

Commissioning and contracting for integrated care

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1 Executive summary

Many clinical commissioning groups (CCGs) have started to develop novel contracting and commissioning tools to drive more transformational and sustainable service integration. There is a range of contractual models being discussed and implemented across England. In this paper, we describe two broad frameworks that are currently being developed in five areas of the country to stimulate more integrated models of care – a prime contract and an alliance contract.

In a prime contractor model, the CCG contracts with a single organisation (or consortium) which then takes responsibility for the day-to-day management of other providers that deliver care within the contracted scope or pathway. There is a significant variation on the prime contractor model - the prime provider model - that stipulates that the contracted organisation also provides services directly. An alliance contract sees a set of separate providers enter into a single agreement with a CCG to deliver services, where the commissioner(s) and all providers within the alliance share risk and responsibility for meeting the terms of a single contract.

In practice, these contracts are merely the ‘scaffolding’ for the integrated model and there is no clear demarcation between how different approaches are being used on the ground, or how they stimulate closer partnerships between those providing frontline services for patients. Instead it is the terms of the contract that will act as a lever for collaboration.

Across both models, the three core aims of contract developments for integrated care are:

- to hold providers to account for outcomes
- to hold providers to account for streamlining the delivery of patient care across the gaps between service providers
- to shift the flow of money between providers.



The examples presented in this paper illustrate how different contractual frameworks can formalise pre-existing partnerships or remove barriers to integration. All cases needed considerable investment and resources to establish these new contractual approaches, and required collaboration between commissioners as well as providers. The challenge of establishing new contractual approaches should not be underestimated. Our examples show that it takes a number of years to develop new models that can deliver the intended transformations.

Commissioners will need to develop a new range of competencies to establish and monitor these new contractual models, including a detailed understanding of procurement rules, holding organisations to account for outcomes, and working with new market entrants. As different models are tested, there are new opportunities to develop a range of templates; there are also opportunities for commissioners to learn and share their experiences through learning communities, as well as to increase the support provided by existing organisations such as commissioning support units or NHS clinical commissioners.

There are four essential lessons that CCGs, other commissioners and providers will need to keep in mind while embarking on new models of commissioning and contracting to support integrated care.

- *It is essential to continually engage and communicate with providers, patients and the wider community to define the problem and identify appropriate solutions.* Through this process, all partners can develop a shared vision setting out what they want care to look and feel like in the future – then work back from that point to build a model that meets these aspirations.
- *It will be important to develop transactional and relational approaches.* Nurturing trust and building relationships between providers will be just as important (if not more so) to successful integrated delivery of care as the overarching contract or form of the partnership. Contractual vehicles do not replace the need to establish high-functioning local relationships.
- *Payment mechanisms and incentives will need to be aligned across providers.* Inconsistencies in the way that different providers are reimbursed and incentivised continue to reinforce fragmentation in the delivery of care.



Recent guidance from Monitor provides an opportunity for local variation and flexibility to overcome this fragmentation and develop new models, while innovative forms of payment are developing at a local level.

- *Providers will need to develop appropriate governance and organisational models.* Shifting more accountability onto providers through contractual models leads to greater interdependencies and risk for providers. Providers will be best placed to develop interorganisational forums and processes for decision-making and holding each other to account.

There are major risks as well as potential benefits in commissioning and contracting to support integrated care. In more complex partnerships that involve financial interdependencies and complex flows of money between providers, greater consideration will need to be given to establishing structures and terms of reference for decision-making and risk management so that the interests of all partners are protected. For these reasons, we suggest a cautious approach to implementing new contractual models. CCGs and other commissioners need to carefully consider whether a contractual solution is appropriate and proportionate for addressing the particular problem they want to solve.

Commissioners should enter into such arrangements with their eyes open to the challenges. The costs associated with developing new contractual approaches are high and the process is difficult, time-consuming and resource-intensive, and likely to require dedicated teams or programmes to drive significant improvement. Nevertheless, change on this scale is vital if we are to develop a service that meets the financial challenges and the needs of the population into the future.



2 Introduction

Clinical commissioning groups (CCGs), other commissioners and providers have increasingly been driven by an ambition to strengthen integrated care as a means of improving quality and reducing costs. The King's Fund has been vocal in promoting the benefits of greater joined-up working and closer integration of services across health and social care ([Curry and Ham 2010](#); [Ham and Smith 2010](#); [Ham and Walsh 2013](#)). However, decades of fragmentation between and within health and social care organisations have left a legacy that is frequently held up as a barrier to achieving significant change in the way providers and commissioners work together. When combined with the range of pressures that the health system is facing, many commissioners have started to consider what tools they have at their disposal to stimulate more radical and sustainable service integration.

Previous work by The King's Fund has highlighted the important role that commissioning and contracting can play in stimulating new models of integrated care ([Addicott and Ham 2014](#); [Appleby et al 2012](#)). Over recent months, there has also been a clear signal of support from both the Secretary of State and NHS England for promoting more innovative and flexible approaches to commissioning and contracting to drive transformation. In his inaugural speech in April 2014, NHS England Chief Executive Simon Stevens gave 'permission' for CCGs to explore alternative approaches ([Stevens 2014](#)). And the Secretary of State for Health has recently stated his ambition for CCGs to take on greater accountability for co-ordination of care and outcomes ([Hansard 2014](#)).

Increasing pressures on the system and a more permissive national context have created an opportunity for commissioners to think differently and experiment with alternative commissioning and contracting approaches. Locally, there have already been some efforts to develop new models and there is increasing interest in these across the country. However, there is as yet little evidence on the risks and benefits of different contracting vehicles.

The challenge for CCGs is to understand how they can use the available commissioning and contracting tools innovatively and effectively, particularly in



the face of relentless commissioning cycles, the sheer number of fragmented and complex contracts, and a continually changing regulatory environment. CCGs have varying capacities and resources with which to consider new contractual alternatives. It is not always clear what specific problem is being addressed and how a particular contractual solution seeks to address that problem. In practice, there is possibly an ‘optimism bias’, whereby commissioners are convinced of the benefits of these new contractual tools but fail to convince local providers and wider communities.

This paper attempts to expose some of the confusion and myths surrounding commissioning and contracting for integrated care. We draw on the stories and experiences of five areas that are in the process of developing innovative contractual models as well as a series of interviews with national regulators and agencies, lawyers and procurement specialists. The sites were chosen to represent a range of contractual innovations already under way, operating with different population groups and disease groups – cancer, end-of-life care, musculoskeletal services, mental health rehabilitation, and older people’s services. The sites also demonstrate innovations that developed within the current legislative context as a means of highlighting existing possibilities and challenges.

Most of the innovations we have seen have been driven by CCGs in partnership with local providers. However, there are some examples where providers themselves are leading the thinking around alternative contractual models. Although we focus on contracting from a CCG viewpoint, we do consider the interaction with and impact on other commissioners, providers, patients and wider communities. We conclude with four key lessons that CCGs, other commissioners and providers should consider in future when developing contracting and commissioning arrangements.



3 Emergence of new contractual models

One of the first challenges in considering a new contractual approach is sifting through the array of different models that are being discussed, promoted and implemented – prime contractor, prime provider, integrator, lead provider, accountable provider, accountable care organisation and alliance are just some of the models being discussed. All of these can then be administered within various structures – including a legal contract, agreement or memorandum of understanding – while providers then establish an organisational and/or governance model to deliver care according to the terms of the contract. This paper predominantly focuses on the contractual vehicles used by commissioners rather than the organisational models established by providers to deliver integrated services.

In developing this project, the ambition was to build a typology of these different contractual approaches that clearly describes their characteristics and suitability to different contexts. However, it is apparent from the literature, the working examples we present and discussions with national leaders that there is no clear demarcation between these named models and how they are being used in practice; many of the terms are used interchangeably. In fact, we have made the case elsewhere that naming models up front can even be distracting and unhelpful (Addicott 2014). Rather, there may be greater value in determining how the principles or ambitions that underpin the desired transformation can be built into the terms of a contract.

For the purposes of this paper, we have described two distinct contractual frameworks through which clinical commissioning groups (CCGs) are currently stimulating more integrated service delivery – a prime (or lead) contract and an alliance contract. In the vast majority of current examples in the NHS, these contractual frameworks are focused on a specific population (eg, older people) or disease (eg, musculoskeletal care) boundary. We will briefly describe these frameworks before outlining their principles in more detail. To demonstrate how these frameworks are being used in practice, we identified five sites where commissioners and providers are working together to develop new contractual frameworks. Table 1 overleaf provides an initial overview of these sites, with more details given throughout the report.

