

BMJ Open

What do external consultants from private and not-for-profit companies offer healthcare commissioners? A qualitative study of knowledge exchange

Journal:	<i>BMJ Open</i>
Manuscript ID:	bmjopen-2014-006558
Article Type:	Research
Date Submitted by the Author:	05-Sep-2014
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Primary Subject Heading:	Health services research
Secondary Subject Heading:	Health policy
Keywords:	Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Organisation of health services < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

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6 What do external consultants from private and not-for-profit companies offer
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8 healthcare commissioners? A qualitative study of knowledge exchange
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51
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55 5 key words: knowledge exchange, external provider, private sector, commissioning
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Word count: 5,469

For peer review only

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ABSTRACT

Objectives: The use of external consultants from private and not-for-profit providers in the NHS is intended to improve the quality of commissioning. The aim of this study was to learn about the support offered to healthcare commissioners, how external consultants and their clients work together and the perceived impact on the quality of commissioning.

Setting: NHS commissioning organisations and private and not-for-profit providers

Design: mixed methods case study of eight cases

Data collection: 92 interviews with external consultants (n=36), their clients (n=47) and others (n=9). Observation of 25 training events and meetings. Documentation e.g. meeting minutes and reports.

Analysis: Constant comparison. Data were coded, summarised and analysed by the research team with a coding framework to facilitate cross case comparison.

Results: In the four contracts presented here, external providers offered technical solutions (e.g. software tools), outsourcing and expertise including project management, data interpretation and brokering relationships with experts. In assessing perceived impact on quality of commissioning, two contracts had limited value, one had short term benefits and one provided short and longer term benefits.

Contracts with commissioners actively learning, embedding and applying new skills were more valued. Other elements of success were: (i) addressing clearly agreed problems of relevance to managerial and operational staff (ii) solutions co-produced at all organisational levels (iii) external providers working directly with clients to interpret data outputs to inform locally contextualised commissioning strategies.

Without explicit knowledge exchange strategies, outsourcing commissioning to

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3 external providers resulted in the NHS clients becoming dependent on the external
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5 provider.
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8 Conclusion

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11 NHS commissioning will be disadvantaged longer term if commissioners both fail to
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13 learn in the short term from the knowledge of external providers and in the longer
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15 term lose local skills. Knowledge exchange mechanisms are a vital component of
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17 commissioning and should be embedded in external provider contracts.
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STRENGTHS AND LIMITATIONS OF THIS STUDY (5 points in total)

- This is the largest study of the use of external consultants to support healthcare commissioners in England post-Health and Social Care Act 2012.
- This study illuminates the potential benefits and challenges in using external expertise in commissioning.
- Case study results can offer substantial, information rich accounts of the role of external providers and assess their perceived impact on commissioning decisions. But case studies cannot assess the actual impact on commissioning and are not statistically generalisable. However findings are transferable to similar settings.
- Perhaps because the research team were overly associated with external consultants, we obtained fewer accounts from NHS clients. Recruiting another not-for-profit would have further augmented comparative analyses.
- This study emphasises the importance of taking steps to improve knowledge exchange between external providers and their NHS clients to gain the greatest benefit from these types of contracts.

INTRODUCTION

Healthcare commissioners plan services and allocate funding to meet the needs of specific populations in England. Over two decades, commissioning (or 'purchasing' as it was originally known) has taken different organisational forms, including Health Authorities, Primary Care Groups, Primary Care Trusts (PCTs) and now Clinical Commissioning Groups (CCGs). There are many definitions of 'commissioning' [1]. An early, simple conceptual framework by Øvretveit et al used the Plan-Do-Study-Act model to illustrate commissioning activities [2]. The Department of Health has developed a more complicated model which includes assessing needs, designing services and managing demand and performance [3]. Gradually, commissioning has become both more complex and better understood.

A growing body of evidence suggests that commissioning is "messy, fragmented and largely accomplished in meetings" [4] with progress made through "bite sized pieces of work" [5]. Moreover, commissioning is challenging and difficult to do well, regardless of whether the healthcare system is English, European or American [6]. In 2007, World Class Commissioning was introduced in the NHS [7] along with FESC (Framework for Procuring External Services for Commissioners) which authorised commercial providers to work with commissioners [8]. With the advent of the Coalition government in 2010, FESC was dissolved but the Lead Provider framework for commercial and other external providers such as commissioning support units has taken its place [9]. The assumption with all these initiatives is that use of external providers will lead to higher quality commissioning [8 10]. However, despite an estimated £308.5 million received by external management consultants from the

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3 NHS in 2007-2008 [11], there remains scepticism about the benefits of using these
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5 services. For example a *Health Service Journal* survey of 93 senior commissioning
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7 directors found that nearly half thought that commercial consultants would make only
8
9 a “little” difference [8].
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16 Nonetheless, the terrain for external provision in the NHS has become even more
17
18 favourable. The White Paper *Liberating the NHS* [12] and the Health and Social Care
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20 Act 2012 that followed were predicated on the assumption that “individual creativity
21
22 and innovation is best supported by competition” [13]. Competition in healthcare
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24 services was intended lead to greater patient demand for innovative treatments
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26 which, in turn, would ensure that individuals live longer and healthier lives. However,
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28 a recent editorial on the impact of market based reforms concluded that current
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30 research “offer[s] remarkably similar conclusions about the limited potential of
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32 markets in health and social care to deliver aspirations for improvements in both the
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34 quality and cost of care”[14]. In contrast, preliminary findings from other studies
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36 featured in a recent Nuffield Trust report suggest cautionary optimism [15].
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44 Despite the lack of clarity, there continues to be a policy push to use private
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46 providers in the NHS. Although the primary focus of the 2012 Act may have been
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48 increasing competition amongst healthcare providers such as acute hospitals,
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50 commissioning has also been affected, creating a fragmented healthcare landscape
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52 with commercial companies, not-for-profit agencies, social enterprises, voluntary
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54 sector bodies, commissioning support units, freelance consultants and public health
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3 professionals, all vying to improve and influence commissioning by supplying
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5 commissioners with information, advice and support.
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11 A single case study of a collaboration between a commercial provider and
12
13 commissioning organisation has been reported in the literature. It found “strong
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15 relationships” and “high levels of trust” between the commissioners, commercial
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17 provider and healthcare provider [16]. In addition, a survey with 172 responses from
18
19 commissioners found good levels of satisfaction, with most rating their contracted
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21 commercial providers as ‘good’ or ‘excellent’ [17]. Yet the controversy around
22
23 external providers persists, particularly commercial companies. The aim of this study
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25 was to contribute to the debate by understanding how commissioners and external
26
27 providers work together, the processes of knowledge exchange and the perceived
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29 impact on commissioning decisions.
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37 **METHODS**

38 **Study design**

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40 We selected a mixed methods case study approach, as appropriate for exploratory
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42 questions in a real-life context, where there are few opportunities to control events
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44 and settings [18]. This study received ethical permission from South West Ethics
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46 Committee 2 (10/H0206/52).
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55 **Case site selection**

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3 We recruited two commercial providers and one not-for-profit agency. The first
4 provider approached a competitor on our behalf, following 'snowball' sampling
5 recruitment, which is an accepted feature of ethnographic research [19]. This
6 competitor became the second commercial provider under study. A not-for-profit
7 company was approached and then recruited to contrast commercial and not-for-
8 profit providers.
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20 To preserve anonymity, we will use the term 'external provider' to mean both
21 commercial and not-for-profit for the organisations studied. Using pseudonyms, the
22 external providers were:
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- 26 • Heron – a multi-national with a suite of software tools and mixed expert UK/
27 non-UK staff, offering analytics and project management.
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- 29 • Jackdaw – a small, international company offering one software tool.
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- 31 • Swallow – a national company with a suite of software tools staffed largely by
32 ex-NHS personnel offering analytical and commissioning expertise.
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39 Each external provider was treated as a case. An additional case study was drawn
40 from a sub-contract within the Swallow data, making four external provider cases.
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47 To access the views of NHS commissioners, we recruited four commissioning
48 organisations that had contracts with at least one of the external providers. Using
49 pseudonyms, these were:
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- Carnford CCG - struggling financially, highly collaborative with its healthcare 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.

At the close of fieldwork, we had eight case studies between external providers and commissioning organisations. We were specifically interested in contracts with a significant knowledge exchange component at various stages e.g. beginning, middle and post-contract. Some commissioning organisations had contracts with more than one study provider, for example Norchester worked with both Swallow and Jackdaw and some contracts included commissioning organisations other than Carnford, Deanshire, Norchester and Penborough.

Data collection

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3 We collected interview, observation and documentary data from February 2011 to
4
5 May 2013. Data were collected by LW and EB, who are experienced qualitative
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7 researchers.
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10 11 12 13 Interviews

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16 For each external provider, we first interviewed senior leaders (Chief Executive or
17
18 Directors). Through snowball sampling, we identified other candidates for interview
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20 with relevant knowledge or experience of the external provider and/or contract. For
21
22 Swallow and Jackdaw, the research team independently approached candidates,
23
24 usually by e-mail. For Heron, interview requests from the research team were co-
25
26 ordinated by a Heron consultant. For the commissioning organisations, we
27
28 interviewed the lead NHS contact for the contract (usually identified by the external
29
30 provider) and employed snowball sampling to identify other candidates, including lay
31
32 representatives, local councillors, freelance and commercial consultants from other
33
34 companies. Two NHS healthcare commissioners and one external consultant
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36 declined to be interviewed, while several others did not respond to requests.
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46 Candidates were sent information before interviews and consent was obtained at
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48 interview. Following initial conversations with commissioners and external providers,
49
50 the research team devised a topic guide. It covered type of knowledge wanted by
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52 commissioners, information sources, how information was accessed and influenced
53
54 decisions. The topic guide was revised as new questions emerged. Interviews were
55
56 face to face or by telephone, depending on the preference of the participant and
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3 practicalities. Lasting 20-60 minutes, all interviews were recorded and transcribed by
4
5 an external transcriber.
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11 Data saturation was reached with larger external providers when over 15 external
12 consultants were interviewed. As a small company, Jackdaw's consultants were all
13 interviewed. Data saturation for commissioning organisations was reached when
14 about half of the relevant stakeholders with direct experience of the contract were
15 interviewed, although this proportion had not been predetermined. In total, we
16 interviewed 92 participants including 47 NHS clients, 36 external provider
17 consultants and nine others (e.g. freelance consultants, lay representative). (Table 1)
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27
28 Table 1 Interview participants
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Professional role	Number of participants
NHS	
Managerial commissioner	17
Clinical commissioner	15
Analyst	9
Other NHS	6
Total NHS	47
EXTERNAL	
Commercial/ not for profit consultants	36
Freelance	3
Public health	4

Local authority	1
Lay representative	1
Total external	45
TOTAL STUDY	92

We conducted 25 observations of meetings between external consultants and their NHS clients, external provider and commissioner team meetings and training events. Permission was obtained verbally before attending events. Observation notes were taken with the help of an aide memoire based on the research questions and included details of participants, room layout, verbal exchanges and researcher reflections. Notes were typed up as soon as possible after the data were collected. All interview and observation participants were given pseudonyms. Meeting minutes, reports, website and marketing material, press releases and e-mails were collected and fed into the case summaries. These supplemented, confirmed and challenged emerging findings from interview and observation data.

