Creating capacity: Developing and sharing knowledge between VCSEs and health and care commissioners

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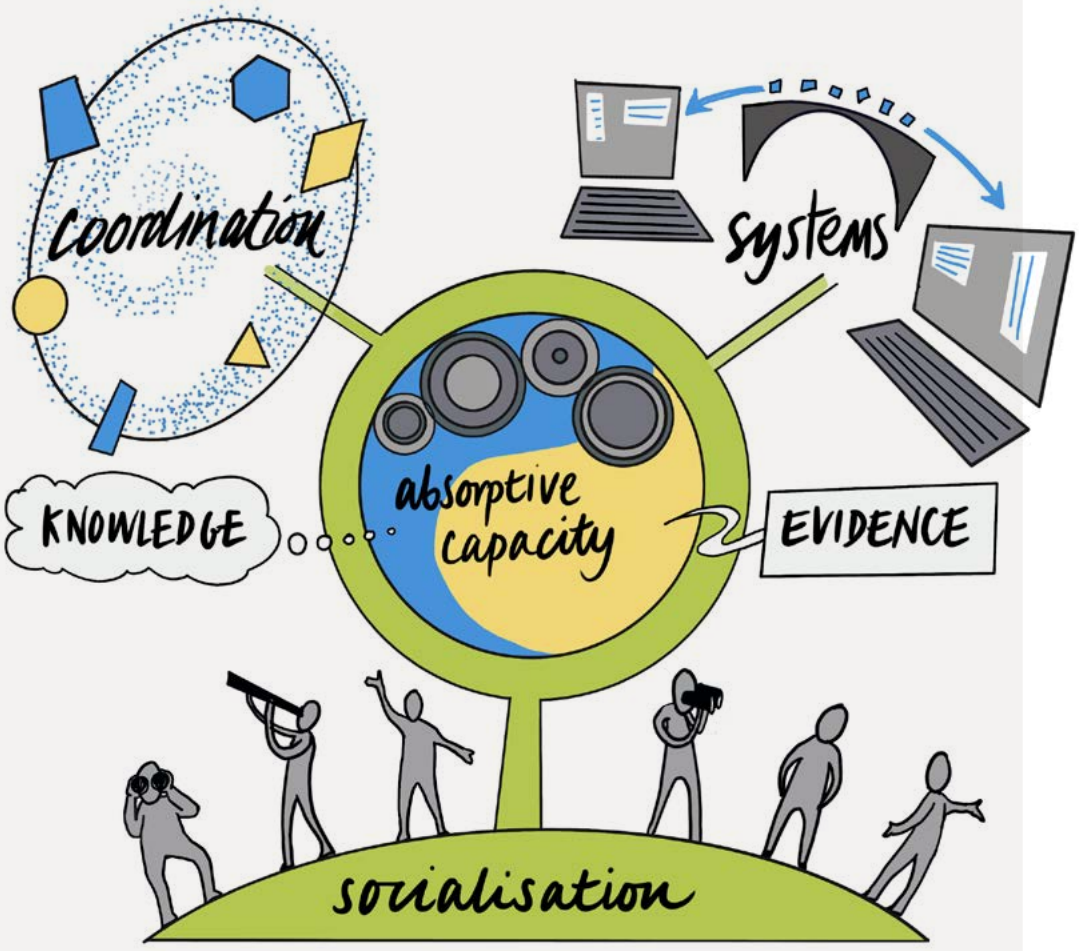

Health and care commissioning and the VCSE sector

Research briefing no.2

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Key messages

- Existing evidence shows that an organisation's performance is affected by its capacity to acquire, assimilate, transform and exploit knowledge – what is sometimes referred to as 'absorptive capacity'. VCSEs and commissioners capacity to use and share knowledge and evidence affects all stages of commissioning, including its outcomes.
- Our research, which included over 160 interviews across six case study localities, found that commissioners and VCSEs acquired, integrated, transformed and used knowledge and evidence from a wide range of sources. While commissioners typically relied on more formal knowledge and evidence, VCSEs tended to use more informal sources gathered through their work with communities and service users.
- Both commissioners and VCSEs saw the value of sharing knowledge and evidence with each other, but encountered some challenging barriers. Overly strong organisational or sectoral identities can prevent organisations from engaging with external knowledge, as can inflexible and disparate information systems and the lack of investment in coordination capability and networking spaces.
- A number of factors can help promote the sharing of knowledge and evidence, and importantly its use. This was more likely to happen when opportunities to interact, exchange and develop a common understanding and shared purpose across sectoral boundaries existed. These opportunities were created through having networking spaces such as those facilitated by local infrastructure bodies, boundary roles across the sectors and strong leadership that demonstrated a commitment to sharing knowledge and evidence across sectors and systems.
- However, significant investment of time and money is needed to make it happen.