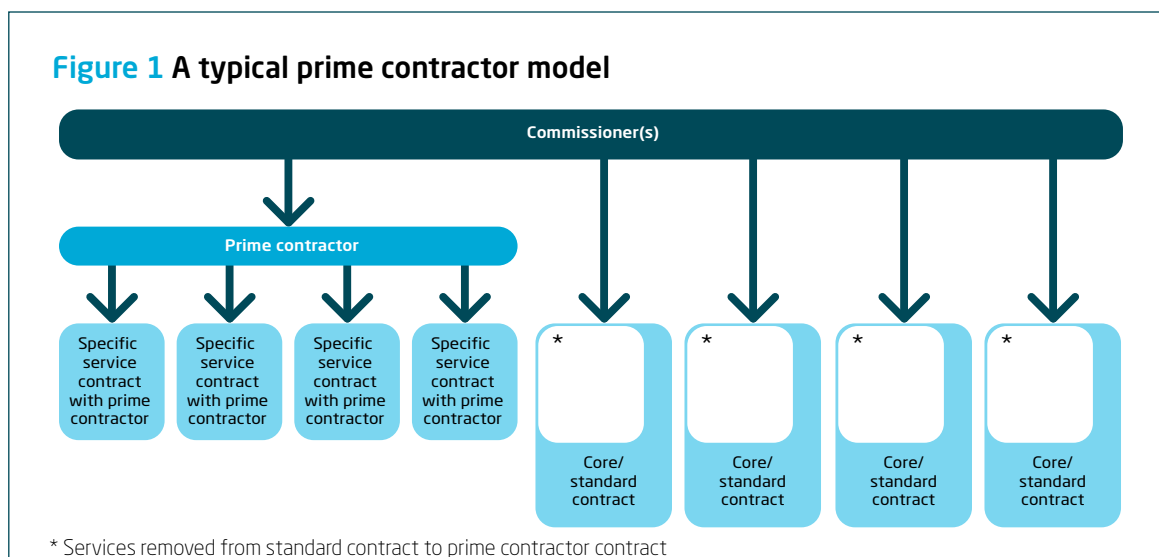


Table 1 Overview of case study sites

	Staffordshire	Bedfordshire	Cambridgeshire	Lambeth	Salford
Focus of contract	Cancer and end-of-life care (separate procurements)	Musculoskeletal care	Older people and adult community services	Integrated personal support (mental health rehabilitation)	Older people
Contract type	Prime contract	Prime contract	Prime provider contract	Alliance contract	Alliance contract and prime provider contract
Main partners in contract development	Cannock Chase CCG North Stafford CCG Stafford & Surrounds CCG Stoke-on-Trent CCG NHS England (cancer only) Public Health England Macmillan Cancer Support	Bedfordshire CCG Circle (appointed prime contractor)	Cambridgeshire and Peterborough CCG Uniting Care Partnership - comprised of Cambridgeshire and Peterborough and Peterborough Foundation Trust and Cambridge University Hospitals Foundation Trust (appointed prime provider)	Lambeth CCG Lambeth Council Provider alliance: Thames Reach, Certitude, South London and Maudsley NHS Foundation Trust and Adult Social Services	Alliance: Salford City Council Salford CCG Salford Royal NHS FT Greater Manchester West Mental Health NHS FT Salix Health (GP provider consortium) 'honorary' member
Motivation for change	Fragmentation Poor access, outcomes and patient experience	Fragmentation Value for money Access problems Variable expenditure and quality of care	Population growth Constrained finances Fragmentation of existing pathways and provision Desire to focus on outcomes rather than activity	To improve quality of care Manage costs Overcome limitations of informal collaboration	Overcome limitations of informal collaboration Population growth
Estimated contract value	£1.2 billion (approx £120 million per year)	£130 million (approx £26.5 million in the first year)	£800 million (approx £160 million in first year)	£24 million (£8 million per year)	Approx £700 million (£98 million in first year)
Length of contract	10 years	5 years	5 years (option of additional 2 years)	2 years (option of additional 1 year)	3½ years (option of additional 3 years)

Prime contract

In a prime contractor model, the CCG contracts with a single organisation (or consortium) which then takes responsibility for the day-to-day management of other providers that deliver care within the contracted scope or pathway (see Figure 1 below). The prime contractor is often referred to as an integrator. The prime contractor manages this supply chain through individual sub-contracts with each of the providers to deliver the specific contracted service. The commissioner removes that specific function from the NHS standard contract or block contract with the provider, and the prime contractor renegotiates the terms of a new contract for that service.



The CCG retains overall accountability for the commissioned services through its direct relationship with the prime contractor, while the prime contractor holds each of the sub-contractors to account individually. Figure 1 shows only a basic depiction of this model; however, in practice, the prime contractor might re-design services within the supply chain so that some providers deliver more or less care than they had under the terms of their preceding contract. And in some cases – such as contracts with independent sector providers with a singular role in delivering care for the defined population – the CCG will not retain any contractual relationship. The prime contractor takes responsibility for designing a delivery model and patient pathway that will most effectively meet the terms of the contract. It uses the terms of the sub-contracts to stimulate and incentivise the necessary behaviours and performance it wishes to see across other providers. The example that follows describes how Macmillan Cancer Support and four CCGs in Staffordshire are working together to design and deliver new models of care around cancer and end-of-life services.



Cancer and end-of-life care services in Staffordshire

History

Since early 2012, Macmillan Cancer Support has been working in partnership with four Staffordshire CCGs to transform the commissioning and delivery of cancer and end-of-life care across the county. The cancer service transformation also involves NHS England. Macmillan has funded a local programme team as a dedicated resource to focus on designing and delivering new models of care. A programme board was established, comprised of the four local CCGs, two local authorities, NHS England (to represent specialised commissioning) and Public Health England. The local authorities and national bodies are not funding the programme directly, but are committed to its ambitions. In November 2013, the programme was selected as one of the government's 14 Integrated Care Pioneer initiatives, to showcase examples of transformational change.

What was the problem?

The programme board was concerned with problems of access, outcomes and experiences for both cancer and end-of-life care across Staffordshire. Care had become fragmented; patients were not aware which provider to contact in a crisis; there have been patterns of inappropriate or unnecessary hospital admissions; and there was limited support to enable people to die at home. There has also been an increase in the number of people living with cancer. All of these factors indicated the need for a new approach.

The programme board wanted to develop services along integrated pathways, focusing on patient outcomes rather than contracts with individual providers. The CCGs currently manage many different contracts for cancer and end-of-life care, most of which are block contracts with no scrutiny of outcomes. Commissioners have concentrated on performance and financial control of these contracts, with little focus on the most appropriate delivery or location of care. There has been little success in shifting resources out of secondary care.

The proposed solution is to shift more care out of acute settings, with an increase in the range and volume of services provided in patients' homes and elsewhere in the community. Reducing costs is not a direct driver of this transformation. However, the prime contractor will be expected to manage and improve services within the available budget; any efficiency savings derived from improved care pathways will be used to accommodate the anticipated increase in demand for local services.



Why a prime contract?

The aim is that bringing together the contracts across all four CCGs will achieve the ambitions outlined above. Commissioners essentially want to appoint a co-ordinator or integrator who will manage contracts and re-design care pathways. They feel they cannot remove duplication and create more efficient pathways themselves within the existing payment and contracting environment.

The plan is to separately procure two 10-year prime contracts - one each for cancer and end-of-life care. Each prime contractor will be accountable for the entire patient journey, and manage sub-contracts with other providers. The intention is that the prime contractors are accountable for patient experiences and outcomes, and will have authority to manage these outcomes through controlling the contracts.

The prime contract was a natural choice for the transformation that the team wanted to achieve. They dismissed an alliance structure because of concerns that there would be no single accountable organisation. Given the complexity of care provision, making one organisation (or consortium) responsible for managing each of the pathways was considered the best way of removing barriers to the delivery of seamless and integrated care, while also ensuring effective monitoring and holding service providers to account.

Stage of development

This programme is ambitious, and the team is taking the time to engage with the community and build the vision and solution in consultation with a range of stakeholders. Since 2012, the team has been working to understand existing pathways (current range of services and whether they are fit for purpose), activity and financial data. They have engaged with patients, the public, carers and clinicians regarding what the problems have been and the improvements needed.

The programme is now in the procurement phase for both cancer and end-of-life care, and a pre-qualification questionnaire has been issued for both contracts. The organisations selected to proceed to the next stage of procurement were announced in November 2014. Preferred bidders for both contracts are likely to be selected in mid-2015.

The CCGs and prime contractors will spend the first two years of the contract testing and delivering a range of approaches and developing appropriate information systems and metrics. They will then spend the next three to four years refining these approaches and implementing new pathways: working with patients, carers, providers and commissioners to design the aspired outcome-based service; moving from short-term contracts and service specifications



to outcome-based specifications; and designing financial incentives. The contractors will then focus on managing care around the new pathways, to deliver improved outcomes.

Payment model

The total contract value is £1.2 billion over 10 years for cancer and end-of-life care combined. It has been a challenge to determine the contract value (eg, allocation of district nursing time for end-of-life care, while some costs are hidden within block contracts).

The programme team has so far based these cost estimates on current spend. There are no immediate plans for a pooled budget with local authorities because of difficulties in isolating the specific component and cost of social care that is provided for cancer and end-of-life care.

At least in the first instance, commissioners will appoint prime contractors to manage the contracts - but will not hand the full programme budget over to them (they will instead receive a fee for managing the contracts). Macmillan has financed the transformation costs (estimated at around £860,000 to date) and will fund the prime contractors' management costs for the first two years. It is expected that the prime contractor will be self-funding within two years of the contract award, and will meet the costs of managing the pathway through efficiency savings.

Terms of the contract

The programme team has undertaken a number of workshops and focus groups, and engaged with the public, patients and clinicians to develop desired outcomes. The team has established what the prime contractors will be expected to achieve at the 10-year mark, as well as incremental outcomes along the way. The programme has mapped these outcome measures against national frameworks. The team is keen to ensure that the outcomes are aspirational enough for the next 10 years.

An outcomes framework has been developed and there will be further dialogue with bidders on this during the Invitation to Submit Online Solutions (ISOS) stage of the procurement. The programme will not specify how the outcomes are to be achieved, but will use the procurement process to stimulate dialogue - discussing and developing delivery models and success indicators.

For the first two years of the contract, there will also be no change in the way money flows to providers. From year three, there might be a different financial arrangement (payment system, payment mechanism or pricing), which will be determined during the initial phase.



There will be no gain share with the prime contractors while information systems are established and members of the programme develop their understanding of the clinical and financial risks. Once the risks are understood and mitigated, contracts will be passed to the prime contractor to manage. The dialogue with bidders will include agreeing appropriate financial incentives.