Data analysis

Although not discussed explicitly in this paper, the notions of the 'social life of information' [20], 'communities of practice' [21], 'mindlines' [22] and 'organisational sense-making' informed our analysis [23]. Constant comparison methods guided analysis, whereby data were compared across categories, continually refined and fed back into data collection (and analysis) cycles [24]. The study team met regularly to identify emerging themes, reflect on the research questions and suggest any possible new questions for the topic guide throughout fieldwork. In May 2013,

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2
3 fieldwork came to a close and team members (EB, LW and AC) developed a coding
4
5 framework based on the research questions, which was applied by both EB and LW.
6
7 Using NVIVO software, we systematically coded cases and developed 20-50 page
8
9 case summaries for each case structured around five domains, four of which came
10
11 from the original research questions (external providers, knowledge accessed,
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13 knowledge transformation, benefits/disadvantages) and one of which emerged from
14
15 the data (models of commissioning). Every member of the research team read these
16
17 summaries independently and conducted cross case analyses, identifying key
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19 themes common to the cases and discrepant data. The team then met to finalise the
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21 agreed key themes.
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29 **Challenges**

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32 Few previous studies have recruited commercial or not-for-profit consultants working
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34 in the NHS. Challenges included research governance, as external consultants
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36 moved freely and quickly around NHS organisations while researchers adhering to
37
38 research governance could not. We wanted to shadow external consultants, but
39
40 many had concerns about client sensitivities so we relied on observation of training
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42 events and larger meetings. Concerns were also expressed about patient data
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44 confidentiality, despite local R&D permissions. Nonetheless, the general enthusiasm
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46 and willingness of external consultants to participate in this study was noteworthy.
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53 **RESULTS**

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3 The core themes that emerged in determining what external providers offer were: (i)
4 technical transfer (e.g. software tool training, operation and application), (ii) expertise
5 (e.g. knowledge and skills in project management and analytics) and (iii) outsourcing
6 (e.g. taking over commissioning teams/ units wholesale). They were also engaged
7 for their 'big picture' perspective, potential to challenge local stakeholders,
8 knowledge from international and national sources and new approaches to recurrent
9 problems. The following vignettes, which sometimes depict entire contracts and
10 sometimes just one work stream, illustrate what external providers offered, how
11 commissioners and external providers worked together and their perceived impact.
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27 **Vignette 1: A technical solution – but what's the problem?**

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29 The external provider in this vignette was imbued with 'public sector values', as the
30 dissemination arm of an academic institution. Marketing a software tool to identify
31 those at higher risk of using healthcare resources, this external provider worked in
32 partnership with other for and not-for-profit companies to reach clients, sometimes
33 via academics.
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41 *It's often that the academicians (sic) through publications, through*
42 *presentations and conferences and so on, that proves the [tool's] viability*
43 *within a particular country or setting, and demonstrates its value. And then the*
44 *government gets – you know – it gets their attention. (External consultant,*
45 *Katie)*
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3 After a six month needs assessment, this software tool was selected by a team of
4 senior information managers acting on behalf of a consortium of commissioning
5 organisations that wanted to “club together and think about how they could do
6 commissioning in a more effective way” (NHS information manager, Shauna).
7
8 However once the tool was fully deployed (about three years after the original needs
9 assessment exercise), the procurement team realised that the basic training for the
10 tool offered by an intermediary external provider was insufficient. They contracted
11 the tool developers directly to deliver advanced training.
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24 The training by the tool developers was delivered by experts from North and South
25 America, with little understanding of the NHS, to seven NHS clients of diverse
26 backgrounds (analytics, primary care commissioning, project management) via
27 webinars. The training was almost entirely technical, which was appreciated by
28 healthcare analysts who confidently applied their new knowledge in novel ways, for
29 example using the software tool to allocate general practice budgets. But technical
30 knowledge alone was insufficient for some NHS clients. For example, a primary care
31 commissioner talked about how they had not “chosen” but were “given” the tool, and
32 then had to find an application. Another client talked about the difficulties in
33 contextualising tool outputs to local circumstances without a data interpreter and a
34 clear strategy from senior NHS managers about how the tool should be used.
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50 *I think what would be really useful is somebody from [external provider] to*
51 *work with the strategic [commissioning] lead and maybe myself to actually*
52 *think about the best way to use it to get the maximum results. So do we just*
53 *look at COPD? Do we look at diabetes? Is there something that we can do*
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3 *with the tool that would give us a really quick win? (NHS project manager,*
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5 *Kourtney)*
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8 Overall at the time of fieldwork, use of this tool had had limited impact on informing
9
10 commissioning, although it was early days as training was ongoing. The lessons
11
12 from this vignette are that technical ‘solutions’ can only solve clearly identified and
13
14 recognised problems. Moreover, translators who can interpret data outputs are
15
16 necessary and maximising those outputs relies on external providers, analysts and
17
18 commissioners working together.
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25 **Vignette 2: A new approach to a recurrent challenge**

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28 The external provider in the second vignette also offered technical transfer through
29
30 software tools. With one tool, clinical reviewers compared patients’ notes to a set of
31
32 standards based on expert consensus on ‘best place of care’ (i.e. hospital or
33
34 community based). Patients either ‘qualified’ to be in their current setting or did not.
35
36 At the instigation of commissioners, two audits using this tool were carried out for an
37
38 acute trust, as a way of identifying unnecessary hospital admissions.
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46 The first audit was entirely conducted by external consultants in autumn 2010 and
47
48 was described as a “disaster” (Medical Director, Hugh). Many patients were
49
50 identified as ‘not qualifying’, a finding contested by the hospital, which placed further
51
52 strain on already difficult relationships between the commissioners and hospital.
53

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55 Nine months later, after the shortcomings of the first audit had been agreed, a
56
57 second audit took place in summer 2011, carried out this time by five local reviewers
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3 from the hospital, community provider and commissioning agency. Local reviewers
4 initially learnt how to use the tool during a two day training session and then that
5
6 learning was augmented and consolidated through experiential application of the tool
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8 during data collection, with external consultants on hand acting in an advisory
9
10 capacity. Interestingly, the proportion of patients 'not qualifying' in the second audit
11
12 (24%) was almost the same as the first audit (28%), but local ownership meant that
13
14 the second audit results were more readily accepted
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22 The NHS clients found the second audit "very useful" (NHS information manager,
23 Joan), but not because the tool gave much insight into unnecessary hospital
24 admissions. Rather through joint data collection with daily de-briefing sessions
25
26 chaired by the hospital medical director, professionals from different care sectors
27
28 learnt more about each other's norms and challenges and developed better working
29
30 relationships. The hospital team also learnt to think differently about the challenges
31
32 of reducing hospital admissions (i.e. from the perspective of where the patient is best
33
34 placed).
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41 *I think the whole question of looking at admissions and what was required,*
42 *and what services could be put around it, is one that is so obvious that*
43 *actually we weren't thinking about it.... And so by modifying that concept I*
44 *think we will learn a lot and gain a lot. So I think they [external provider] did*
45 *bring that. (Medical director, Hugh)*
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3 Further audits using the same method (but not the software tool) were conducted in
4 other hospital wards, but the commercial provider was not involved. Several months
5 after the second audit, we received an e-mail stating that the results had not fed into
6 any commissioning decisions but that the ensuing local relationships were highly
7 valued. The lesson from this vignette was that where possible, external providers
8 could helpfully ensure that the work is conducted by clients, so that the clients take
9 ownership and skills are more easily transferred.
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22 **Vignette 3: “Going from good to great”**