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Background

Existing evidence shows that an organisation's performance is affected by its capacity to acquire, assimilate, transform and exploit knowledge – what is sometimes referred to as 'absorptive capacity'. Such contributions, however, generally focus on organisations in the corporate sector. Previous research has looked at how health and care commissioners use knowledge and evidence to inform decision-making and improve services[1]. Less is known about how this works in VCSE organisations, or across networks of organisations. Understanding how knowledge is developed, used and shared within and across VCSEs and commissioning organisations seems particularly relevant and important in the current context of co-commissioning and the development of Integrated Care Systems (ICSs).

This briefing is part of a series on different aspects of our study on health and care commissioning and the VCSE sector which involved talking to over 160 commissioners and VCSE organisations in England. The briefing has been especially written for commissioners and VCSEs. It looks at how commissioners and VCSEs develop, use and share knowledge and evidence and how this might help transform the way they work together to meet local population needs and improve the quality of services.

What is absorptive capacity?

We outline below some of the key ideas around the concept of absorptive capacity which provides a useful framework for organisations to help them think about the way they work with knowledge and evidence. The literature on absorptive capacity recognises that knowledge within organisations comes in many shapes. A distinction is made between the following types of knowledge:

- **Formal knowledge**, such as structured data, programmes and written procedures.
- **Informal knowledge**, embedded in systems and procedures, which shapes how an organisation functions, communicates and analyses situations.
- **Tacit knowledge** arising from the capabilities that people have developed over time through experience.
- **Cultural knowledge** relating to customs, values and relationships with clients and other stakeholders.

Absorptive capacity relates to how organisations engage with knowledge and is defined as an organisation's ability to value, assimilate, and apply new knowledge to improve organisational learning and performance. It has two elements, namely[2]:

- **Potential absorptive capacity** – an organisation's ability to acquire (i.e. by identifying and accessing relevant knowledge) and assimilate knowledge (i.e. by analysing and interpreting this information).
- **Realised absorptive capacity** – an organisation's ability to put newly acquired knowledge into action through transformation (i.e. by combining existing knowledge with the newly assimilated knowledge) and exploitation (i.e. by using the knowledge that has been transformed).

An organisation's absorptive capacity has been found to be influenced by three capabilities[3]:

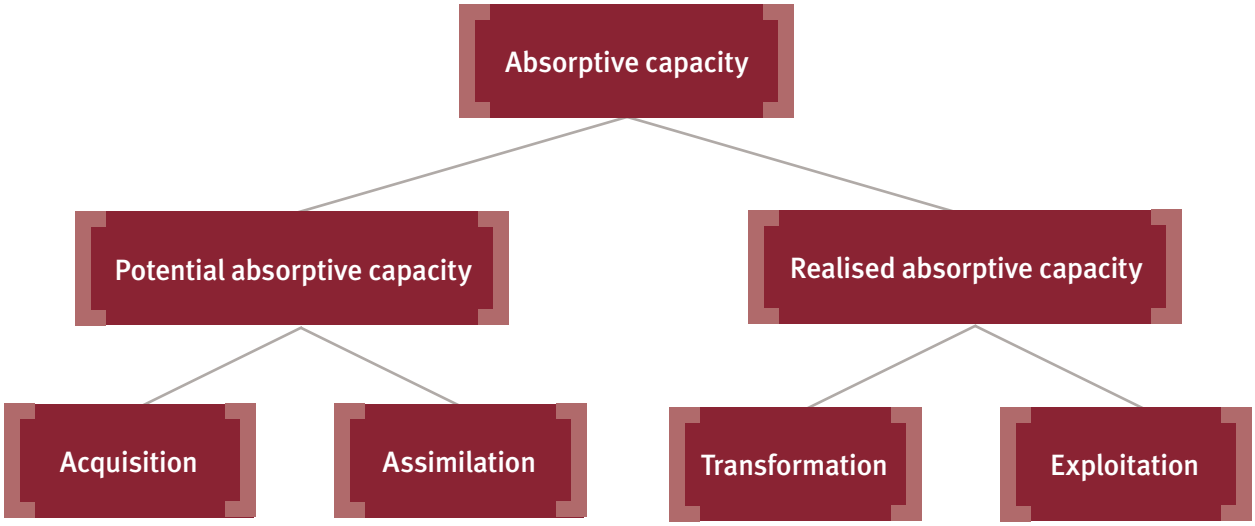
- **Socialisation:** An organisation's ability to develop a shared identity, norms and culture etc.
- **Coordination:** Organisational mechanisms or structures, such as education and training, interfaces across similar functions, distinct liaison roles etc.
- **Systems:** An organisation's formal knowledge exchange processes, procedures and mechanisms including written guidelines and IT etc.