The prime contractor will present commissioning plans to the CCGs each year for sign-off and to ascertain whether they require public consultation (as the CCGs cannot devolve that responsibility). Once approved, the prime contractors will then work with local providers to deliver the plans.

Challenges and features of success

This is a large-scale and novel transformation project. As such, the programme team has dedicated considerable time to communicating its intent, locally and nationally. As with any change of this nature and level of ambition, some providers and members of the community are anxious about its implications. Many of these anxieties relate to the procurement process and the possibility of new market entrants, particularly the provision of NHS services by for-profit providers.

However, there is an appetite and willingness locally for improvement and integration - on the part of health, social care and public health colleagues. These colleagues are represented within the programme board and in delivery groups. This partnership working has been core to the success of this programme, alongside continual engagement with providers, patients and members of the public.

Macmillan has been a pivotal partner in the programme, providing financial support and also acting as facilitator and adviser. Its support has provided the CCGs with the resources and freedom to build a team to concentrate on developing the programme.

A prime contract could be a simple and relatively straightforward model for CCGs, whereby they would in effect outsource their contract management function to the prime contractor. Commissioners report that they do not currently have the necessary levers for more ambitious transformation through traditional contracting and commissioning tools. They have limited capability and capacity to remove duplication or create more efficient pathways using traditional NHS standard contracts and block contracts. As such, this prime contractor model additionally intends to stimulate delivery transformation, as well as shifting contract



management responsibilities to another organisation. The prime contractor should not just be the contracting vehicle, but be accountable for the organisation and delivery of services.

Given this expectation, the prime contractor takes on a great deal of risk for the pathway or population in question, and must be confident that it has the skills and knowledge to be ultimately responsible for the performance of the sub-contracted providers. The prime contractor manages this risk through the terms of the sub-contracts and the mechanisms for holding those within the supply chain to account. The terms of the sub-contracts intend to stimulate providers to work together and with the prime contractor to deliver care across the pathway. They can allow more flexibility for contracting models and different reimbursement rates than the standard NHS contract and tariff system. There is no necessity for providers to design a separate interorganisational form outside of these sub-contracts.

Typically – but not exclusively – the prime contractor is allocated a capitated budget to manage all care for the specific population or disease group. To varying extents, a proportion of this budget is ‘at risk’, dependent on the prime contractor (through its supply chain) meeting stipulated outcome measures. The model is based on the premise that these measures are more likely to be achieved if the prime contractor manages the pathway and encourages providers to work together more efficiently. In this sense, the CCG contracts the prime contractor to be the service integrator. The example that follows describes how Bedfordshire CCG is tackling one of its largest areas of spend with a view to reducing fragmentation and improving care pathways.

Musculoskeletal services in Bedfordshire

History

As in other areas, Bedfordshire CCG is under some financial pressure. Musculoskeletal care is its fourth biggest area of spend (consuming 7 per cent of the budget), largely driven by a reliance on hospital-based services in some locations. There has not been a formal network of musculoskeletal providers across Bedfordshire, but there are some informal relationships that have successfully emerged because of the relatively small geographical area.



What was the problem?

The CCG felt that it had already addressed the 'low-hanging fruit' and needed to make a more substantial impact on reducing spend. It made the initial decision to focus on musculoskeletal services because it was a high-cost and high-volume area. While the original ambition was not necessarily to reduce those costs, the high spend and some outlier cost issues made it worth investigating further to try to limit increases in spending. Through initial analysis, the CCG identified that it was paying a large amount of money (particularly in outpatient and inpatient services) and was not seeing any proportionate improvement in outcomes. There were access problems, and a regular failure to meet the 18-week target. Patients reported unco-ordinated and inconsistent care and variations in communication, and had no central point of contact.

There were also variable patterns of expenditure and provision across the area - the legacy of different commissioning organisations. As a result, musculoskeletal care across Bedfordshire had been fragmented, inequitable and of variable quality. This fragmentation was reinforced by the CCG's contractual arrangements, whereby it managed between 25 and 30 individual provider contracts for musculoskeletal services - each commissioned in an isolated fashion, to deliver an isolated part of the pathway.

Why a prime contract?

Given the high spend, problems with access and an over-reliance on hospital-based services, the CCG determined that more attention needed to be given to managing the musculoskeletal referral pathway and providing more care in the community. It initially considered commissioning a community triage service, but felt that this would act as only a bolt-on to a fragmented system, where the community provider would not have had sufficient control over other parts of the patient pathway and no incentive to limit secondary care provision.

Instead, the CCG decided to commission and incentivise an organisation to manage the pathway - realising that it did not have sufficient experience of pathway management, nor the incentives to do this itself. The ambition was that a single prime contractor would have greater ability to align incentives across the pathway through a programme budget and overarching outcomes.

Initially, local providers started to come together (convened by the CCG) to consider improvements they wanted to see in the delivery of musculoskeletal services. During this process, the CCG realised that it needed to develop a market and go out to procurement, as it was not confident that a prime contractor could be appointed from existing local



organisations. The CCG originally built the specification through talking to GPs, other clinicians and patient representatives. It also sought input from external and national experts, mindful of potential conflicts of interest arising from involving local experts who might be attached to any bid for the contract.

Stage of development

In April 2014, the CCG appointed a consortium led by Circle Clinical Services Ltd as the prime contractor. The CCG now has a direct contractual relationship with Circle, which manages the contracts within the supply chain. In practice, the CCG has continued to play a brokering role with local providers as Circle establishes their sub-contracts. The CCG holds a standard NHS contract with Circle; however, Circle cannot issue NHS standard contracts because it is not a statutory NHS body. Instead, it is starting with a contract that resembles the terms and conditions of a standard NHS contract.

All musculoskeletal services are within the scope of the contract, except for suspected cancer, immediate life-threatening conditions and trauma, and children’s services. Circle is focused on three core objectives in its prime contractor role – patient choice, quality and efficiency. These objectives (particularly efficiency) will be delivered through more flexible pathways. Circle is breaking down the steps of the pathway and looking at opportunities to improve performance (as well as how it can influence providers to adopt best practice). The pathway is based on:

- prevention
- primary care assessment and referral
- community-based specialist triage, assessment and management
- hospital-based intervention and immediate rehabilitation.

Circle works closely with one of its consortium partners, Horizon Health Choices Ltd (an existing GP provider organisation), which acts as the referral management centre, triaging patients to appropriate services. Circle has employed a ‘choice adviser’ in the Horizon hub, whose role is to explain relevant provider statistics to patients to support them to make an informed choice. The choice adviser discusses the range of providers within the local area, some of which (eg, Milton Keynes Hospital NHS Foundation Trust) are outside of the supply chain but can still receive patients from the contracted population.



Payment model

The prime contract arrangement is underpinned by a capitation-based funding formula, incorporating risk/gain-share and additional financial incentives for delivering improved patient and clinical outcomes. The annual budget started at £26.5 million in the first year, increasing approximately 1.3 per cent each year over the course of the five years.

Terms of the contract

Circle receives 95 per cent of contract value up front, for which it takes full financial risk. An additional 2.5 per cent is paid to Circle to cover management costs. For this sum, the Circle consortium must deliver the basic service specification. Circle can retain the first 5 per cent of any surplus from this 95 per cent at the end of the year. Anything over 5 per cent is split 50/50 with the CCG. This serves as a further financial incentive to the CCG and GPs (who are outside of the Circle contracting pathway) to improve the quality and efficiency of care.

Circle's performance is judged against two sets of quality measures. The first set is the standard metrics expected of any NHS-funded provider (basic standards of care). The second set is a series of 'super-CQUIN' (Commissioning for Quality and Innovation) measures that the CCG has developed:

1. innovative use of technology
2. delivery of high-quality patient experience
3. delivery of improved patient outcomes
4. delivery of truly integrated care
5. production of an annual report that includes stakeholder feedback and plans for improvement.

The remaining 2.5 per cent of the contract value is at risk, based on achieving these 'super-CQUIN' measures. As much as possible, the CCG wants these measures to flow through the sub-contracts. Per capita funding for musculoskeletal services is already relatively low in Bedfordshire, so the financial value of the quality incentives was pitched to be worth at least as much as standard CQUIN incentives, but not too high as to make the delivery of basic system quality unachievable. The 2.5 per cent that is at risk is divided across the five outcome categories.

The threshold and weighting of the outcome measures (and how the data would be collected) were negotiated during contract finalisation and due diligence. Patient



outcomes are the heaviest weighted outcome measure. The outcome measures become more ambitious through the life of the contract. In year one, they are measured, but not applied to performance management (but Circle takes the full 2.5 per cent as additional mobilisation fees); in year two, they increase quarter by quarter so that it is at the full risk by the end of the second year.

Challenges and features of success

Key leaders at the CCG had some prior knowledge and experience of outcome-based contracting, having worked closely with colleagues at Milton Keynes Primary Care Trust to develop an outcome-based contract in the past. As such, there was some enthusiasm for transformation at the CCG to re-design pathways, hold providers to account for achieving outcomes, and increase value by commissioning through a programme budget.

Overall, establishing sub-contracts and setting up the supply chain has taken longer than expected and is still in progress. On reflection, the CCG wondered if it should have stipulated that bidders come to procurement with an established supply chain. However, a prime contractor cannot agree sub-contracts until they sign the prime contract, and building pre-contract relationships with a number of bidders might present an unnecessary burden to local providers. Therefore, in future, the CCG would aim to be more engaged in the early procurement stages to broker the negotiations between the prime contractor and potential supply chain providers.