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25 In addition to contracting external providers for their technical offer, as illustrated in
26 the previous two vignettes, external consultants were also engaged for their
27 expertise in project management. The NHS commissioning organisation involved in
28 this vignette was “trying to go from good to great as a commissioner” (Carol, NHS
29 commissioning manager), so one of external provider’s numerous work streams was
30 to carry out a set of activities to help their NHS clients prepare for a ‘World Class
31 Commissioning assurance day’.
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45 As part of this process, the external providers carried out a ‘gap analysis’, based on
46 the World Class Commissioning competencies, where they challenged their NHS
47 clients to “*demonstrate that you actually do that. Give me the tangible evidence*”
48 (Helen, external consultant). Other activities included identifying experts in
49 commissioning to visit the client site, setting up visits to other NHS commissioning
50 organisations, engaging local clinicians and providing project management training
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3 and tools. The external consultants sought to complement the client's strengths, and
4
5 a commissioning manager spoke about some of the processes used:
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8 *They often brought people in, drafted people in from [North America] to talk to*
9
10 *us about ideas that we were having. So quite often we'd have ideas or they*
11
12 *would suggest ideas to us about what we could do locally, and they would*
13
14 *expand and build on that, and come back with a rounder package, which we*
15
16 *would then test out.* (Sarah, NHS commissioning manager)
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23 The culture within the NHS client organisation prioritised collaboration, innovation,
24
25 transparency and engagement. This may have fostered the strong relationship they
26
27 developed with the external consultants, who commented on how this had gone
28
29 beyond developments with other NHS clients, where external providers were
30
31 sometimes perceived as a threat. The consultants described the client
32
33 commissioners in terms of Belbin's team roles, which the external providers
34
35 deliberately complemented [25].
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39 *So they were the plants and shapers, but they weren't the completer finishers.*
40
41 *I would say that that was evident when we were working with them, that they*
42
43 *had a huge amount of ideas. Lots of shaping, lots of meetings, huge meeting*
44
45 *culture, and then the actual discipline of completing it and measuring it was*
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47 *not there.* (Patricia, external consultant)
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3 The main challenges raised by both sides were those of defining what work was
4 needed, and how to ensure that work from the World Class Commissioning work
5 stream and others remained relevant.
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10 *Over the two year period the world changed around us, so we ended up*
11 *having to reset what it was that we needed from them several times. And I'm*
12 *sure you can appreciate that that takes – it's a little like a juggernaut, isn't it? -*
13 *it takes turning around and renegotiating, for them and us, of what was*
14 *needed, and finding out that something different was needed, and putting that*
15 *into place, meant things stalled several times along the way. (Carol, NHS*
16 *commissioning manager)*
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30 The NHS client achieved their goal by being rated amongst the top five English
31 commissioning organisations. Most NHS participants were pleased with this result,
32 although subsequently a few queried whether this had been worth the cost. The
33 lesson in this vignette is that good levels of knowledge exchange is possible when
34 client organisations are ready and willing to work with external providers who, in turn,
35 are adaptable and complement (rather than replace or duplicate) the commissioners'
36 skills.
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49 **Vignette 4: 'Data driven' commissioning**

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52 Although external providers in this study mainly offered technical solutions and
53 expertise, there was one example where commissioning had been completely
54 outsourced. The external provider managed all aspects of the contracts of a group of
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3 hospitals worth over £100 million, which were described as “very expensive and
4
5 quite difficult to control” (Joel, external consultant).
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11 The external provider perceived the NHS as driven by politics and people rather than
12 by data, whereas their own ethos was to “use data to drive decision making”
13 (Kristen, external consultant). The external team consisted of a programme
14 manager, administrators and “lots of analysts”, who undertook “forensic investigation
15 of the data”, mainly by finding errors in coding leading to over-charging (Joel,
16 external consultant). Nurses, with essential clinical knowledge, were also placed in
17 hospitals to verify patient notes against invoices, as commissioners had limited ways
18 of checking the accuracy of claims. The approach the external provider took with
19 healthcare providers was confrontational.
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32 *[We said]...“If you don’t supply us with this data, we can’t validate our patient*
33 *activity, therefore we are not going to pay for it.” So [a] slight – at times, very -*
34 *antagonistic approach. (Dennis, external consultant)*
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39 In an attempt to reduce hostility, a NHS commissioner was seconded for one year to
40 improve relationships between the external provider, the NHS hospitals and local
41 commissioning organisations mid-contract. During fieldwork, several participants
42 noted that relationships were better, partly due to this intervention.
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52 Analytical expertise and good quality data were highly valued by this external
53 provider to inform decision making. The ‘standard’ team they offered consisted of an
54 analyst, project manager and clinical lead in contrast to the NHS, where analysts,
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3 commissioning managers and clinicians tended to work separately in silos. A NHS
4
5 client said this analytical support was vital and that the external provider did “the
6
7 basics really well” (Jacob, NHS commissioning manager). This resulted in savings
8
9 estimated as over a million pounds.
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15 Initially the draft contract had included a knowledge translation strategy so that a
16
17 NHS team could develop these analytical skills. But this clause was eliminated by
18
19 the NHS client to reduce contract costs. This contract was repeatedly renewed. As a
20
21 result, by 2019, the external provider will have operated this outsourced
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23 commissioning service for 10 years with no mechanisms in place to develop skills
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25 within the NHS. The lesson from this vignette is that if clients and external providers
26
27 do not agree knowledge transfer strategies within the contract to the NHS client
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29 organisation or other external providers such as commissioning support units, the
30
31 client is likely to end up reliant on support from one external provider long term. This
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33 creates a monopoly, which is at odds with both the competitive thrust of the 2012
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35 Health and Social Care Act and which also, importantly, undermines the influence of
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37 local clinical intelligence that the government has stated should be at the heart of
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39 commissioning.
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48 **DISCUSSION**

49 **Principal findings**

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52 External provider involvement was intended to improve the quality of commissioning.
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56 To achieve this, external providers offered technical applications, expertise and
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3 outsourcing. The impact of the contracts illustrated in these vignettes was shaped by
4 the original objectives of the contracts and the expectations and ability of external
5 providers and client organisations to meet those objectives (which may have been
6 over-optimistic). We recognise that the 'success' or failure of these contracts is multi-
7 dimensional and can be understood in the short and long term. With this in mind, we
8 suggest that these vignettes show that external providers were only partly
9 successful in improving the perceived quality of commissioning, largely because the
10 knowledge exchange interactions between external providers and NHS clients were
11 limited. The use of external providers proved problematic in several ways.
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27 Vignette 1 illustrated that access to a software tool and technical training was
28 inadequate; external providers needed to supply translators who could interpret the
29 data, work with clients to contextualise outputs and help identify ways to use the
30 outputs to inform commissioning decisions. Without this, the software tools did not
31 address genuine problems currently being experienced, because of changes since
32 initial procurement and insufficient consultation with operational staff. There was also
33 a split between the senior management agenda and those expected to operate or be
34 informed by the tools. Contracts with external providers co-produced by all the
35 actively interested parties may have a greater chance of success. If not, the tools
36 can become a time consuming problem in their own right.
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53 Vignette 2 emphasised the importance of clients undertaking the work themselves,
54 such as audit data collection, rather than relying on external providers. But often
55 NHS participants reported limited time or capacity, especially following the launch of
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3 *Liberating the NHS*, which led to the departure of many experienced commissioning
4 staff. Transferring skills and knowledge to clients may appear to undercut future
5 procurement of external providers, but conversely may increase trust and perceived
6 usefulness, which could improve the prospects of repeat business. This vignette
7 highlighted another key point, mainly that the impact from contracting the external
8 provider had unanticipated benefits such as adoption of an innovative method (but
9 not the product itself) and the serendipitous mending of previously fractured
10 relationships amongst local healthcare organisations that needed to work together.
11 In Vignette 2, participants found these outcomes more useful than the direct input of
12 the external provider, which was described as of little value.
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29 Vignette 3 was an example of what commissioners and external providers could
30 achieve together - if healthcare clients at all levels were genuinely willing and ready
31 (which may not be the case). The external provider adapted their expectations to fit
32 clients' reality and negotiated mutually acceptable understandings and timeframes.
33 Moreover, the external consultants complemented their NHS clients by matching
34 consultant 'completer/ finishers' to client 'blue sky thinkers'. In allocating external
35 consultants to clients, these less obvious characteristics received careful thought
36 during procurement. The clients also learnt useful new skills such as ways of
37 measuring the impact of their commissioning activities. Overall, this contract
38 appeared to meet clients' expectations.
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55 Vignette 4 was undoubtedly a short term success in financial savings to the NHS, but
56 not in longer term improvement in the perceived quality of commissioning amongst
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3 the NHS clients. This finding cautions both external providers and their NHS clients
4
5 to value and make provision for explicit knowledge transfer mechanisms, as the NHS
6
7 clients ended up dependent on the external provider's increasing monopoly of skills,
8
9 the potential benefits through skilling local staff were not realised and longer term the
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11 role of local clinical intelligence was diminished. Given that the success of this
12
13 contract was largely due to the significant input of analysts, finding ways of cross-
14
15 pollinating analytical, clinical and managerial expertise through the use of 'standard'
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17 teams consisting of professionals from each group may help bring about more 'data
18
19 driven' commissioning in the NHS, reducing dependency on external providers.
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27 **Strengths and weaknesses**

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29 This is the largest study of commercial and not-for-profit providers and healthcare
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31 commissioners following the 2012 Health and Social Care Act. These external
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33 providers permitted substantial access and provided a comprehensive view of their
34
35 work, although we note that perspectives from NHS clients, especially operational
36
37 analysts and commissioners, were difficult to obtain. We recognise that entering the
38
39 field via the commercial provider may have affected NHS recruitment and we would
40
41 have liked to recruit more 'negative' cases from one commercial provider, who
42
43 steered us away from less successful contracts. However, ample data was collected,
44
45 both positive and negative, to create coherent case studies, which provide
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47 conclusions based upon carefully collected and systematically analysed data.
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56 **Relevance of study with regards to wider literature**

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3 There is scant literature on use of external providers in the NHS. A study published
4 before the Health and Social Care Act 2012 concluded that commissioners did not
5 always use external support from commercial providers to its full potential, which our
6 study confirms [17]. We found factors contributing to success included building
7 effective working relationships, which were partial in Vignette 1 and absent in
8 Vignettes 2 (hospital audit) and 4 (data driven commissioning). The importance of
9 trust and good working relationships was also identified in a post-2012, single case
10 study of collaboration between clinical commissioners and external providers [16]
11 and in a recent study of commissioning support units (Petsoulas et al, submitted to
12 BMJ Open). In fact, this latter study concluded that good quality internal relationships
13 are so important to commissioners, that in commissioners' determination to forge
14 these relationships, they are bringing analysts back into CCGs. This directly
15 challenges current governmental policy on competition.
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36 Although the literature on use of external consultants in the English NHS is sparse,
37 an impressive, instructive body of literature exists on the use of commercial
38 consultants in the private sector. For example, a study of commercial consultants in
39 the Canadian telecommunications industry found that the single most important
40 factor of success was the willingness of commercial companies to adapt to "client
41 readiness" [26], which was evident in Vignette 3 where commissioners at all levels
42 were highly motivated to improve their World Class Commissioning rating. Another
43 Canadian management academic put forward six propositions for successful
44 engagement including a clear agreement concerning requirements and expectations,
45 which was missing in Vignettes 1 and 2 where the NHS operational staff did not co-
46 produce or contribute to the contract at the procurement stage. A further marker of
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3 success was a good fit between consultant and client, including consultant type [27],
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5 which was present in Vignette 3 (e.g. allocating 'completer/ finishers'). However
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7 despite the prevalence of this literature, and other relevant studies, once again we
8
9 note that the findings of research have made a limited impact on policy and practice
10
11 within public services [28]. As contracts with external consultants become more
12
13 widespread, drawing this literature to the attention of both external providers and
14
15 healthcare commissioners who are using external support will become more
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17 imperative.
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20 21 22 23 **CONCLUSION**