[1] Currie G, Croft C, Chen Y, Kiefer T, Staniszewska S, Lilford R. (2018) The capacity of health service commissioners to use evidence: a case study. Health Services Delivery Research 2018;6:1–158

[2] Flatten TC, Greve GI, and Brettel M. (2011) Absorptive capacity and firm performance in SMEs: The mediating influence of strategic alliances. European Management Review 2011;8:137–52

[3] Currie G, Croft C, Chen Y, Kiefer T, Staniszewska S, Lilford R. (2018) The capacity of health service commissioners to use evidence: a case study. Health Services Delivery Research 2018;6:1–158

Figure 1: The key components of absorptive capacity



Key findings

Different types of knowledge and evidence are used and shared. Commissioners and VCSEs in the study sites acquired, integrated, transformed and used knowledge and evidence from a wide range of different sources ranging from national statistics and trade journals to user feedback and staff experience. In order to develop effective commissioning relationships, research participants highlighted the need to be able to access, use and share knowledge and evidence about:

- Each other – the services they provide, where they operate, their track record etc.
- The communities and service users they work with – the scale of need, how services are experienced etc.
- The structures and processes that are an integral part of commissioning and co-commissioning.

They felt it was important that this knowledge and evidence was shared:

- Among different people within their own organisation - for example, across different teams
- Between organisations like themselves – for example, between several VCSEs bidding for a contract together or jointly responding to a consultation; or between the NHS and other statutory bodies; and
- Between organisations that were different to them – for example, between VCSEs and commissioning organisations.

Organisations' capacity to use and share knowledge and evidence affects all stages of commissioning, including its outcomes.

The research suggests that the capacity to acquire, use and share knowledge and evidence was important for identifying and meeting population needs and addressing health inequalities. It helped organisations to determine what they were aiming to achieve through commissioning, what each party could offer, whether to go ahead or not, and how collaborative the relationship between the different parties might be (see briefing 1). Having the ability to acquire and use knowledge and evidence was important for organisations when negotiating the terms and conditions of contracts. It also played a central role when monitoring services to ensure outcomes were being achieved and to decide whether changes needed to be made.

Commissioning organisations typically rely on more formal knowledge and evidence than VCSEs.

We found that commissioners were more likely to acquire and use knowledge and evidence from more formal sources, such as national statistics and academic publications. The knowledge and evidence used by VCSEs were predominately informal, tacit and cultural, including that gathered through staff and volunteers working directly with communities and service users. Some of the commissioners we interviewed felt VCSEs needed to improve the quality of their data and their capacity to work with data. However, many recognised the value of the distinct knowledge of VCSE organisations because of the way they engaged and worked with communities and service users. They were able to contribute knowledge on local needs and assets, what works in terms of interventions/actions, and who to involve.

Commissioners and VCSEs see the value of sharing knowledge and evidence but it isn't easy.