Advantages of prime contract model

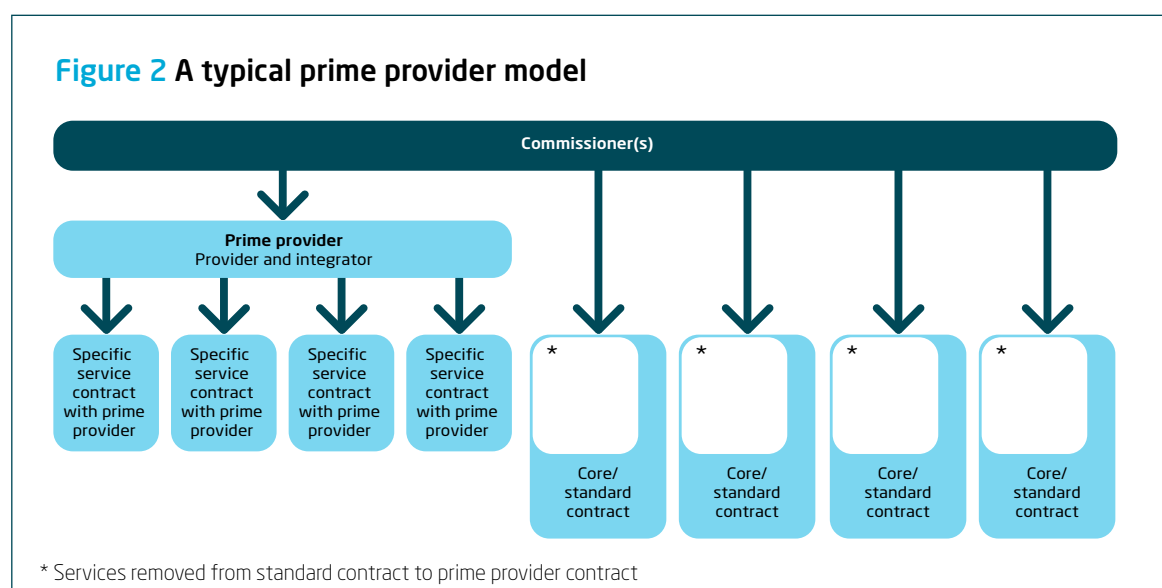
- Simple for commissioners to manage
- Enables pathway management
- Shifts clinical accountability onto integrator and providers

Disadvantages of prime contract model

- High financial and relational risk for prime contractor
- Concern over management of co-morbidities and other boundaries
- Providers may not have sufficient skills in contracting, supply chain management and commissioning

Prime provider contract

There is a significant variation on the prime contractor model – the prime provider model – which stipulates that the contracted organisation also provides services directly (*see* Figure 2 below). While a prime contractor will not deliver care directly as part of the agreement, a prime provider would deliver some or all care within the contract. The prime provider could be a new or existing provider from within the local health economy, or a consortium of providers and ‘integrators’.



In situations where the prime provider model is being used, the intention is to limit further fragmentation that could be caused by introducing a new organisation (ie, the integrator) into the landscape. Instead, the intention is that the prime provider has greater leverage for transformation by directly building its provider capacity and delivery model to meet the terms of the contract. The size and nature of the sub-contracts could change over time; the prime provider might choose to deliver the majority of services itself, or sub-contract for large portions of care. These arrangements will not be specified by the commissioner; rather, the prime provider will develop and change them as appropriate to meet the terms of the contract.

Similar to the prime contractor model, a prime provider would typically receive a capitated budget to provide all care specified in the contract. The prime provider would also use this budget to ‘buy’ additional services (through sub-contracts) that it cannot deliver directly. These models entail CCGs transferring their commissioning responsibilities and risk to a prime contractor or provider. Yet



one important question remains: will all existing providers have the necessary commissioning and contract management skills to take on this role? For this reason, some prime providers may in fact prefer to join a consortium with other organisations to ensure they have access to the necessary provider and contracting experience, and many commissioners are seeking solutions from outside their existing provider network. The example that follows describes how Cambridgeshire and Peterborough Clinical Commissioning Group is using the prime provider model to deliver an integrated service for older people.

Integrated service for older people in Cambridgeshire and Peterborough

History

Cambridgeshire and Peterborough Clinical Commissioning Group is the second largest CCG in England, with 108 GP practices, more than 800 GPs and a registered population of almost 900,000. It is organised into eight local commissioning groups, which have decision-making authority and manage resources through delegated budgets. A member of each local commissioning group is represented on the CCG governing body. The eight local commissioning groups form four broad systems, each of which is distinct, with different health care requirements and issues, and a diverse range of services within their boundaries.

The CCG has identified three strategic priorities: improving out-of-hospital care for frail older people; improving out-of-hospital end-of-life care; and reducing inequalities in coronary heart disease. This programme addresses the first (and partly the second) of these priorities.

What was the problem?

The CCG felt there was considerable scope for improvement in the delivery of older people's services. The local health economy faced numerous challenges, including an increasing number of older people (particularly the older old) and significant financial constraints (with minimal or no growth in health and likely reductions in local authority spend). Addressing these challenges led the CCG to consider a radical new approach, aiming to develop outcome-based commissioning and promote innovation.

Cambridgeshire and Peterborough also has a broader unstable provider mix: all three acute trusts have been subject to scrutiny by Monitor and/or the Care Quality Commission (CQC); there has been high turnover among senior leaders; and some local relationships



are strained, partly due to financial stress. More generally, care for older people across Cambridgeshire and Peterborough has been fragmented and reactive, and focused on measurement of specific processes rather than outcomes. These problems have manifested in failure to achieve accident and emergency (A&E) targets, delayed transfers, high rates of hospital occupancy, challenges in sharing information, and pressure on limited resources in community and primary care services.

Why a prime provider contract?

The CCG realised that incremental change was not going to be sufficient to achieve its ambitions. Traditional payment systems reinforce fragmentation, and it wanted to use its commissioning levers to stimulate more transformational change. It concluded that the answer was to have an integrated service for older people. It tested a number of ideas but essentially wanted to extract money from different contracts into a single pool, and establish a five-year arrangement with a single prime provider to control the budget for the whole patient pathway and relevant services. The CCG wanted to secure a focus on outcomes, a new approach to payment, a fresh approach to provision, and a longer-term contract.

The CCG also wanted this prime provider to directly deliver community services and take responsibility for integrating care, in order to avoid any further fragmentation by introducing an additional player. It was not convinced about the value that a remote integrator could add for addressing the specific problems it was trying to solve. If services are to move into the community, then the prime provider needs to be able to control that shift in care at a strategic and operational level and ensure that services are available to meet increasing demand.

Stage of development

The CCG established an Older People Programme Board, chaired by its clinical lead for older people. The board includes patient and local authority representatives, local clinicians and managers from each local commissioning group, as well as key members of the CCG's management team. The board's role is to oversee delivery of older people's service transformation and make recommendations to the CCG governing body. A core management team has been assembled to work exclusively on the programme, with staff costs of approximately £800,000 a year. The team will also manage the transition in April 2015 when the contract goes live.



The CCG went out to procurement because it wanted to develop new solutions to long-standing system issues and because of the scale of its ambitions and the financial value of the contract; clear interest from a wide range of potential providers; and the discipline provided by the procurement process.

The contract encompasses a population approach for people aged 65 and over, with the budget covering co-ordination of emergency hospital care, mental health services and end-of-life care for this group, including community specialist palliative care. The team quickly realised it would not be feasible to distinguish between older people and adults, and separation would have created an artificial boundary. As such, the contract includes community health services for older people (over-65s) and adults. Planned or elective care is out of contract scope on the grounds that inclusion would potentially distract from the focus on community and unplanned care pathways and increase the complexities of choice for planned procedures. There is an option to include planned care by agreement at a later stage in the contract.

There were around 90 evaluators from local commissioning groups, district and county councils, patient representatives, and specific workstream groups (estates, workforce, governance, quality, patient engagement and information technology) who reviewed the final bids. In October 2014, UnitingCare Partnership, a consortium of Cambridgeshire and Peterborough NHS Foundation Trust with Cambridge University Hospitals NHS Foundation Trust, was selected as the preferred bidder. The new service is expected to start in April 2015.

Payment model

This is an £800 million contract over five years, worth approximately £160 million in the first year. The payment model is essentially a 'year of care' capitated approach for the population aged 65 and over, combined with a new 'payment by outcomes' system worth up to 15 per cent of the total contract value in the latter years of the contract. The contract financial value incorporates a QIPP (Quality, Innovation, Productivity and Prevention) saving requirement, and a forecast of population growth. If the actual annual population growth varies from locally agreed projections by more than a set tolerance, a financial adjustment will be made.

Terms of the contract

The CCG has developed an outcomes framework based on seven domains.

Overarching domains

1. Ensuring that people have an excellent and equitable experience of care and support, with care organised around the patient.



2. Treating and caring for people in a safe environment and protecting them from avoidable harm.
3. Developing an organisational culture of joined-up working, patient-centred care, empowered staff and effective information-sharing.

Pathway domains

4. Early intervention to promote health, wellbeing and independence.
5. Treatment and/or support during an acute episode of ill health.
6. Long-term recovery and sustainability of health.
7. Care and support for people at the end of their life.

The CCG has reduced the number of metrics within these outcomes to around 63, which are weighted and have a value attached (which translates into the outcome-based incentive payment). Some metrics are already available and measurable; others will require collection of baseline data in the early part of the contract; a further smaller group of outcomes are developmental and will be defined in time.

The first 12 months will be a 'bedding in' period and performance will be managed using NHS standard contract performance mechanisms. For the second and third years, the outcome-based incentive payment will be 10 per cent, rising to 15 per cent for the remaining two years.

Challenges and features of success

Local authority services are not directly included in the contract scope and do not contribute to the budget. However, they are members of the programme board, which is responsible for overall delivery, and have fully participated throughout the design and procurement process (dialogue sessions with bidders, evaluation of bids and interviews with bidders). Local authorities and other social care providers are committed to working with the CCG and the new prime provider to achieve their joint ambitions.