24
25 A major goal of the Health and Social Care Act 2012 was to introduce multiple types
26
27 of external providers to increase competition with the assumption that this leads to
28
29 improved quality of commissioning. This assumption is problematic, as the impact of
30
31 competition on healthcare has yet to be clarified, even with regards to service
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33 provision, which is where this embryonic research field has focused to date [14 15].
34
35 Much less is known about the impact of competition on commissioning. But even if
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37 competition were likely to improve the quality of commissioning, our study suggests
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39 that the right elements may not be in place to optimise any such benefits.
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48 Several features were crucial to achieving positive impacts from involving external
49
50 providers, such as a clearly agreed problem of relevance and importance to both
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52 operational and managerial staff and co-produced solutions. This indicated genuine
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54 client 'readiness' to work with external providers. Other characteristics were
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56 continual re-assessment of the problem (and proposed solution) and local staff
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3 taking responsibility for undertaking the work to learn new skills, instead of relying
4 largely on external consultants. If the contract involved information provision,
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7 external providers needed to supply not only technical solutions, but also skills in
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10 interpretation with locally contextualised strategies to inform commissioning,
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12 developed in genuine partnership with the right NHS staff. One way of improving the
13
14 impact of data on commissioning might be for commissioners to adopt the model
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16 from the external provider in Vignette 4 by using integrated internal teams of
17
18 clinicians, analysts and managers to cross-fertilise expertise. Without these
19
20 elements, the use of external providers appears to have only sporadic benefits of
21
22 limited value for commissioning.
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29 However, this raises a dilemma. If local expertise is essential for high-quality
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31 commissioning, then employing a non-local external commercial or not-for-profit
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33 provider to develop and supply such expertise puts the contracting organisation in a
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35 vulnerable position, as the contracting organisation becomes increasingly dependent
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37 on the external provider (as illustrated by Vignette 4). This is likely to worsen over
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39 time. But developing the expertise in-house does not solve the problem either,
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41 unless there is a plan to maintain that expertise to be resilient to shocks such as re-
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43 organisations and departures of key personnel.
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50 The NHS is increasingly contracting with external providers to help with the
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52 commissioning process and the current government is encouraging this, whilst at the
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54 same time wanting to ensure that local clinicians and their patients have primacy in
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56 the decision making. That being so, then, at the minimum, knowledge exchange
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3 strategies need to be enshrined explicitly in such contracts in order to optimise
4
5 commissioning by developing and enhancing local skills. Both NHS clients and
6
7 external providers have an obligation to NHS patients to ensure that the potential for
8
9 knowledge exchange is fully exploited.
10

11 12 13 14 15 16 **ACKNOWLEDGEMENTS**

17
18 Thanks to all those who took part in this study. Thanks also to Maya Bimson,
19
20 Michael Bainbridge, Tim Wye, Jude Carey, Adwoa Webber, Neil Riley and William
21
22 House for commissioning input and Andrée le May for conceptual assistance at the
23
24 interpretative and final report writing stages.
25
26

27 28 **AUTHOR'S CONTRIBUTIONS**

29
30 LW conceived the study and was responsible for its overall direction. She contributed
31
32 to research design, led on data collection and analysis in two sites and drafted this
33
34 paper. Emer Brangan collected data across six sites, analysed data and commented
35
36 on this draft paper. Ailsa Cameron, John Gabbay, Jonathan Klein and Catherine
37
38 Pope contributed to research design and data analysis and commented on drafts of
39
40 this paper. Rachel Anthwal contributed to analysis, developed actionable messages
41
42 for commissioners and commented on drafts of this paper.
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51 52 **COMPETING INTERESTS**

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54 The authors declare that we have no competing interests
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FUNDING

This work was supported by the National Institute for Health Research HS&DR programme grant number 09/1002/09. The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the [name programme], NIHR, NHS or the Department of Health.

DATA SHARING

No additional data available.

For peer review only

REFERENCES

1. Newman M, Bangpan M, Kalra N, et al. Commissioning in health, education and social care Models, research bibliography and in-depth review of joint commissioning between health and social care agencies. London: EPPI Centre Institute of Education University of London, 2012.
2. Ovretveit J. *Purchasing for health: A multi-disciplinary introduction to the theory and practice of commissioning*. Buckingham: Open University Press, 1995.
3. Department of health. Health Reform in England: update and commissioning framework, 2006.
4. Checkland K, Snow S, McDermott I, et al. Management practice in primary care organisations: the roles and behaviours of middle managers and GPs: Final report: NIHR Service Delivery and Organisation Programme, 2011.
5. Smith J, Shaw S, Porter A, et al. Commissioning high quality care for people with long term conditions: An action research study: NIHR Service Delivery and Organisation Programme, 2013.
6. Ham C. World class commissioning: a health policy chimera? *Journal of Health Services Research & Policy* 2008;**13**(2):116-21
7. Department of Health. World Class Commissioning. London: Department of Health, 2007.
8. Mooney H. HSJ commissioning supplement: an in-depth look at FESC. *Health Service Journal* 2007
9. Welikala J. Private firms and local authorities in running to provide commissioning support. *Health Service Journal* 6 August 2014
10. NHS England. Lead provider framework. Secondary Lead provider framework 2014. <http://www.england.nhs.uk/ourwork/commissioning/comm-supp/ld-provider-frwrk/>.
11. House of Commons Select Committee. The use of management consultants by the NHS and the Department of Health: Fifth report of the 2008-2009 session. London: The Stationery Office, 2009.
12. Department of Health. Liberating the NHS. London: Department of Health, 2010.
13. Langsley A. Andrew Lansley: competition is critical for NHS reform. *Health Service Journal* 13 February 2012
14. Dickinson H, S S, Glasby J, et al. The limits of market-based reforms. *BMC Health Services Research* 2012;**13 (suppl 1)**
15. Charlesworth A, Kelly E. Competition in UK health care: reflections from an expert workshop. London: Nuffield Trust, 2013.
16. Chambers N, Sheaff R, Mahon A, et al. The practice of commissioning healthcare from a private provider: learning from an in-depth case study. *BMC Health Services Research* 2013;**13 (suppl 1):S4:54**
17. Naylor C, Goodwin N. The use of external consultants by NHS commissioners in England: what lessons can be drawn for GP commissioning? *Journal of Health Services Research and Policy* 2011;**16**:153 doi: DOI: 10.1258/jhsrp.2010.010081[published Online First: Epub Date]].

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- 2
- 3 18. Yin R. *Case Study Research*. 3rd edition ed. London: Sage, 2002.
- 4 19. Hammersley M, Atkinson P. *Ethnography: Principles and Practice*. London:
- 5 Routledge, 1995.
- 6 20. Brown J, Duguid P. *The social life of information* Boston Mass USA: Harvard
- 7 Business School Press, 2000.
- 8 21. Wenger E. *Communities of practice: leaning, meaning and identity*. New York:
- 9 Cambridge University Press, 1998.
- 10 22. Gabbay J, le May A. *Practice-Based Evidence for Healthcare*. Oxford:
- 11 Routledge, 2011.
- 12 23. Weick K. *Sensemaking in organisations*. London: Sage, 1995.
- 13 24. Patton M. *Qualitative Research and Evaluation Methods*. London: Sage, 2002.
- 14 25. Belbin RM. *Management Teams: Why they succeed or fail*. Third ed. Oxford:
- 15 Butterworth-Heinemann, 2010.
- 16 26. Appelbaum S, Steed J. The critical success factors in the client-consulting
- 17 relationship. *Journal of Management Development* 2005;**24**(1):68-93
- 18 27. MacLachline R. Factors for consulting engagement success. *Management*
- 19 *Decision* 1999;**37**(5):394-402
- 20 28. Nutley S, Walter I, Davies H. *Using Evidence: how research can inform public*
- 21 *services*. Bristol: The Policy Press, 2007.
- 22
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BMJ Open

What do external consultants from private and not-for-profit companies offer healthcare commissioners? A qualitative study of knowledge exchange

Journal:	<i>BMJ Open</i>
Manuscript ID:	bmjopen-2014-006558.R1
Article Type:	Research
Date Submitted by the Author:	30-Oct-2014
Complete List of Authors:	Wye, Lesley; University of Bristol, Academic Unit of Primary Health Brangan, Emer; University of Bristol, School of Social and Community Medicine Cameron, Ailsa; University of Bristol, School for Policy Studies Gabbay, John; University of Southampton, Wessex Institute for Health Research and Development Klein, Jonathan; University of Southampton, Southampton Business School Anthwal, Rachel; University of Bristol, School of Social and Community Medicine Pope, Catherine; University of Southampton, Health Sciences
Primary Subject Heading:	Health services research
Secondary Subject Heading:	Health policy
Keywords:	Health policy < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Organisation of health services < HEALTH SERVICES ADMINISTRATION & MANAGEMENT, Quality in health care < HEALTH SERVICES ADMINISTRATION & MANAGEMENT

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8 healthcare commissioners? A qualitative study of knowledge exchange
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55 5 key words: knowledge exchange, external provider, private sector, commissioning
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ABSTRACT

Objectives: The use of external consultants from private and not-for-profit providers in the NHS is intended to improve the quality of commissioning. The aim of this study was to learn about the support offered to healthcare commissioners, how external consultants and their clients work together and the perceived impact on the quality of commissioning.

Setting: NHS commissioning organisations and private and not-for-profit providers

Design: mixed methods case study of eight cases

Data collection: 92 interviews with external consultants (n=36), their clients (n=47) and others (n=9). Observation of 25 training events and meetings. Documentation e.g. meeting minutes and reports.