The research highlighted how commissioners and VCSEs were increasingly working together to share knowledge and evidence but this varied greatly from one case study site to the other. When it worked, participants found that sharing knowledge and evidence could lead to better problem solving, better quality services and better outcomes. However, some highlighted that existing organisational structures, skills and resources limited what could be achieved. Some VCSEs, particularly smaller VCSEs, felt that the capacity constraints they were experiencing prevented them from acquiring the specialist knowledge (e.g. how procurement systems work) and skills (e.g. analysing administrative data for monitoring purposes) they needed to contribute. Likewise, some commissioners felt limited by siloed working, bureaucracy and the lack of flexibility of their own organisation, including data governance rules and systems (see briefing 4).

Bridging the differences between commissioners and VCSEs is a key challenge.

Research participants revealed numerous differences between commissioners and VCSEs which acted as barriers to organisations sharing and then transforming evidence and knowledge. They reflected how each had their own culture which affected the way they framed and valued things, and even talked about them. They also had different views as to what counted as good evidence and what types of knowledge and forms of evidence were needed when writing a proposal or demonstrating outcomes. On a more practical level, they highlighted how data collection was often made more difficult because of the different data management, monitoring systems and technologies organisations had in place. Some VCSEs felt that the sharing of knowledge and evidence only happened one way – they provided data and insights but it wasn't reciprocated by commissioners. They were also unsure if and how commissioners were using the knowledge and evidence they had provided, affecting how they felt about sharing in the future.

Figure 2: Barriers to the development of shared knowledge and evidence

Socialisation	Overly strong organisational or sectoral identity that stops organisations engaging with external knowledge; distinct and conflicting norms, values and cultures.
Coordination	Lack of shared spaces and forums or uneven control of those spaces; lack of resources (including money, time and skills) and investment in coordination capacity and capability.
Systems	Inflexible information governance; lack of investment in shared IT infrastructure.

> *"I think the language is very different, and we've got a database that we use, and we are constantly tweaking it in order to give our funders what they actually want, because they do, and they change what they want as well [...] So there is a bit of tension about that and there is no consistent management information system. We've all got our own and we haven't got the investment to go and buy a completely new management information system. We haven't got the cash and we haven't got the staff resources to do that, because we're at full capacity. Well, we're over capacity."* (VCSE RESPONDENT)

> *"There's vast amounts of information that's generated through the local authority, which is not greatly helpful when it comes to commissioning decisions but it's sort of just what we have to go on. I think there's a massive space there for voluntary organisations to be able to support with that [...] the information that they could collect could be really helpful and useful for us to be able to utilise from a commissioning standpoint but I think at the moment, the only formal route for that is through the monitoring."*
> (COMMISSIONER)

A number of factors help promote the sharing of knowledge and evidence.

At an organisational level, the development of knowledge and learning was supported by the availability of evidence and knowing where to find it; the internal systems for acquiring and sharing knowledge and evidence; and having a supportive organisational culture that valued and encouraged learning. But the sharing of knowledge and evidence between commissioners and VCSEs was more likely to happen when opportunities to interact, exchange and develop a common understanding and shared purpose across sectoral boundaries existed. Opportunities were created by having coordination capabilities, in particular:

- **Networking spaces** – networks facilitated by local VCSE infrastructure bodies, larger VCSE organisations, Partnership Boards, Health and Well-being Boards, and ICSs, in which people could come together and network to share knowledge and evidence that help build connections and relationships
- **Boundary spanners** – usually people with experience of working in both statutory and VCSE organisations who are able to bring their knowledge with them and help build shared understanding between organisations and sectors
- **Strong leadership** – leaders on both sides that demonstrate a commitment to sharing knowledge and evidence across sectors and systems, working collaboratively and developing mutual trust.

ICSs which have partnership working at their core were recognised as an opportunity for the NHS, local authorities and VCSEs to further develop the sharing of knowledge, data and learning.

Local infrastructure bodies can support and strengthen the sharing of knowledge and evidence.

Networking spaces, such as those facilitated by local infrastructure bodies, were important for the sharing of knowledge and evidence across organisations. They played a key role in the sharing of knowledge and evidence across the VCSE sector and helped reduce the capacity issue that often affected smaller VCSEs. This involved activities such as forums, joint events and delivering training. In the majority of the sites, commissioners helped fund these bodies, and in particular the funding of 'boundary spanning' posts to build relationships between VCSEs and commissioners. Sometimes these posts focused on building networks across health and care as a whole, in other cases they focused on building networks between VCSEs and commissioners in a specific field.