One possible unintended consequence of taking planned care out of the programme is that activity is re-classified as elective in order to save money within the prime provider contract. The CCG is working with acute trusts to monitor any increases in their elective activity and will also need to work with the prime provider to manage these financial boundary issues. A key element of the bid responses covered management of the consequences and risks beyond the core scope of the contract.



Advantages of prime provider model

- Increased direct control over provision across a pathway
- Demand risk shifts to provider(s)
- Enables money to move within the pathway
- Clear governance arrangements through contractual/sub-contractual mechanisms

Disadvantages of prime provider model

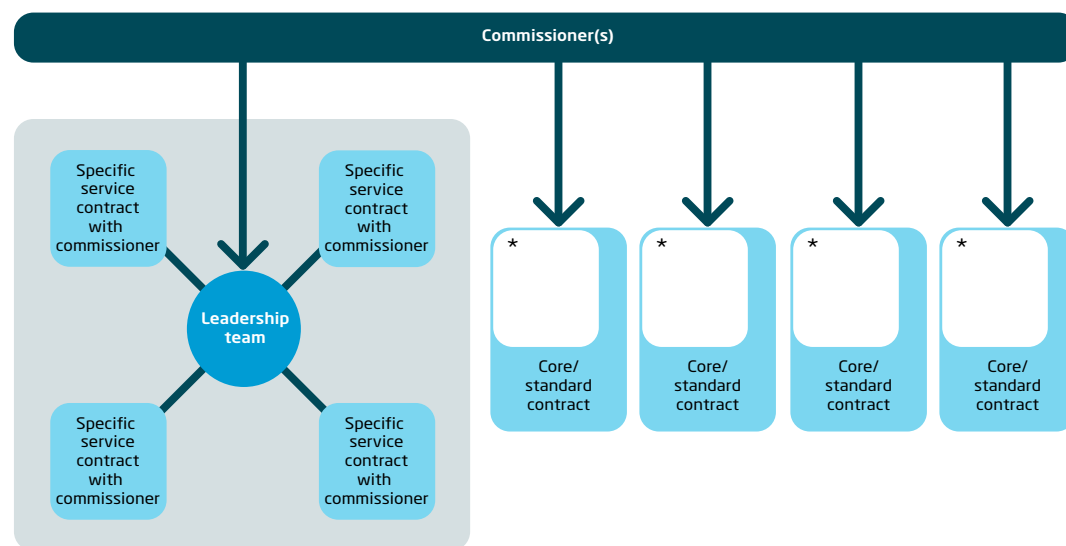
- Possible provider monopoly
- Perverse incentives – may limit patient choice and encourage cream-skimming
- Provider organisation may not have sufficient skills in contracting, supply chain management and commissioning

Alliance contract

The second broad framework we consider in this paper is the alliance contract model, whereby a set of providers enters into a single arrangement with a CCG to deliver services (*see* Figure 3 overleaf). The key difference from the prime contractor model is that the commissioner(s) and all providers within the alliance share risk and responsibility for meeting the agreed outcomes. They are not co-ordinated by a prime contractor or integrator, and there are no sub-contractual arrangements. All organisations within the alliance are equal partners and they must instead rely on internal governance arrangements to manage their relationships and delivery of care. Alliance contracting is a fairly recent development in the NHS; most examples come either from the construction industry in Australia or from health partnerships in New Zealand (Gould 2014; [Timmins and Ham 2013](#)).

The intention of this approach is that integration and collaboration are formalised through the contract, as commissioners and providers within the alliance are legally bound together to deliver the specific contracted service. As such, they should be incentivised to innovate and identify efficiencies across the system, rather than

Figure 3 A typical alliance contract model



* Services removed from standard contract to alliance contract

solely within their organisation. This is distinct from an alliance of providers that might come together informally for a time-limited period on a particular project. An alliance contract typically binds commissioners and providers together to share risk and rewards. Some alliance agreements are emerging between providers without direct commissioner involvement, instead using the provider alliance structure to contract with CCGs.

At the time of writing, the alliance model is not supported through an NHS standard contract. Similar to a prime contractor model, the specific service would need to be stripped out of the standard contract that the CCG holds with each of the providers, and re-packaged within a single contract that sits across all providers in the alliance (sitting alongside existing NHS contracts). Compared to a prime contract or prime provider contract, an alliance contract is potentially more complex for CCGs to put together; in addition, they would still retain considerable responsibility for co-ordination and act as a ‘partner’ of the alliance.

A contract of this type carries both greater risk and greater reward for providers, who are accountable for their own performance and that of other providers within the alliance. Success is judged by the performance of the alliance overall rather than the performance of single organisations within it. The members of the alliance will



need to decide a governance framework through which the money can flow and decisions can be made, as well as a model of service delivery. Given the mutual dependencies, an alliance contract might be most suitable where there are well-established provider relationships.

While the provider members of the alliance are accountable to the CCG, those within the alliance must determine the mechanisms by which they will hold each other to account. The alliance is reliant on high levels of trust across its relationships, and appropriate levers are required to limit undue risk. Members of the alliance will develop a contractual joint venture to govern the alliance and stipulate the necessary safeguards around issues such as individual provider failure or malpractice. Members collectively govern the alliance through a leadership board with an agreed membership and terms of reference. The commissioner will have a direct relationship and single line of accountability to this leadership board. The example that follows illustrates an alliance contract model being developed in Lambeth, south London, to integrate personalised support services.

Integrated personalised support services in Lambeth

History

There is a long history of collaboration between the main providers of mental health services in Lambeth: South London and Maudsley (SLaM) NHS Foundation Trust, several voluntary sector providers, and primary care and social care services provided by Lambeth Council. The Lambeth Living Well Collaborative was established in 2010 as a forum to bring these local providers together with service users and commissioners, to build relationships and consider different ways of delivering mental health services that ultimately achieve the locally derived 'big three outcomes' for service users: recover and stay well; make independent choices and achieve personal goals; and participate on an equal footing in daily life.

The Collaborative has been strengthened by the development of an integrated commissioning team between the CCG and local authority, and the joint appointment of an assistant director of integrated commissioning for adult mental health. However, Lambeth Clinical Commissioning Group and Lambeth Council have so far continued to retain independent budgets for mental health.



What was the problem?

Much of the activity in re-designing mental health services has been commissioned through existing contractual arrangements, requiring considerable investments in capacity, temporary workforce solutions with no added financial reward, and considerable risk to providers. Those involved in the Collaborative felt they had achieved as much as they could by 'tinkering at the edges' through existing contractual mechanisms and informal partnerships. They wanted to drive a larger-scale innovation that would significantly improve the quality of care and manage costs. Existing contracting mechanisms did not incentivise providers to consider new or innovative approaches. They needed more substantial levers to achieve system change and deliver significant cost savings.

The Collaborative chose to develop a new contractual approach specifically for mental health rehabilitation services - or integrated personalised support - for several reasons. SLaM currently has 33 inpatient rehabilitation beds across two acute wards and there are up to 150 people in long-term residential care. Although the rehabilitation service serves a relatively small number of people, it is an area of high cost (£10.5 million annually).

Rehabilitation services were showing variable outcomes (particularly for people with severe and enduring mental illness); the system was fragmented, providers were not communicating effectively, and care was dominated by a biomedical approach (particularly in secondary care). A more imaginative, people-focused service was required.

Why an alliance contract?

Members of the Collaborative wanted a contract that could formally cover a group of providers that were already functioning quite well together as a collective. An alliance contract was considered most suitable because it would: 1) build on the local collaborative approach; 2) recognise the contribution of the range of providers; 3) reduce the risk of a dominant provider; and 4) ensure that outcomes drive the changes that the team wanted to see. The legacy of the relationships developed through the Collaborative and the focus on co-production and community development gave commissioners further confidence that an alliance approach would be the best option.

Stage of development

A subset of four providers with an interest in exploring a whole system or alliance contract came together - Thames Reach, Certitude, SLaM and Adult Social Care. The commissioners and these four providers wanted to keep the group small to test the approach with trusted



partners, before considering how they would bring in additional members to deliver other aspects of care. The intention is that the contract will go live on 1 March 2015.

The long history of collaboration in Lambeth has led commissioners to believe that existing providers from within the Collaborative hold the greatest potential to deliver the 'big three outcomes' listed earlier. In January 2014, commissioners received approval from the CCG board and the local authority procurement board to proceed with the alliance provider model based on a two-year contract, with a one-year extension.

As the alliance group is still quite new, its members are determining how their relationships and interdependencies will work in practice. The commissioners have sought external facilitation and legal advice to work through some of these issues, including defining the most appropriate legal structure. Members are concerned to get the right governance structure in place to allow the most effective relationships, build trust and ensure mutual accountability.

Payment model

The contract will be co-commissioned by the CCG and the local authority, with a memorandum of understanding in place. The financial flows will initially be lump sum payments based on commissioner-approved financial plans from the providers, gradually moving towards direct cost reimbursements.

Terms of the contract

The outcomes that are built into the contract will be centred around the 'big three' outlined earlier; detailed measures for each will be set during negotiations with alliance members. Commissioners and alliance members will then negotiate the outcome thresholds and financial incentives, and how these are shared across providers. There are no rules around how this split works, other than that it should be openly negotiated and agreed.

There will be no risk-sharing initially, and there will be some pump-priming investment to establish alternative service models. Partners felt that it was important to get providers to the table first, and then tackle the more complicated issues of downside risk. This period also gives the alliance some time to think about how to disinvest in the 33 inpatient beds.