Analysis: Constant comparison. Data were coded, summarised and analysed by the research team with a coding framework to facilitate cross case comparison.

Results: In the four contracts presented here, external providers offered technical solutions (e.g. software tools), outsourcing and expertise including project management, data interpretation and brokering relationships with experts. In assessing perceived impact on quality of commissioning, two contracts had limited value, one had short term benefits and one provided short and longer term benefits. Contracts with commissioners actively learning, embedding and applying new skills were more valued. Other elements of success were: (i) addressing clearly agreed problems of relevance to managerial and operational staff (ii) solutions co-produced at all organisational levels (iii) external consultants working directly with clients to interpret data outputs to inform locally contextualised commissioning strategies.

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3 Without explicit knowledge exchange strategies, outsourcing commissioning to
4
5 external providers resulted in the NHS clients becoming dependent.
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8 Conclusion

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11 NHS commissioning will be disadvantaged longer term if commissioners both fail to
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13 learn in the short term from the knowledge of external providers and in the longer
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15 term lose local skills. Knowledge exchange mechanisms are a vital component of
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17 commissioning and should be embedded in external provider contracts.
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24 Word count: 5828
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STRENGTHS AND LIMITATIONS OF THIS STUDY (5 points in total)

- This is the largest study of the use of external consultants to support healthcare commissioners in England post-Health and Social Care Act 2012.
- This study illuminates the potential benefits and challenges in using external expertise in commissioning.
- Case study results can offer substantial, information rich accounts of the role of external consultants and assess their perceived impact on commissioning decisions. But case studies cannot assess the actual impact on commissioning and are not statistically generalisable. However findings are transferable to similar settings.
- Perhaps because the research team were overly associated with external consultants as this was the access point in fieldwork, we obtained fewer accounts from NHS clients. Recruiting another not-for-profit agency would have further augmented comparative analyses.
- This study emphasises the importance of taking steps to improve knowledge exchange between external consultants and their NHS clients to gain the greatest benefit from these types of contracts.

INTRODUCTION

Healthcare commissioners plan services and allocate funding to meet the needs of specific populations in England. Over two decades, commissioning (or 'purchasing' as it was originally known) has taken different organisational forms, including Health Authorities, Primary Care Groups, Primary Care Trusts (PCTs) and now Clinical Commissioning Groups (CCGs). There are many definitions of 'commissioning' ¹. An early, simple conceptual framework by Øvretveit et al used the Plan-Do-Study-Act model to illustrate commissioning activities ². The Department of Health has developed a more complicated model which includes assessing needs, designing services and managing demand and performance ³. Gradually, commissioning has become both more complex and better understood.

A growing body of evidence suggests that commissioning is "messy, fragmented and largely accomplished in meetings" ⁴ with progress made through "bite sized pieces of work" ⁵. Moreover, commissioning is challenging and difficult to do well, regardless of whether the healthcare system is English, European or American ⁶. In 2007, World Class Commissioning was introduced in the NHS ⁷ along with FESC (Framework for Procuring External Services for Commissioners) which authorised commercial providers to work with commissioners ⁸. With the advent of the Coalition government in 2010, FESC was dissolved but the Lead Provider framework for commercial and other external providers such as commissioning support units has taken its place ⁹. The assumption with all these initiatives is that use of external providers will lead to higher quality commissioning ^{8 10}. However, despite an estimated £308.5 million received by external management consultants from the NHS in 2007-2008 ¹¹, there

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3 remains scepticism about the benefits of using these services. For example a *Health*
4 *Service Journal* survey of 93 senior commissioning directors found that nearly half
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6 thought that commercial consultants would make only a “little” difference ⁸.
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13 Nonetheless, the terrain for external provision in the NHS has become even more
14 favourable. The White Paper *Liberating the NHS* ¹² and the Health and Social Care
15 Act 2012 that followed were predicated on the assumption that “individual creativity
16 and innovation is best supported by competition” ¹³. Competition in healthcare
17 services, which does not necessarily imply privatisation, was intended lead to greater
18 patient demand for innovative treatments. The assumption was that this, in turn,
19 would ensure that individuals live longer and healthier lives. However, a recent
20 editorial on the impact of market based reforms concluded that current research
21 “offer[s] remarkably similar conclusions about the limited potential of markets in
22 health and social care to deliver aspirations for improvements in both the quality and
23 cost of care”¹⁴. In contrast, preliminary findings from other studies featured in a
24 recent Nuffield Trust report suggest cautionary optimism ¹⁵.
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44 Despite the lack of clarity, there continues to be a policy push towards competition in
45 the NHS. Although the primary focus of the 2012 Act may have been increasing
46 competition amongst healthcare providers such as acute hospitals, commissioning
47 has also been affected, creating a fragmented healthcare landscape with commercial
48 companies, not-for-profit agencies, social enterprises, voluntary sector bodies,
49 commissioning support units, freelance consultants and public health professionals,
50 all vying to improve and influence commissioning by supplying commissioners with
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3 information, advice and support. But some of these new providers need substantial
4 help themselves. For example, the Nuffield Trust published guidance for voluntary
5 organisations interested in offering commissioning support in November 2013¹⁶.
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13 A single case study of a collaboration between a commercial provider and
14 commissioning organisation has been reported in the literature. It found “strong
15 relationships” and “high levels of trust” between the commissioners, commercial
16 provider and healthcare provider¹⁷. In addition, a survey with 172 responses from
17 commissioners found good levels of satisfaction, with most rating their contracted
18 commercial providers as ‘good’ or ‘excellent’¹⁸. Yet the controversy around external
19 providers persists, particularly commercial companies.
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33 To help inform the debate, clarifying what external providers offer is of particular
34 interest. Definitions of ‘knowledge’ and ‘knowledge exchange’ proliferate in the
35 literature¹⁹. In this paper, knowledge is defined as any tacit or explicit information,
36 skill or expertise and ‘exchange’ is defined as reciprocal transfer. For example, the
37 knowledge from commercial and not-for-profit companies under study included
38 technical skills in deploying software tools and expertise in applying and interpreting
39 data output. However, clients also had valuable knowledge to share, such as which
40 local general practices would be most receptive to software tool deployment and how
41 to modify the software to maximise its usability.
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3 The aim of this study was to contribute to the debate about the use of external
4 providers in the National Health Service by understanding how commissioners and
5 external consultants work together, the processes of knowledge exchange and the
6 perceived impact on commissioning decisions. This study includes data for contracts
7 both pre-dating and occurring contemporaneously with the implementation of the
8 2012 Health and Social Care Act.
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20 **METHODS**

21 **Study design**

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23 We selected a mixed methods case study approach, as appropriate for exploratory
24 questions in a real-life context, where there are few opportunities to control events
25 and settings ²⁰. This study received ethical permission from South West Ethics
26 Committee 2 (10/H0206/52).
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39 **Case site selection**

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41 We recruited two commercial providers and one not-for-profit agency. The first
42 external provider approached a competitor on our behalf, following 'snowball'
43 sampling recruitment, which is an accepted feature of ethnographic research ²¹. This
44 competitor became the second commercial provider under study. A not-for-profit
45 company was approached and then recruited to contrast commercial and not-for-
46 profit providers.
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3 To preserve anonymity, we will use the term 'external provider' to mean both
4 commercial and not-for-profit for the organisations studied. Using pseudonyms, the
5 external providers were:
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10 • Heron – a multi-national with a suite of software tools and mixed expert UK/
11 non-UK staff, offering analytics and project management.
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- 13 • Jackdaw – a small, international company offering one software tool.
14
- 15 • Swallow – a national company with a suite of software tools staffed largely by
16 ex-NHS personnel offering analytical and commissioning expertise.
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21 Each external provider was treated as a case. An additional case study was drawn
22 from a sub-contract within the Swallow data, making four external provider cases.
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29 To access the views of NHS commissioners, we recruited four commissioning
30 organisations that had contracts with at least one of the external providers. Using
31 pseudonyms, these were:
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37 • Carnford CCG - struggling financially, highly collaborative with its healthcare
38 providers and reliant on the use of tools and the data produced from those
39 tools to influence commissioning decisions.
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- 41 • Deanshire CCG – relatively confident as a commissioning organisation,
42 focused on governance, carrying out some innovative projects in partnership
43 with commercial providers.
44
45
- 46 • Norchester CCG - financially challenged, emphasis on (ideally academic
47 research) evidence based policy making, piloting new ways of commissioning
48 contracts, with substantial aid from commercial and not-for-profit providers.
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- 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.

At the close of fieldwork, we had eight case studies of the transactions between external providers and commissioning organisations. We were specifically interested in contracts with a significant knowledge exchange component at various stages e.g. beginning, middle and post-contract. Some commissioning organisations had contracts with more than one study provider, for example Norchester worked with both Swallow and Jackdaw and some contracts included commissioning organisations other than Carnford, Deanshire, Norchester and Penborough.

Data collection

We collected interview, observation and documentary data from February 2011 to May 2013, which was nine months after the publication of *Liberating the NHS* the White Paper that led to the 2012 Health and Social Care Act. Data were collected by LW and EB, who are experienced qualitative researchers.

