrated Care
3. Organisational Behaviour in Health Care

Depending on what findings emerge, we plan within 6 months of the project end to submit papers to such journals as: Nonprofit and Voluntary Sector Quarterly; Social Science and Medicine; Health Policy; International Journal of Integrated Care.

## **7 Project/Research Timetable**

We anticipate the project will take three years because certain aspects of commissioner-VCSE relationships (e.g. building trust, VCSE responses to monitoring) develop and become fully visible only over a whole commissioning cycle. The action learning developmental work in WP4 is a sequential cycle of activities (initial profiling; developing development activities; action learning). The accompanying Gantt chart shows the time-dependencies across the project.

## 8 Project management

Should HSDR accept this proposal, then once the contract is signed we will hold a first PPI Steering Committee as early as feasible (to get their input from the outset), and start the preliminary work, applications for ethical approval and RF recruitment.

Overall project management will be through the PPI Steering Committee. The applicants (and later the VCSE co-researchers) will meet regularly. These meetings will undertake the more concrete day-to-day management and coordination. Each WP has a named lead responsible for completing it and ensuring it provides any interim outputs necessary for the other WPs, ensuing work stages and PPI activities. The same applies to PPI activity. We will coordinate our work with the other projects mentioned under 'Exclusions' above, and with the complementary project that Mohan et al. are proposing should HSDR fund that proposal too.

## 9 Ethics

We will obtain HRA ethical approval for fieldwork involving NHS staff and premises, and informants who are NHS patients. For other individuals, organisations and sites we will seek university and (as necessary) local authority research ethics approvals. Any resulting changes to this protocol will be communicated to the research sponsor. The researchers declare that they have no, and no seeming, conflicts of interest in this study.

## 10 PPI

As the most relevant public and patient constituency, PPI in this proposal focuses on VCSEs that represent and consult patients, and/or provide NHS-funded services.

### Preparing this proposal

PenPIG (SW Peninsula CLAHRC Patient Involvement Group), HEPE (Healthy Environment Public Engagement), the Greater Manchester Transforming Care board, National Voices (Jeremy Taylor), Dimensions, and individuals working in hospices contributed to the project foci and design. HEPE added: 'Just to say, the group is really interested in social prescribing, so it should be a productive discussion.' Discussions with VCSE members since stage 1 have resulted in adjustments to our research questions, the list of potential negative and positive consequences of commissioning VCSEs, proposed sample and the possible barriers and risks. Three consultees have put themselves forward for the PPI Steering Group. Our costings include the PPI activities below.

### Patient and Public Participation in the Research Activity

#### *PPI Steering Committee*

We will establish a PPI Steering Committee chaired by independent person (Jeremy Taylor of National Voices has agreed in principle) to oversee PPI work and participate as below in the research itself. We will invite:

- A majority of members from VCSEs which represent or advocate patient interests, including a VCSE which has struggled to win contracts.

- Patient representatives recruited via the Birmingham and Plymouth research development services, and/or through care group experts for the tracer groups.
- Individual experts including Victor Adebowale, Stewart Hetherington (NCVO), Juan Baeza.
- Researchers from the other projects with whom we will liaise (see above).
- A care group expert from each of the focal care groups.

We anticipate about 12 of the 18 or so members being patients and/or from VCSEs. We will assist them to travel to meetings (as INVOLVE recommend), provide materials in alternative formats where needed (e.g. large print). We will establish the Steering Committee early (see flowchart) so that they can help shape the research questions, methods and sample. We will hold further meetings shortly before each main stage of work (site selection; start fieldwork; start analysis; produce outputs), inviting the members to suggest and contribute to:

1. Any necessary 'in-flight' amendments to research questions and design.
2. Identifying relevant existing instances of good practice, study sites, data, data sources and access.
3. Sense-making and analysis of the data, including reality-checks of findings and recommendations.
4. Co-producing the outputs below and dissemination activity.
5. Giving the outputs impact: testing, translation and transmission to VCSEs and networks (e.g. Guilds) likely to use them.

The PPI representatives will contribute output production and dissemination as a distinct project phase after the final report.

#### *VCSE Co-researchers*

We will recruit an individual VCSE member from each case study site as a co-researcher, starting from Steering Committee nominations. This use of 'research intermediaries', similar to 'researchers in residence'<sup>46</sup>, is intended to address the reported problem that lack of time, skills and resources, and the acontextual nature of some research, are in many VCSEs barriers to research use.<sup>2,47</sup> We aim to move away from a 'linear' towards a 'relationship' or (preferably) 'systems model'<sup>48</sup> that engages with VCSEs' own motivations for exploiting research.