> *"...the idea behind this post, one of the things is to look at how to best share the information from the voluntary sector back with the health system, and from the health system back to the voluntary sector because there was a real desire to work more with the voluntary sector but a recognition that the health system is complex. The voluntary sector is big and complex as well and if you're in one or the other, it can be a big enough task to know about your own system that you're in and so this post is to support people to navigate the other system that they're not necessarily based in."* (VCSE RESPONDENT)

> *"...people have the opportunity to come together and do some of that learning, which I guess will be around letting go, working with best intent, working as a system, understanding what you can share, co-production, working with people from different sectors."* (COMMISSIONER)

Conclusion and implications

Both commissioners and VCSEs can benefit from sharing knowledge and evidence.

While an organisation's capacity to use internal sources of knowledge and evidence is hugely important, it is as important for an organisation to be able to draw from sources of knowledge and evidence beyond their own organisation. In the context of commissioning, this can help both commissioners and VCSEs improve understanding of local needs and respond more effectively to them. However, the study highlights that there are significant disparities of practice and organisational cultures among commissioners and VCSEs that represent challenging barriers to the sharing of knowledge and evidence, and importantly to its use. We found that both within individual organisations and in the networks that existed between them, there was considerable potential absorptive capacity, but this often wasn't realised.

Greater coordination and integration requires capacity building and investment.

Closer collaboration between commissioners and VCSEs can help address some of these existing challenges and strengthen organisations' capacity to share knowledge and evidence. However, significant investment of time and money is needed to support the development of systems that enable the flow of knowledge and evidence between organisations. This involves agreeing together what evidence would be most useful to collect and how best to provide common access to the data once it has been collected. It is certainly difficult to achieve because of the different contexts in which organisations operate and some organisations being too inward looking. However, progress towards a common goal and a more collective outlook can be made through creating opportunities to exchange learning in networking spaces and boundary spanning roles that encourage dialogue. It involves having leaders in place who champion the sharing of knowledge and evidence and support the development of the joined up processes and systems. Looking to the future, the move to ICSs could help grow these opportunities.

Further resources

Kenley, A. and Wilding, K. (2021) *Better data, bigger impact: A review of social sector data*, Pro Bono Economics.

Baylin E., Pedro L., Cole A. (2021) *Making better use of voluntary sector data and intelligence in health service planning: A report by members of the Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance*.

Gilburt, H. and Ross, S. (2023) *Actions to support partnership: Addressing barriers to working with the VCSE sector in integrated care systems*, The King's Fund.

Data Collective (2023) *Improving Data About the Sector*.

Sheaff, R., Ellis Paine, A., Exworthy, M., Gibson, A., Stuart, J., Jochum, V., Allen, P., Clark, J., Mannion, R. & Asthana, S. (Forthcoming) *Consequences of how third sector organisations are commissioned in the NHS and local authorities in England: a mixed methods study.* Health Services Delivery Research 11.

Sheaff, R., Ellis Paine, A., Exworthy, M., Hardwick, R. & Smith, C. (2023) *Commodification and healthcare in the third sector in England: from gift to commodity—and back?*, Public Money & Management, DOI: 10.1080/09540962.2023.2244350

About this research

The Universities of Plymouth and Birmingham and the London School of Hygiene and Tropical Medicine have worked together on a research project funded by the National Institute for Health Research (NIHR) that explores in more depth the VCSE sector and health and care commissioning relationship and identifies where improvements could be made. The project is based on analysis of Clinicial Commissioning Group spend on VCSEs, and six local cases studies. It focuses on services provided in the fields of learning disabilities, social prescribing and end of life care. The research was undertaken by the authors of this briefing, alongside Alex Gibson, Pauline Allen, Jonathan Clark, Russell Mannion, Sheena Asthana, Rebecca Hardwick and Chris Smith.

This is one of four briefings so far produced from the research. Other briefings, articles and reports will be published in due course. See see the website for further details.

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