Interviews

For each external provider, we first interviewed senior leaders (Chief Executive or Directors). Through snowball sampling, we identified other candidates for interview with relevant knowledge or experience of the external provider and/or contract. For

1
2
3 Swallow and Jackdaw, the research team independently approached candidates,
4 usually by e-mail. For Heron, interview requests from the research team were co-
5 ordinated by a Heron consultant. For the commissioning organisations, we
6 interviewed the lead NHS contact for the contract (usually identified by the external
7 provider) and employed snowball sampling to identify other candidates, including lay
8 representatives, local councillors, freelance and commercial consultants from other
9 companies. Two NHS healthcare commissioners and one external consultant
10 declined to be interviewed, while several others did not respond to requests.
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24 Candidates were sent information before interviews and consent was obtained at
25 interview. Following initial conversations with commissioners and
26 external consultants, the research team devised a topic guide. It covered type of
27 knowledge wanted by commissioners, information sources, how information was
28 accessed and influenced decisions. The topic guide was revised as new questions
29 emerged. Interviews were face to face or by telephone, depending on the preference
30 of the participant and practicalities. Lasting 20-60 minutes, all interviews were
31 recorded and transcribed by an external transcriber.
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46 Data saturation was reached with larger external providers when over 15 external
47 consultants were interviewed. As a small company, Jackdaw's consultants were all
48 interviewed. Data saturation for commissioning organisations was reached when
49 about half of the relevant stakeholders with direct experience of the contract were
50 interviewed, although this proportion had not been predetermined. In total, we
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interviewed 92 participants including 47 NHS clients, 36 external consultants and nine others (e.g. freelance consultants, lay representative). (Table 1)

Table 1 Interview participants

Professional role	Number of participants
NHS	
Managerial commissioner	17
Clinical commissioner	15
Analyst	9
Other NHS	6
Total NHS	47
EXTERNAL	
Commercial/ not for profit consultants	36
Freelance	3
Public health	4
Local authority	1
Lay representative	1
Total external	45
TOTAL STUDY	92

We conducted 25 observations of meetings between external consultants and their NHS clients, external provider and commissioner team meetings and training events. Permission was obtained verbally before attending events. Observation notes were taken with the help of an aide memoire based on the research questions and

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2
3 included details of participants, room layout, verbal exchanges and researcher
4 reflections. Notes were typed up as soon as possible after the data were collected.
5
6
7 All interview and observation participants were given pseudonyms. Meeting minutes,
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9 reports, website and marketing material, press releases and e-mails were collected
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11 and fed into the case summaries. These supplemented, confirmed and challenged
12
13 emerging findings from interview and observation data.
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20 **Data analysis**

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23 Our analysis, in common with much qualitative work, used deductive and inductive
24 processes, and a similar approach has been described elsewhere in the literature ²².
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27 Initial analyses of the data were inductive, and used constant comparison to identify
28
29 codes and compare these and emerging categories. This process was repeated and
30
31 fed back into data collection (and further analysis) cycles ²³. The study team met
32
33 regularly to identify emerging themes, reflect on the research questions and suggest
34
35 new questions for the fieldwork. Although not discussed explicitly in this paper,
36
37 theories which the authors have previously engaged with about the 'social life of
38
39 information'²⁴, 'communities of practice'²⁵, 'mindlines'²⁶ and 'organisational sense-
40
41 making'²⁷ informed our analysis. Through reflective discussion amongst the team we
42
43 examined how these theories, as well as the initial research questions, deductively
44
45 informed our analysis. (For example during discussion of one data item a team
46
47 member noted knowledge transformation using 'mindlines' at which point the team
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49 discussed reasons for this, challenged it and explored cases that supported and
50
51 refuted this assertion).
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3 By May 2013 when fieldwork came to a close team members (EB, LW and AC)
4
5 developed a coding framework based on these discussions and framed around the
6
7 research questions. Using NVIVO software, EB and LW systematically coded cases
8
9 and developed 20-50 page case summaries for each case structured around five
10
11 domains. Four of these domains were deductively derived from the original research
12
13 questions (external providers, knowledge accessed, knowledge transformation,
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15 benefits/disadvantages). The final domain (models of commissioning) emerged
16
17 inductively from the analysis and surrounding discussions. Every member of the
18
19 research team read these summaries independently and conducted cross case
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21 analyses, identifying key themes common to the cases and searching for discrepant
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23 data. The team then met to finalise the agreed key themes.
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31 **Challenges**

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34 Few previous studies have recruited commercial or not-for-profit consultants working
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36 in the NHS. Challenges included research governance, as external consultants
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38 moved freely and quickly around NHS organisations while researchers adhering to
39
40 research governance could not. We wanted to shadow external consultants, but
41
42 many had concerns about client sensitivities so we relied on observation of training
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44 events and larger meetings. Concerns were also expressed about patient data
45
46 confidentiality, despite local R&D permissions. Nonetheless, the general enthusiasm
47
48 and willingness of external consultants to participate in this study was noteworthy.
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55 **RESULTS**

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3 The core themes that emerged in determining what external providers offer were: (i)
4 technical transfer (e.g. software tool training, operation and application), (ii) expertise
5 (e.g. knowledge and skills in project management and analytics) and (iii) outsourcing
6 (e.g. taking over commissioning teams/ units wholesale). They were also engaged
7 for their 'big picture' perspective, potential to challenge local stakeholders,
8 knowledge from international and national sources and new approaches to recurrent
9 problems. The following vignettes, which sometimes depicted entire contracts and
10 sometimes just one work stream, illustrated what external providers offered, how
11 commissioners and external consultants worked together and their perceived impact.
12 In selecting the vignettes, we chose one from each participating external provider
13 where we had sufficient client-external provider accounts. In meeting the objectives
14 of the study, the selected vignettes demonstrated a range of the 'offers' available.
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33 **Vignette 1: A technical solution – but what's the problem?**

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36 The external provider in this vignette was imbued with 'public sector values', as the
37 dissemination arm of an academic institution. Marketing a software tool to identify
38 individuals at higher risk of using healthcare resources such as hospital beds , this
39 external provider worked in partnership with other for and not-for-profit companies to
40 reach clients, sometimes via academics.
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48 *It's often that the academicians (sic) through publications, through*
49 *presentations and conferences and so on, that proves the [tool's] viability*
50 *within a particular country or setting, and demonstrates its value. And then the*
51 *government gets – you know – it gets their attention. (External consultant,*
52 *Katie)*
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6 After a six month needs assessment, this software tool was selected by a team of
7
8 senior information managers acting on behalf of a consortium of commissioning
9
10 organisations that wanted to “club together and think about how they could do
11
12 commissioning in a more effective way” (NHS information manager, Shauna).
13
14 However once the tool was fully deployed (about three years after the original needs
15
16 assessment exercise), the procurement team realised that the basic training for the
17
18 tool offered by an intermediary external provider was insufficient. They contracted
19
20 the tool developers directly to procure advanced training.
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28 The training by the tool developers was delivered by experts from North and South
29
30 America, with little knowledge of the NHS, to seven NHS clients of diverse
31
32 backgrounds (analytics, primary care commissioning, project management) via
33
34 webinars. The training was almost entirely technical, which was appreciated by
35
36 healthcare analysts who confidently applied their new knowledge in novel ways, for
37
38 example using the software tool to allocate general practice budgets. But technical
39
40 knowledge alone was insufficient for some NHS clients. For example, a primary care
41
42 commissioner talked about how they had not “chosen” but were “given” the tool, and
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44 then had to find an application. Another client talked about the difficulties in
45
46 contextualising tool outputs to local circumstances without a data interpreter and a
47
48 clear strategy from senior NHS managers about how the tool should be used.
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53 *I think what would be really useful is somebody from [external provider] to*
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55 *work with the strategic [commissioning] lead and maybe myself to actually*
56
57 *think about the best way to use it to get the maximum results. So do we just*
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3 *look at COPD? Do we look at diabetes? Is there something that we can do*
4 *with the tool that would give us a really quick win? (NHS project manager,*
5 *Kourtney)*
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10 Overall at the time of fieldwork, use of this tool had had limited impact on informing
11 commissioning, although it was early days as training was ongoing. The lessons
12 from this vignette are that technical 'solutions' can only solve clearly identified and
13 recognised problems. Moreover, translators who can interpret data outputs are
14 necessary and maximising those outputs relies on external consultants, analysts and
15 commissioners working together.
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28 **Vignette 2: A new approach to a recurrent challenge**

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30 The external provider in the second vignette also offered technical transfer through
31 software tools. With one tool, clinical reviewers compared patients' notes to a set of
32 standards based on expert consensus on 'best place of care' (i.e. hospital or
33 community based). Patients either 'qualified' to be in their current setting or did not.
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35 At the instigation of commissioners, two audits using this tool were carried out for an
36 acute trust, as a way of identifying unnecessary hospital admissions.
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48 The first audit was entirely conducted by external consultants in autumn 2010 and
49 was described as a "disaster" (Medical Director, Hugh). Many patients were
50 identified as 'not qualifying', a finding contested by the hospital, which placed further
51 strain on already difficult relationships between the commissioners and hospital.
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56 Nine months later, after the shortcomings of the first audit had been agreed, a
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3 second audit took place in summer 2011, carried out this time by five local reviewers
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5 from the hospital, community provider and commissioning agency. Local reviewers
6
7 initially learnt how to use the tool during a two day training session and then that
8
9 learning was augmented and consolidated through experiential application of the tool
10
11 during data collection, with external consultants on hand acting in an advisory
12
13 capacity. Interestingly, the proportion of patients 'not qualifying' in the second audit
14
15 (24%) was almost the same as the first audit (28%), but local ownership meant that
16
17 the second audit results were more readily accepted
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25 The NHS clients found the second audit "very useful" (NHS information manager,
26
27 Joan), but not because the tool gave much insight into unnecessary hospital
28
29 admissions. Rather through joint data collection with daily de-briefing sessions
30
31 chaired by the hospital medical director, professionals from different care sectors
32
33 learnt more about each other's norms and challenges and developed better working
34
35 relationships. The hospital team also learnt to think differently about ways to reduce
36
37 hospital admissions (i.e. from the perspective of where the patient is best placed).
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41 *I think the whole question of looking at admissions and what was required,*
42
43 *and what services could be put around it, is one that is so obvious that*
44
45 *actually we weren't thinking about it.... And so by modifying that concept I*
46
47 *think we will learn a lot and gain a lot. So I think they [external provider] did*
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49 *bring that. (Medical director, Hugh)*
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3 Further audits using the same method (but not the software tool) were conducted in
4 other hospital wards, but the external provider was not involved. Several months
5 after the second audit, we received an e-mail stating that the results had not fed into
6 any commissioning decisions, but that the ensuing local relationships were highly
7 valued. The lesson from this vignette was that where possible, external consultants
8 could helpfully ensure that the work is conducted by clients, so that the clients take
9 ownership and skills are more easily transferred.
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22 **Vignette 3: “Going from good to great”**