These co-researchers would participate as equals in the research, so that they and their VCSEs can 'learn by doing' evidence-basing and research with career researchers. We will select the co-researchers for their ability to do so which, subject to the initial findings from WP4, we anticipate may include experience in providing VCSE services and dealing with commissioners; willingness to participate in action learning sets and the tasks that follow; and ability to deal with commissioning documents (specifications, application forms etc.). Nevertheless, individuals with these abilities may also require support to participate as co-researchers. Again subject to the first year findings from WP4, we anticipate offering them training and mentorship in:

1. Good data-collection practice (open vs. closed questioning; non-leading questions; checking for counter-evidence; awareness of sources of bias etc.).

2. Finding out from potential commissioners (and elsewhere e.g. other VCSEs) what information a credible bid has to contain, obtaining it and assembling it into a bid.
3. What monitoring data commissioners are likely to require, and how to gather, interpret and present it.

Mentoring will be one-to-one on a 'buddy' basis to give informal besides meeting-based contact. We will also run three (annual) cross-site action learning workshops which will provide further peer-to-peer mentoring. JC, ME, RMa, RMi and RS are experienced health-worker developers.

## 11 Project Expertise

The project requires, and the research team offers, the following expertise and contributions:

- ◆ Allen: Expertise on contracts, legal bases of VSCEs. Background in economics, with access to economics expertise at LSHTM. Liaison with PruComm's research on commissioning. Contributions to WP1 and WP3.
- ◆ Asthana: Expertise on particular VSCEs; researchers in residence; relationship between VSCEs and NICE guidance (as NICE Board member); health policy. Leads the evaluation of the social prescribing network in Cornwall. Contributions to WP1, WP3.
- ◆ Clark: Expertise on sociology and healthcare staff development. Lead for PPI, contribution to WP4.
- ◆ Exworthy: Expertise on health policy, geographical dispersal of health services, governance. Lead for WP3.
- ◆ Gibson: Expertise in quantitative and geographical analyses of health service use, resourcing and funding formulae. Lead for WP2.
- ◆ Mannion: Expertise on healthcare quality and economics of organisations. Contribution to design, data collection and interpretation of results across all four WPs.
- ◆ Miller: Expertise on commissioner – voluntary sector relationship, including health and social care integration, and practical developmental support for commissioners and VCSEs. Leads WP4. Liaison with other research projects on the third sector.
- ◆ Sheaff: Expertise on commissioning, ownership differences in healthcare organisations, primary care integration, evidence-basing in organisations. Background in NHS management. Role: Overall management. Lead for WP1, contribution to PPI.
- ◆ 2 Research Fellows: to be appointed. One at Plymouth, one at HSMC Birmingham. Arrange and undertake fieldwork; extract, clean, collate and help analyse data. Exworthy and Mannion will supervise the Birmingham RF, Asthana and Sheaff the Plymouth RF.

All the team will contribute to data analysis, synthesis of findings, writing-up, dissemination, supporting and mentoring VCSE co-researchers, and knowledge mobilisation.

## 12 Success criteria and barriers to proposed work

Success criteria will be engagement of the above range of VCSEs and commissioners in researching and developing the commissioning of, and co-commissioning by, VCSEs; producing

and disseminating the above-listed outputs; academic and scientific studies (published papers) on third sector organisations and commissioning them in the health sector; and uptake of project findings and/or developmental activities outwith and after the project itself.

An anticipated barrier is the difficulty of research access to sampled commissioners during times of NHS organisational turbulence. To mitigate this problem we will maintain a 'reserve list' of replacement commissioner study sites. Commissioners and VCSEs often fail to understand each others' different perspectives, making it necessary to convince them that the effort of developing learning activities will benefit both sides. To address this barrier WP4 will start by inviting both sides to identify potential benefits first, then work back to co-design the development activities accordingly. Lastly, we will mitigate the potential of our sample VCSEs being unable to supply suitable co-researchers by having a 'reserve list' of sample sites. In the worst case however the scientific, as opposed to the PPI, aims of the project (WP1,WP2, WP3) could be achieved without any co-researchers at all, as could the developmental aims of WP4.