Challenges and features of success

Although the history of collaboration in Lambeth has been instrumental in building the foundation for a formal alliance, there are still challenges in engaging the full range of



providers across the system. Strategic leaders (particularly joint commissioners within the CCG and local authority) have had to be resolute in sharing their vision and engaging other stakeholders throughout the journey.

The nature of the alliance contract could also present a particular financial challenge to SLaM. The ambition to reduce the cost of rehabilitation services will be realised through disinvestment in the inpatient beds provided by the mental health trust. The challenge for SLaM and the CCG is to make this disinvestment without destabilising the provider and other services they deliver. Nevertheless, the trust realises that it (and others in the local health economy) needs to develop more innovative approaches given these financial challenges. An alliance approach has the potential to mitigate some of this risk. The shared risk and reward could be set to allow SLaM a softer landing as it seeks to remove fixed costs from the system.

An alliance that is formally established to enter into a contract for a particular service or population might then be in an advantageous position to bid for and deliver other contracts. Relationships based on strong mutual trust are key to the success of the model, and might also benefit the integration and delivery of other service areas. If commissioners have a local alliance with a stable governance structure, which is already demonstrating many of the expected competencies, it may be unnecessary to test the market before issuing contracts for other services – provided they are satisfied that the alliance is the most capable provider ([Monitor 2013](#)). The next example describes how providers and commissioners in Salford are using the alliance provider model to improve older people’s services.

Older people’s services in Salford

History

Providers and commissioners across Salford - including Salford Royal NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust, Salford Clinical Commissioning Group and Salford City Council - have a history of close partnership working. The local health economy has areas of high deprivation and health inequalities, but providers and commissioners are in a strong position - high-performing, solvent, and financially stable. In 2011, most community services were transferred to Salford Royal as part of the Transforming Community Services agenda. The CCG (and the primary care



trust before it) and the local authority have a strong history of integrated commissioning, with pooled budgets for learning difficulties, intermediate care and physical and sensory impairment.

These four statutory organisations have embarked on a programme to integrate care and support for older people, developing a new model of care alongside service and financial integration. Over the past two years, these partners have developed proposals with the triple aims of improving outcomes, delivering a better patient experience and reducing cost.

What was the problem?

The transfer of community services to Salford Royal was a catalyst for change. It stimulated an increased focus on integrated care and recognition of the need to remove gaps between other services, including primary, social and intermediate care. Providers and commissioners realised that care was disjointed and wanted to find a better way to link services across organisations.

After considerable local debate, the decision was made to focus on the transformation of care for people aged 65 years and older. There was a clear case for integrating care for older people: a growing elderly and ageing population, with increasing co-morbidities and long-term conditions; low self-reliance; and late presentation of symptoms. Providers and commissioners believed that developing a new approach for this population could deliver better outcomes and experience and help contain costs, while significant improvements could be made through re-designing services and supporting people to take a greater role in their own care.

The partners agreed that a formal programme structure would be necessary to deliver this type of whole system change. Salford's Integrated Care Programme (ICP) was established in May 2012, with a partnership board accountable to the statutory partners. Partners agreed seven key improvement measures for older people's care: reducing emergency admissions to hospital; reducing permanent admissions to care homes; increasing satisfaction with services; improving quality of life; increasing people's ability to manage their condition; raising rates of flu vaccination; and increasing the proportion of people that die in a place of their choosing. A new model of integrated health and social care was developed through a co-design process (with professionals and older people), which was tested in two neighbourhoods and is currently being rolled out across the city.



Why an alliance contract?

From early on, the ICP partners recognised that existing contractual and payment mechanisms acted as a potential barrier to integrated care. It was agreed, however, that the initial focus should be on designing new models of care, and that the contracting and payment arrangements should be designed to support these. In early 2013, having developed an outline model of care, contractual and payment options were reviewed. Partners were keen to retain the ‘partnership of equals’ approach they had already established through the ICP governance. It was therefore agreed that an alliance contract would be the most appropriate vehicle for bringing together commissioners and providers, as it would enable the provision of more integrated care and services and share risk.

Partners in Salford are not describing their approach as an alliance contract as such (instead referring to it as an ‘agreement’). It is being used as a vehicle to bind commissioners and providers with shared strategic intent, decision-making, goals and improvement measures. The alliance agreement is seen as a mechanism that enables partners to align services and financial resources within a single contractual framework, with joint standards and performance indicators agreed for all parties. It also provides a vehicle to implement different payment regimes and to share risks and rewards.

Stage of development

The alliance agreement builds on and codifies commitments that the existing statutory partners have made through the ICP. While it will enable service delivery to be aligned to the new model of care, the agreement supplements rather than replaces existing service contracts. However, it does provide a mechanism (through mutual agreement) to alter contracts to ensure effective alignment with the new model of care and the associated improvement measures.

The agreement began in October 2014 and is being implemented on a phased basis. It has an initial duration of three and a half years in line with the term of the pooled budget and financial plan (see below), with an option for a further three-year extension.

The existing four ICP partners have made a clear commitment to engage with general practice through the alliance. Salix Health - a new partnership established by Salford GPs - has recently joined the ICP. It is currently a non-voting member of the alliance but is expected to become a full member in time.



Payment model

For the year 2014/15, Salford has a pooled health and social care budget for older people of approximately £98 million (comprised of two-thirds funding from the CCG and one-third from the local authority). The pooled budget includes acute and community services provided by Salford Royal, care services provided or sub-contracted by the local authority, other CCG expenditure (including continuing health care and St Ann's Hospice) and older people's mental health services provided by Greater Manchester West. A four-year investment and disinvestment plan has been agreed, which includes investment in the new model of care and a planned reduction in expenditure associated with a reduction in hospital and care home admissions.

Terms of the contract

Both the ICP and the alliance agreement are underpinned by the same seven improvement measures, which will be reflected in service contracts. The alliance members have chosen not to introduce financial incentives at this stage. While they can see how financial incentives might apply to driving performance improvement in discrete service areas, there is concern about how to establish specific performance incentives for an area of much broader scope such as older people's services.

As part of the alliance agreement, the existing ICP board was reformulated as an alliance board for integrated care. While the board retains responsibility for the design of integrated care solutions for older people, the focus has shifted to an assurance role. The ICP board has delegated authority from commissioners to make strategic decisions and hold the alliance and partners to account for delivering the agreed model of care and associated benefits.

Partners have also established an operational board, accountable to the alliance board. This board is responsible for overseeing the operational delivery of those services that are included within the pooled budget, with a particular focus on those that play a material role in the new integrated model of care.

In this context, the partners have agreed in principle that Salford Royal should act as a 'prime provider' within the alliance, responsible for both direct provision and supply chain management. The rationale for this approach is that a single organisation with one funding envelope, a single set of goals and one vision for Salford's health and social care economy is able to avoid many of the problems of fragmentation experienced in systems that are virtually integrated.



The alliance agreement will be retained as the vehicle for making collective strategic decisions on integration of care, while devolving and delegating responsibility for operational delivery to Salford Royal as prime provider.

Challenges and features of success

Alliance members are adamant that the alliance agreement and prime provider contracts are tools to enable the delivery of more integrated care, rather than an end in themselves. The ultimate goal is to establish a set of enduring, functional relationships and deliver high-quality, efficient care for patients and service users. Members were concerned that starting a transformation programme with a contract was not likely to be successful, so instead focused on building relationships, establishing a shared vision and developing a new model of care.

Relationships are considered to be much more important than the agreement or service contracts - establishing trust, sharing knowledge, identifying and working to common values and behaviours, and a shared commitment. The agreement and partnership in Salford is jointly led by providers and commissioners. Members of the alliance acknowledged that this is difficult to bring together through procurement, and instead favoured an approach where local providers and commissioners co-designed a model together. This has been facilitated by the existence of strong relationships between organisations prior to the programme.

Advantages of alliance contract model

- Strong incentives to collaborate
- Limits dominance of a single organisation
- Strengthens relationship between commissioners and providers
- Retains the active involvement of commissioners

Disadvantages of alliance contract model

- Shared financial and clinical risk, reliant on the performance of other providers



- More complex for commissioners to manage
- Requires existing relationships founded on strong trust, which might not be present in all areas
- Possibility of weak leadership and accountability unless appropriate governance arrangements are established

While the prime contract and alliance contract models described here represent the broad distinction between emergent models, there are a number of principles that underpin these developments. The contract is merely the ‘scaffolding’ for the integrated model. The contractual frameworks themselves do not automatically stimulate greater integration of services or explicitly hold the contract-holder(s) to account for improving outcomes. As with similar models in other countries, both models also carry the risk that the contracted organisation will try to control the cost and quality of care by limiting choice, and attempting to treat patients ‘within network’ (see Addicott and Shortell 2014). It is the *terms* of the contract (or what we are referring to as the underpinning principles) that aim to elicit collaboration and quality improvement, while retaining patient choice. We would argue that consideration of these underpinning principles, discussed in more detail in the next section, should guide the overarching framework of any contractual model chosen.



4 Contract principles: terms of the contract

Across emergent contractual models for integrated care in the NHS and internationally, there have been three core drivers or underpinning principles: to hold providers to account for outcomes; to deliver services more collaboratively in order to streamline patient care; and to shift the flow of money between providers. These principles are common to the architecture of both prime and alliance contracts and should be considered when developing any contracting and commissioning models for integrated care.

Contracting to deliver outcomes

Clinical commissioning groups (CCGs) and other commissioners have expressed dissatisfaction with the performance measures available for incentivising innovation or collaboration. Many recent developments have been driven by a greater focus on outcome-based contracting, which instead shifts greater responsibility onto providers to design suitable care pathways to achieve these outcomes. Some outcome measures might relate directly to clinical outcomes, while others could focus specifically on incentivising collaboration.