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25 In addition to contracting external providers for their technical offer, as illustrated in
26 the previous two vignettes, external consultants were also engaged for their
27 expertise in project management. The NHS commissioning organisation involved in
28 this vignette was “trying to go from good to great as a commissioner” (Carol, NHS
29 commissioning manager), so one of the numerous work streams was to carry out a
30 set of activities to help their NHS clients prepare for a ‘World Class Commissioning
31 assurance day’.
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45 As part of this process, the external consultants carried out a ‘gap analysis’, based
46 on the World Class Commissioning competencies, where they challenged their NHS
47 clients to “*demonstrate that you actually do that. Give me the tangible evidence*”
48 (Helen, external consultant). Other activities included identifying experts in
49 commissioning to visit the client site, setting up visits to other NHS commissioning
50 organisations, engaging local clinicians and providing project management training
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3 and tools. The external consultants sought to complement the client's strengths, and
4
5 a commissioning manager spoke about some of the processes used:
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8 *They often brought people in, drafted people in from [North America] to talk to*
9 *us about ideas that we were having. So quite often we'd have ideas or they*
10 *would suggest ideas to us about what we could do locally, and they would*
11 *expand and build on that, and come back with a rounder package, which we*
12 *would then test out.* (Sarah, NHS commissioning manager)
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23 The culture within the NHS client organisation prioritised collaboration, innovation,
24 transparency and engagement. This may have fostered the strong relationship they
25 developed with the external consultants, who commented on how this had gone
26 beyond developments with other NHS clients, where external consultants were
27 sometimes perceived as a threat. The consultants described the client
28 commissioners in terms of Belbin's team roles, which the external team deliberately
29 complemented²⁸.
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39 *So they were the plants and shapers, but they weren't the completer finishers.*
40 *I would say that that was evident when we were working with them, that they*
41 *had a huge amount of ideas. Lots of shaping, lots of meetings, huge meeting*
42 *culture, and then the actual discipline of completing it and measuring it was*
43 *not there.* (Patricia, external consultant)
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3 The main challenges raised by both sides were those of defining what work was
4 needed, and how to ensure that work from the World Class Commissioning work
5 stream and others remained relevant.
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10 *Over the two year period the world changed around us, so we ended up*
11 *having to reset what it was that we needed from them several times. And I'm*
12 *sure you can appreciate that that takes – it's a little like a juggernaut, isn't it? -*
13 *it takes turning around and renegotiating, for them and us, of what was*
14 *needed, and finding out that something different was needed, and putting that*
15 *into place, meant things stalled several times along the way. (Carol, NHS*
16 *commissioning manager)*
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30 The NHS client achieved their goal by being rated amongst the top five English
31 commissioning organisations. Most NHS participants were pleased with this result,
32 although subsequently a few queried whether this had been worth the cost. The
33 external consultants also valued learning from their NHS clients, as previously they
34 had not helped clients with World Class Commissioning assurance processes. The
35 lesson in this vignette is that knowledge exchange is possible when client
36 organisations are ready and willing to work with external providers who, in turn, are
37 adaptable and complement (rather than replace or duplicate) the commissioners'
38 skills.
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55 **Vignette 4: 'Data driven' commissioning**

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3 Although external providers in this study mainly offered technical solutions and
4 expertise, there was one example where commissioning had been completely
5 outsourced. The external provider managed all aspects of the contracts of a group of
6 hospitals worth over £100 million, which were described as “very expensive and
7 quite difficult to control” (Joel, external consultant).
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18 The external provider perceived the NHS as driven by politics and people rather than
19 by data, whereas their own ethos was to “use data to drive decision making”
20 (Kristen, external consultant). The external team consisted of a programme
21 manager, administrators and “lots of analysts”, who undertook “forensic investigation
22 of the data”, mainly by finding errors in coding leading to over-charging (Joel,
23 external consultant). Nurses, with essential clinical knowledge, were also placed in
24 hospitals to verify patient notes against invoices, as commissioners had limited ways
25 of checking the accuracy of claims. The approach the external consultants took with
26 healthcare providers was confrontational.
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39 *[We said]...“If you don’t supply us with this data, we can’t validate our patient*
40 *activity, therefore we are not going to pay for it.” So [a] slight – at times, very -*
41 *antagonistic approach. (Dennis, external consultant)*
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46 In an attempt to reduce hostility, a NHS commissioner was seconded for one year to
47 improve relationships between the external provider, the NHS hospitals and local
48 commissioning organisations mid-contract. During fieldwork, several participants
49 noted that relationships were better, partly due to this intervention.
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3 Analytical expertise and good quality data were highly valued by this external
4 provider to inform decision making. The 'standard' team they offered consisted of an
5 analyst, project manager and clinical lead in contrast to the NHS, where analysts,
6 commissioning managers and clinicians tended to work separately in silos. A NHS
7 client said this analytical support was vital and that the external provider did "the
8 basics really well" (Jacob, NHS commissioning manager). This resulted in savings
9 estimated as over a million pounds.
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22 Initially the draft contract had included a knowledge transfer strategy so that a NHS
23 team could develop these analytical skills. But this clause was eliminated by the
24 NHS client to reduce contract costs. This contract was repeatedly renewed. As a
25 result, by 2019, the external provider will have operated this outsourced
26 commissioning service for 10 years with no mechanisms in place to develop skills
27 within the NHS. The lesson from this vignette is that if clients and external providers
28 do not agree knowledge transfer strategies within the contract to the NHS client
29 organisation or other external providers such as commissioning support units, the
30 client is likely to end up reliant on support from one external provider long term. This
31 creates a monopoly, which is at odds with both the competitive thrust of the 2012
32 Health and Social Care Act and which also, importantly, undermines the influence of
33 local clinical intelligence that the government has stated should be at the heart of
34 commissioning.
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55 DISCUSSION

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Principal findings

External provider involvement was intended to improve the quality of commissioning. To achieve this, external providers offered technical applications, expertise and outsourcing. The impact of the contracts illustrated in these vignettes was shaped by the original objectives of the contracts and the expectations and ability of external providers and client organisations to meet those objectives (which may have been over-optimistic). We recognise that the 'success' or failure of these contracts is multi-dimensional and can be understood in the short and long term. With this in mind, we suggest that these vignettes show that external providers were only partly successful in improving the perceived quality of commissioning, largely because the knowledge exchange interactions between external providers and NHS clients were limited. In fact, only in vignette 3 was there substantial genuine knowledge exchange, with both sides receiving benefits, as in the other vignettes knowledge went just one way (i.e. external provider to client). The use of external providers proved problematic in several ways.

Vignette 1 illustrated that access to a software tool and technical training was inadequate; external providers needed to supply translators who could interpret the data, work with clients to contextualise outputs and help identify ways to use the outputs to inform commissioning decisions. Without this, the software tools did not address genuine problems currently being experienced, because of changes since initial procurement and insufficient consultation with client operational staff. There was also a split between the senior management agenda and those expected to operate or be informed by the tools. Contracts with external providers co-produced

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3 by all the actively interested parties may have a greater chance of success. If not,
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5 the tools can become a time consuming problem in their own right.
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11 Vignette 2 emphasised the importance of clients undertaking the work themselves,
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13 such as audit data collection, rather than relying on external providers. But often
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15 NHS participants reported limited time or capacity, especially following the launch of
16
17 *Liberating the NHS*, which led to the departure of many experienced commissioning
18
19 staff. Transferring skills and knowledge to clients may appear to undercut future
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21 procurement of external providers, but conversely may increase trust and perceived
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23 usefulness, which could improve the prospects of repeat business. This vignette
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25 highlighted another key point, mainly that the impact from contracting the external
26
27 provider had unanticipated benefits such as adoption of an innovative method (but
28
29 not the product itself) and the serendipitous mending of previously fractured
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31 relationships amongst local healthcare organisations that needed to work together.
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33 In Vignette 2, client participants found these outcomes more useful than the direct
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35 input of the external provider, which was described as of little value.
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44 Vignette 3 was an example of what commissioners and external consultants could
45
46 achieve together - if healthcare clients at all levels were genuinely willing and ready
47
48 (which may not be the case). The external consultants adapted their expectations to
49
50 fit clients' reality and negotiated mutually acceptable understandings and
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52 timeframes. Moreover, the external consultants complemented their NHS clients by
53
54 matching consultant 'completer/ finishers' to client 'blue sky thinkers'. In allocating
55
56 external consultants to clients, these less obvious characteristics received careful
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3 thought during procurement. The clients also learnt useful new skills such as ways of
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5 measuring the impact of their commissioning activities. Overall, this contract
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7 appeared to meet clients' expectations.
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13 Vignette 4 was undoubtedly a short term success in financial savings to the NHS, but
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15 not in longer term improvement in the perceived quality of commissioning amongst
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17 the NHS clients. This finding cautions both external providers and their NHS clients
18
19 to value and make provision for explicit knowledge transfer mechanisms, as the NHS
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21 clients ended up dependent on the external consultants' increasing monopoly of
22
23 skills. The potential benefits through skilling local staff were not realised and longer
24
25 term the role of local clinical intelligence was diminished. Given that the success of
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27 this contract was largely due to the significant input of analysts, finding ways of
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29 cross-pollinating analytical, clinical and managerial expertise through the use of
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31 'standard' teams consisting of professionals from each group may help bring about
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33 more 'data driven' commissioning in the NHS, reducing dependency on external
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35 providers.
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44 **Strengths and weaknesses**

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47 This is the largest study of commercial and not-for-profit providers and healthcare
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49 commissioners following the 2012 Health and Social Care Act. These external
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51 providers permitted substantial access and provided a comprehensive view of their
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53 work, although we note that perspectives from NHS clients, especially operational
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55 analysts and commissioners, were difficult to obtain. We recognise that entering the
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3 field via the external provider may have affected NHS recruitment and we would
4
5 have liked to recruit more 'negative' cases from one external provider, who steered
6
7 us away from less successful contracts. However, ample data was collected, both
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9 positive and negative, to create coherent case studies, which provide conclusions
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11 based upon carefully collected and systematically analysed data.
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14 15 16 17 18 **Relevance of study with regards to wider literature** 19