Making contract-holders accountable for achieving and improving outcomes seeks to mitigate concerns around ‘cream-skimming’ – where a contract-holder will do the bare minimum within the budget in order to maximise profit above all other considerations. CCGs can additionally link outcomes to incentive payments – that is, the contract would stipulate that a proportion of the budget is paid dependent on achieving a certain threshold on these outcome measures. If the contract-holder does not achieve the threshold, it does not receive that allocation of the budget.

Outcomes can be weighted, depending on their likely impact on the overarching ambition of the transformation or their ‘value’ (Porter 2010). In order to stimulate continual improvement, the thresholds might become more ambitious over time, the proportion of the budget that is at risk might increase, and/or the outcome



measures themselves might change over the life of a contract to reflect longer-term ambitions.

All of these considerations need to be made through reviewing current evidence and in consultation with clinicians, patients and the wider community. Engaging clinicians in developing these outcomes is important to ensure their longer-term buy-in to the transformation programme and, therefore, to its ultimate success. Similarly, agreeing outcomes in consultation with patients, carers and the wider community is vital for developing and communicating the focus and ambition of the programme, rather than being driven by contract and procurement technicalities. Commissioners and others involved in the programme must have a clear understanding of the desired outcomes and be able to articulate them to a range of audiences.

The process of developing and agreeing outcomes is time-consuming and resource-intensive, and is likely to require continual consultation. There are no shortcuts to this process; engaging with relevant stakeholders to discuss and agree the desired outcomes is a vital step in contract development, and one that should not be sidestepped or undervalued. As more outcome-based contracts develop, there will be a greater pool of existing frameworks to draw on, including the NHS Outcomes Framework ([Department of Health 2013](#)). While these resources will prove valuable, they are not a substitute for local engagement and developing outcomes that reflect local priorities.

Outcomes should be few, clear, concise and readily communicated. Ultimately, the outcomes will be operationalised into a greater number of key performance indicators. Outcomes can be specified at the outset for contract design and/or procurement purposes, while the more detailed key performance indicators and thresholds can be negotiated in partnership with the contracted provider(s) or integrator. Some of the common higher-level contractual outcomes identified across the examples described in this paper are as follows:

- patient experience and satisfaction with services
- early detection and intervention, to support people to recover and stay well
- supporting people to manage their condition, and increasing patient involvement in decision-making



- improved patient outcomes (including survival rates)
- reducing emergency admissions to hospital
- delivery of co-ordinated and patient-centred care, demonstrating joined-up working
- effective information-sharing, including use of technology.

Contracting for service integration

Stimulating greater collaboration and integration of services is a common driver across efforts to contract and commission in different ways. The King's Fund and many others (Curry and Ham 2010; Ham and Walsh 2013; Shaw *et al* 2011) have made the case for the benefits of integrated service delivery, but have also clearly outlined the barriers that continue to stand in the way of achieving this at an organisational or system level. Organisational silos and fragmented (and even conflicting) contractual levers can present obstacles to informal integration. There is much that providers from different organisations can do to communicate and work collaboratively within a traditional contracting environment. However, such efforts are often reliant on goodwill, isolated individual relationships, particular individuals and personalities, and small-scale change – all of which have limited impact or sustainability, and can be thwarted by intraorganisational ambitions.

Many of the problems that patients and service users experience in their care relate to the gaps between services and providers. Contracts should focus on holding providers to account for streamlining the delivery of care across these gaps for the population or disease group in question. For instance, a contract could require that all patients with diabetes receive a follow-up call from a member of the community service team within 48 hours of hospital discharge. If both the acute and community providers share responsibility for achieving this outcome, then the hospital will be incentivised to communicate the discharge to the community team and the community team will be incentivised to make the follow-up telephone call. A prime contractor, prime provider or an alliance of providers would take responsibility for designing care pathways and processes to deliver care in this way.



Providers can be incentivised to collectively develop innovative solutions through a shared outcomes framework that includes a combination of: 1) direct measures of organisational integration; 2) measures that focus specifically on the gaps between services; and 3) clinical measures that are most efficiently achieved in partnership.

Contracting to shift costs

Many of the examples we have seen have been driven by an ambition to deliver more care outside of acute hospitals, reducing the number of unnecessary admissions and A&E attendances. These ambitions are based on what is known about patient preferences, but also a drive to deliver more cost-efficient care within an increasingly unstable financial context. However, transformational changes in delivery – such as shifts in the location of care or the way patients move around the system – require transformational changes in the flow of money. There are some challenges that CCGs and other commissioners must consider in this process.

Activity cannot be reallocated from acute providers until adequate provision is available within other (community) settings. Patients and providers will continue to use traditional referral routes and treatment options until viable alternatives are available. If CCGs intend to shift care patterns through new contracting tools, there needs to be a corresponding shift in the proportion of funding across providers. This might require some initial ‘pump-priming’ – either by commissioners directly or in negotiation with the organisation(s) taking on the contract. In order to sustain this shift, commissioners may need to focus on supporting other providers who will see some disinvestment in their services, to ensure that they are not unnecessarily destabilised. New funding pools would allow some of these decisions to be taken directly by prime contractors and other providers.

This conundrum is further complicated by the fact that different commissioners hold different purses. CCGs hold a budget for the bulk of acute and community care, local authorities are responsible for social care and public health, while NHS England pays for specialist services and primary care. This potentially undermines commissioners’ flexibility to shift money around the system. Through the process of contract development, commissioners should consider how money will flow across providers in order to allow for greater service integration. Recent national policies, such as the Better Care Fund and possibilities of co-commissioning primary care, provide an opportunity to support more integrated financial flows.



We have made the case elsewhere for greater alignment across these currencies and financial incentives ([Appleby et al 2012](#); [Ham and Walsh 2013](#)) through a combination of different models, such as bundled payments, a year of care tariff or capitated budgets based on outcomes. Capitation transfers financial risk to the provider(s), giving them a strong incentive to be more efficient by investing in prevention or shifting care into lower-cost settings. Capitated budgets and incentives are linked to the delivery of outcomes, and are not simply block contracts by another name. Providers are held to account for achieving the outcomes outlined in the contract, and payments are adjusted or withheld accordingly. This is particularly important if the new contractual approaches described here are to realise their intended impact. A prime or alliance contract will not achieve the intended shift in integration of services unless it is accompanied by a radical change in the way money flows through the system.

Payment to different providers using variable currencies reinforces fragmentation and conflict. Pooling budgets will allow for more efficient reallocation of funding across the system and also provide the opportunity to consider streamlining these currencies through a programme or capitated budget. This requires collaboration across commissioners as much as collaboration between providers. Payment flows and currencies is a key issue in supporting integrated care through contracting, and this is one of the lessons we highlight in the next section.

CCGs and other commissioners should focus on considering how the three principles we have just described (outcomes, service integration and shifting costs) will be reinforced through the terms of a contract. The proportion of attention given to each will largely be guided by the problem that is to be solved. In some cases, the primary driver will be to save or shift money; in others, it could be to improve the quality of services; while others still might prioritise more effective co-ordination of care to lessen the 'gaps' between providers. In all likelihood, commissioners will be motivated by a combination of all three principles; but they must be clear about what their local ambitions are in order to design and develop a suitable solution.

Essentially, the attention given to these principles will guide the realisation of commissioning ambitions, in combination with a formalised or named contractual vehicle. CCGs may consider being less prescriptive about the contractual vehicle in the early stages of transformation, but instead work with providers (or bidders



if testing the market) on these three underpinning principles, which should reveal the most appropriate structural and contractual configuration to achieve the desired service model.



5 Designing the contract

Boundaries and scope

The terms of the contract should be specific enough to identify and hold providers to account on outcomes, to stimulate improvements in service integration, and to shift costs across the system. This needs to be balanced with allowing enough flexibility for the contract-holder(s) to work with providers to develop appropriate solutions to the problem that needs to be addressed. Over-specifying the services themselves (as well as the outcomes) risks simply reproducing old service models and stifling the incentives and capacity for innovation.

Nevertheless, from the outset, it will be important that CCGs and providers work together to consider the boundaries and scope of the contract.

A key distinction between international examples and those from within the NHS in England is the population focus. International examples frequently focus on the total population for which the commissioner is responsible. Accountable care organisations (ACOs) in the USA and the alliance example in Canterbury, New Zealand, for example, are accountable for all of the patients covered by a particular commissioner (private or government insurer) within their catchment ([Shortell et al 2014](#); [Timmins and Ham 2013](#)). Models that are emerging in England, however, tend to focus more narrowly on a disease or population group within a commissioning area. This more focused approach makes it easier to establish expected outcomes and allows CCGs to test different contracting options to stimulate bespoke solutions. However, CCGs will need to carefully consider the scope and boundaries of the group they are contracting services for, as well as how they will manage any cross-boundary issues.

The distinction between a population group focus (eg, older people) and a disease group focus (eg, musculoskeletal care) is quite important and largely driven by the nature of the problem identified and the complexity of the pathway. For example, a CCG might choose to focus on a disease-based boundary where it has concerns over the quality or efficiency of a clinical or service pathway; whereas a population-



based boundary might be an appropriate solution where there are problems in care co-ordination or a projected increase in the number of people in that population group.

Both approaches entail certain challenges. A disease-based approach is often criticised for ineffectively managing co-morbidities, while a population-based approach can trigger artificial boundaries based on age or other factors, which can lead to a two-tiered system of care. This has implications both for the possible segmentation of patient care and for how commissioners hold providers to account for outcomes that may be partially attributable to care delivered outside the scope of the contract. Defining the population, managing any boundaries and specifying what is in and outside the scope of the contract will require considerable consultation with local providers and communities. These considerations will be vital in establishing the overall budget or contract value.