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21 There is scant literature on use of external providers in the NHS. A study published
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23 before the Health and Social Care Act 2012 concluded that commissioners did not
24
25 always use external support from commercial providers to its full potential, which our
26
27 study confirms ¹⁸. We found factors contributing to success included building effective
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29 working relationships, which were partial in Vignette 1 and absent in Vignettes 2
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31 (hospital audit) and 4 (data driven commissioning). The importance of trust and good
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33 working relationships was also identified in a post-2012, single case study of
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35 collaboration between clinical commissioners and external providers ¹⁷ and in a
36
37 recent study of commissioning support units ²⁹. In fact, this latter study concluded
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39 that good quality internal relationships are so important to commissioners, that in
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41 commissioners' determination to forge these links, they are bringing commissioning
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43 support analysts, who were their former commissioning colleagues before the 2012
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45 Health and Social Care Act, back into CCGs. This directly challenges current
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47 governmental policy on competition.
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3 Although the literature on use of external consultants in the English NHS is sparse,
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5 an impressive, instructive body of literature exists on the use of commercial
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7 consultants in the private sector. For example, a study of commercial consultants in
8
9 the Canadian telecommunications industry found that the single most important
10
11 factor of success was the willingness of commercial companies to adapt to “client
12
13 readiness”³⁰, which was evident in Vignette 3 where commissioners at all levels
14
15 were highly motivated to improve their World Class Commissioning rating. Another
16
17 Canadian management academic put forward six propositions for successful
18
19 engagement including a clear agreement concerning requirements and expectations,
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21 which was missing in Vignettes 1 and 2 where the NHS operational staff did not co-
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23 produce or contribute to the contract at the procurement stage. A further marker of
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25 success was a good fit between consultant and client, including consultant type³¹,
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27 which was present in Vignette 3 (e.g. allocating ‘completer/ finishers’). However
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29 despite the prevalence of this literature, and other relevant studies, once again we
30
31 note that the findings of research have made a limited impact on policy and practice
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33 within public services³². As contracts with external consultants become more
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35 widespread, drawing this literature to the attention of both external providers and
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37 healthcare commissioners who are using external support will become more
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39 imperative.
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48 **CONCLUSION**

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50 A major goal of the Health and Social Care Act 2012 was to introduce multiple types
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52 of external providers to increase competition with the assumption that this leads to
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54 improved quality of commissioning. This assumption is problematic, as the impact of
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56 competition on healthcare has yet to be clarified, even with regards to service
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3 provision, which is where this embryonic research field has focused to date ^{14 15}.

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5 Much less is known about the impact of competition on commissioning. But even if
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7 competition were likely to improve the quality of commissioning, our study suggests
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9 that the right elements may not be in place to optimise any such benefits.
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16 Several features were crucial to achieving positive impacts from involving external
17
18 providers, such as a clearly agreed problem of relevance and importance to both
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20 operational and managerial staff and co-produced solutions. This indicated genuine
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22 client 'readiness' to work with external providers. Other characteristics were
23
24 continual re-assessment of the problem (and proposed solution) and local staff
25
26 taking responsibility for undertaking the work to learn new skills, instead of relying
27
28 largely on external consultants. If the contract involved information provision,
29
30 external providers needed to supply not only technical solutions, but also skills in
31
32 interpretation with locally contextualised strategies to inform commissioning,
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34 developed in genuine partnership with the right NHS staff. One way of improving the
35
36 impact of data on commissioning might be for commissioners to adopt the model
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38 from the external provider in Vignette 4 by using integrated internal teams of
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40 clinicians, analysts and managers to cross-fertilise expertise. Without these
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42 elements, the use of external providers appears to have only sporadic benefits of
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44 limited value for commissioning.
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53 However, this raises a dilemma. If local expertise is essential for high-quality
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55 commissioning, then employing a non-local external commercial or not-for-profit
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57 provider to develop and supply such expertise puts the contracting organisation in a
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3 vulnerable position, as the contracting organisation becomes increasingly dependent
4 on the external provider (as illustrated by Vignette 4). This is likely to worsen over
5 time. But developing the expertise in-house does not solve the problem either,
6 unless there is a plan to maintain that expertise to be resilient to shocks such as re-
7 organisations and departures of key personnel.
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18 The NHS is increasingly contracting with external providers to help with the
19 commissioning process and the current government is encouraging this, whilst at the
20 same time wanting to ensure that local clinicians and their patients have primacy in
21 the decision making. That being so, then, at the minimum, knowledge exchange
22 strategies need to be enshrined explicitly in such contracts in order to optimise
23 commissioning by developing and enhancing local skills. Both NHS clients and
24 external providers have an obligation to NHS patients to ensure that the potential for
25 knowledge exchange is fully exploited.
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40 **ACKNOWLEDGEMENTS**

41
42 Thanks to all those who took part in this study. Thanks also to Maya Bimson,
43 Michael Bainbridge, Tim Wye, Jude Carey, Adwoa Webber, Neil Riley and William
44 House for commissioning input and Andrée le May for conceptual assistance at the
45 interpretative and final report writing stages.
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55 **AUTHOR'S CONTRIBUTIONS**

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3 LW conceived the study and was responsible for its overall direction. She contributed
4 to research design, led on data collection and analysis in two sites and drafted this
5 paper. Emer Brangan collected data across six sites, analysed data and commented
6 on this draft paper. Ailsa Cameron, John Gabbay, Jonathan Klein and Catherine
7 Pope contributed to research design and data analysis and commented on drafts of
8 this paper. Rachel Anthwal contributed to analysis, developed actionable messages
9 for commissioners and commented on drafts of this paper.
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22 **COMPETING INTERESTS**

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25 The authors declare that we have no competing interests
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32 **FUNDING**

33
34 This work was supported by the National Institute for Health Research HS&DR
35 programme grant number 09/1002/09. The views and opinions expressed therein are
36 those of the authors and do not necessarily reflect those of the [name programme],
37 NIHR, NHS or the Department of Health.
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47 **DATA SHARING**

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49 No additional data available.
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REFERENCES

1. Newman M, Bangpan M, Kalra N, et al. Commissioning in health, education and social care Models, research bibliography and in-depth review of joint commissioning between health and social care agencies. London: EPPI Centre Institute of Education University of London, 2012.
2. Ovretveit J. *Purchasing for health: A multi-disciplinary introduction to the theory and practice of commissioning*. Buckingham: Open University Press, 1995.
3. Department of health. Health Reform in England: update and commissioning framework, 2006.
4. Checkland K, Snow S, McDermott I, et al. Management practice in primary care organisations: the roles and behaviours of middle managers and GPs: Final report: NIHR Service Delivery and Organisation Programme, 2011.
5. Smith J, Shaw S, Porter A, et al. Commissioning high quality care for people with long term conditions: An action research study: NIHR Service Delivery and Organisation Programme, 2013.
6. Ham C. World class commissioning: a health policy chimera? *Journal of Health Services Research & Policy* 2008;**13**(2):116-21.
7. Department of Health. World Class Commissioning. London: Department of Health, 2007.
8. Mooney H. HSJ commissioning supplement: an in-depth look at FESC. *Health Service Journal* 2007.
9. Welikala J. Private firms and local authorities in running to provide commissioning support. *Health Service Journal* 6 August 2014.
10. NHS England. Lead provider framework. Secondary Lead provider framework 2014. <http://www.england.nhs.uk/ourwork/commissioning/comm-supp/ld-provider-frwrk/>.
11. House of Commons Select Committee. The use of management consultants by the NHS and the Department of Health: Fifth report of the 2008-2009 session. London: The Stationery Office, 2009.
12. Department of Health. Liberating the NHS. London: Department of Health, 2010.
13. Langsley A. Andrew Lansley: competition is critical for NHS reform. *Health Service Journal* 13 February 2012.
14. Dickinson H, S S, Glasby J, et al. The limits of market-based reforms. *BMC Health Services Research* 2012;**13** (suppl 1).
15. Charlesworth A, Kelly E. Competition in UK health care: reflections from an expert workshop. London: Nuffield Trust, 2013.
16. Holder H. Role of the voluntary sector in providing commissioning support London: Nuffield Trust, 2013.
17. Chambers N, Sheaff R, Mahon A, et al. The practice of commissioning healthcare from a private provider: learning from an in-depth case study. *BMC Health Services Research* 2013;**13** (suppl 1):S4:54.

18. Naylor C, Goodwin N. The use of external consultants by NHS commissioners in England: what lessons can be drawn for GP commissioning? *Journal of Health Services Research and Policy* 2011;**16**:153.
19. Contandriopoulos D, Lemire M, Denis JL, et al. Knowledge Exchange Processes in Organizations and Policy Arenas: A Narrative Systematic Review of the Literature. *Millbank Quarterly* 2010;**88**(4):444-83.
20. Yin R. *Case Study Research*. 3rd edition ed. London: Sage, 2002.
21. Hammersley M, Atkinson P. *Ethnography: Principles and Practice*. London: Routledge, 1995.
22. Fereday J, Muir-Cochrane E. Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods* 2006;**5**(1)(83).
23. Patton M. *Qualitative Research and Evaluation Methods*. London: Sage, 2002.
24. Brown J, Duguid P. *The social life of information* Boston Mass USA: Harvard Business School Press, 2000.
25. Wenger E. *Communities of practice: leaning, meaning and identity*. New York: Cambridge University Press, 1998.
26. Gabbay J, le May A. *Practice-Based Evidence for Healthcare*. Oxford: Routledge, 2011.
27. Weick K. *Making sense of the organisation*. Oxford: Blackwell Business, 2001.
28. Belbin RM. *Management Teams: Why they succeed or fail*. Third ed. Oxford: Butterworth-Heinemann, 2010.
29. Petsoulas C, Allen P, Checkland K, et al. Views of NHS commissioners on commissioning support provision. Evidence from a qualitative study examining the early development of clinical commissioning groups in England. *BMJ Open* 2014;**4**:e005970., **eScholarID:237405**
30. Appelbaum S, Steed J. The critical success factors in the client-consulting relationship. *Journal of Management Development* 2005;**24**(1):68-93.
31. MacLachline R. Factors for consulting engagement success. *Management Decision* 1999;**37**(5):394-402.
32. Nutley S, Walter I, Davies H. *Using Evidence: how research can inform public services*. Bristol: The Policy Press, 2007.