Some services may remain technically outside the scope of the contract. For instance, primary care is the responsibility of NHS England and cannot currently be directly commissioned by CCGs (although there are plans to develop different options for co-commissioning primary care between NHS England and CCGs). Alternatively, there might be no appetite to pool budgets across CCGs and local authorities, meaning that social care would not be within the scope of the contract.

While these boundaries present a challenge, the challenge can be addressed in a number of ways. In most of the examples we looked at, some services remained outside the scope of the contracts and CCGs had a range of ways of continuing to encourage collaboration. They can give other commissioners or providers representation on a board, to ensure that they are engaged in the overall ambition of the transformation programme – with the possibility that they may become more formally involved over time. Collaboration across these different commissioners is important to the success of an integrated model of care. CCGs can also establish outcome measures that support and incentivise those providers and/or integrators within the contract to continue to collaborate with providers outside of its scope. Furthermore, it is possible that improving the delivery of care within a specified pathway will also change the way providers interact more broadly in the delivery of other services.



Ambitions to stimulate greater integration of care through different contractual options will take time to be realised. As such, commissioners will also need to consider the appropriate length of the contract. Short-term contracts (traditionally 12 months) deter many providers from ‘pump-priming’ or making other upfront investments in new models of care, fearing their contract will not be renewed and they will not reap the benefits of that investment. The five cases presented here are aiming for contracts of between three and ten years. A longer period allows for a phased implementation process, along the lines of that described in Staffordshire.

Providers have different attitudes towards risk and they have varying capacities to understand, share and absorb financial risk. The challenge of this collective risk (and the initial upfront investment required to change the service model) is compounded by relatively short-term contracts. As there is no certainty that the contract will be extended, providers may find it difficult to commit to these terms.

There is a tension between establishing a contract that allows sufficient time for outcomes and savings to be realised, but is also short enough to minimise the risk to commissioners if it is unsuccessful. While local commissioners have been restricted in the past by national limitations on the length of contracts, they now have much greater flexibility. CCGs should rely on developing robust outcome measures and mechanisms of accountability within the terms of the contract to mitigate the risks associated with long-term contracts.

Resources for contracting

Whichever contractual approach is followed, it will in all cases require significant investment and resources; the time, effort and difficulty involved in establishing new contractual approaches should not be underestimated. In the examples we have drawn on, CCGs have spent up to two years planning and engaging with other local stakeholders in order to agree a contractual model and meaningful outcomes. The financial cost to commissioners is very high and requires considerable upfront investment. For example, Cambridgeshire and Peterborough CCG has been spending in the region of £1 million per year on setting up the transformation programme (including £800,000 on staff costs). When done at scale, it is unlikely that planning and contracting for this level of transformation can be successfully achieved within existing resources. These contractual vehicles intend to shift some commissioning responsibilities and risk onto providers (or integrators). It is unclear



whether providers have the skills to manage these responsibilities and this level of risk, and they may need ongoing support from CCGs. CCGs will need to consider what investment they can make in developing and supporting new contractual models (and contract-holders), particularly if the decision is made to go through procurement.

Procurement

One of the major considerations for CCGs is the process of procurement, as there are some myths around what is allowed and supported within the regulatory context and competition law. CCGs are often uncertain about procurement rules – for example, whether procurement is obligatory; when procurement is necessary; and how the process of procurement works. Some CCGs believe that all new contract developments are required to go through procurement, while others do not realise that they are able to issue longer-term contracts. This report does not intend to provide a detailed overview of procurement rules, or debate their merits. Rather, we use the evidence we have collected to illustrate how and when procurement is used within the contracting models explored.

It is evident from media reports and conversations with commissioners and providers that there are many anxieties around procurement and contracting. These anxieties have arisen across the country, but are also keenly felt in discussions at a local level within areas that are testing new contracting vehicles.

Our examples include some CCGs that are using procurement (Cambridgeshire, Bedfordshire and Staffordshire) whereas others have instead decided to work with existing providers (Lambeth and Salford). Both of our examples of alliance contracts have a long-standing history of partnership working, and have continued to build on these relationships rather than test the market. This is to demonstrate that CCGs can make strategic decisions to go through procurement and test the market – which is particularly useful where there are questions about the quality of existing provision and/or where the contract scope and value is substantial. Similarly, CCGs that have not gone through procurement can also make a strategic decision to work with existing providers – because they have confidence that a local solution can be reached and/or that the contract removes barriers to integration for a group of providers that already work well together.



CCGs are not required to test the market, but any organisation can challenge this decision and Monitor will then investigate whether commissioners have broken competition laws. CCGs do not need to formally seek upfront ‘approval’ from Monitor to test the market or otherwise. Rather, Monitor’s role is to provide an external challenge and scrutiny on competition, working with CCGs as they develop their ideas and intentions and then continuing this engagement.

Sources of support and guidance

There are three main areas where CCGs will need support with contracting: financial, legal and procurement. At the outset, the CCGs we worked with looked to Monitor and NHS England to help guide them through the broader technicalities and permissions of contract development and new approaches to commissioning. Monitor has recently issued guidance on compliance with its integrated care requirements as well as competition, procurement and choice ([Monitor 2014, 2013](#)). It is also concerned that some CCGs are making significant inroads on new contractual forms with no prior discussion with national regulators. Many of these challenges are live issues that are being tested in real time.

At the moment, there are very few ‘complete’ examples of new contracting and commissioning models designed to strengthen integrated care. In the absence of any templates or formal guidance, CCGs have been seeking bespoke advice to develop solutions that best meet the needs and configuration of their local health economy. As a number of these emergent ideas are tested, there are opportunities for commissioners to learn and share their experiences as a way of encouraging other CCGs to consider alternative contracting models.

Across the examples we focused on, CCGs occasionally looked to commissioning support units (CSUs) for help. One of the challenges will be to build CSU capabilities to provide support to commissioners at a local level. CCGs need specific support from CSUs with financial modelling, and risk and population profiling. After the contract is awarded, they will also need support with data analytics to monitor the outcomes stipulated within the contract. However, it is unlikely that either CCGs or CSUs will develop or hold the complete range of complex financial, legal and procurement skills necessary to develop a variety of contractual vehicles. CCGs need particular support in these three areas.



We found that CCGs frequently relied on legal firms to assist with contract development, on management consultancies to help understand their population and define the contract value, and on actuaries to assess financial risk and support procurement. This level of support all adds significantly to the cost of procurement and the contract development process – costs which might be prohibitive for less financially stable CCGs, restricting them to a traditional cycle of contracting and commissioning. While bespoke solutions are essential, and will be a significant factor in the eventual success of transformation programmes, considerable time and resources are being spent on building these solutions. Yet the cost and resources involved in buying expertise to replicate these models across the country is not sustainable or defensible in the long term. As such, alternative models of support may be required, such as developing learning communities or increasing the support provided by existing organisations such as CSUs or NHS Clinical Commissioners. These communities and additional support would also be helpful for providers who are taking on additional contracting and commissioning responsibilities through prime provider or other models.

Some CCGs might consider alliance and prime contracts to be a way of devolving responsibility for contract management and accelerating the pace of change. However, it is evident that commissioners will actually be required to develop a new range of competencies to establish and monitor these new contractual models – not least of which will be holding organisations to account on outcomes and working with new market entrants and consortia.

If government and other national agencies are keen to promote alternative contracting and commissioning vehicles, then commissioners need the necessary support to develop these. This support includes financial, legal and procurement advice and may include a range of contractual templates that CCGs can use and adapt for their local context. Furthermore, it is likely that providers might require continuing support from CCGs and national agencies in fulfilling their own emergent responsibilities around supply chain management and managing financial risk.



6 Lessons for commissioners

Before embarking on new models of commissioning and contracting to support the delivery of integrated care, we suggest that clinical commissioning groups (CCGs), other commissioners and providers focus their efforts on four key areas, as follows.

It is essential to engage and communicate with local providers, patients and the wider community

The contractual approaches under discussion here are only the formal vehicle or scaffolding through which integrated care can be promoted and developed. Local stakeholders have a vital role to play in contributing to and buying into programme ambitions, and working together to deliver the outcomes within the terms of the contract. So, from the outset, CCGs need to engage with a broad range of providers, patients and the wider community to define the problem(s) and potential solutions. Rather than trying to convince providers and communities of the need for a different contractual vehicle at the outset, CCGs need to engage these groups to reach a consensus about what a better service should look and feel like. It is only through this process that the most appropriate model and contracting vehicle will emerge. Experience suggests that CCG leaders need to ‘hold their nerve’ when embarking on new approaches in the face of opposition, challenge and uncertainty. Having a shared, meaningful and convincing narrative for change will help them do so.

Through this iterative process, CCGs need to establish a clear and convincing vision that is shared and supported by all stakeholders. This vision should focus on how the solution will solve the problem rather than the details of the contractual model. Similarly, acute hospitals, which may suffer disinvestment as a result of a new approach, will need to buy into the rationale for that approach and be assured that commissioners will support them through any destabilising effects.

Commissioners may wish to engage clinical and community advocates to champion the programme’s ambitions with various audiences and to gather ideas and feedback.



CCGs can use members of their governing body to engage GP networks, which will also be critical to the programme's success. These leaders are key advocates for the programme, and engagement of this nature is of critical value to its success.

Commissioners may also need to engage providers and/or other commissioners that are outside of the legal scope of the contract. For instance, health and wellbeing boards could be a useful broker between CCGs and local authorities in building a shared vision where there is no joint contracting tool or legal arrangement to drive integration.

Commissioners should stay continually engaged throughout the various stages of public consultation and dialogue through the process of competitive tendering. All of the commissioners we spoke to agreed that the value of continual engagement through this process could not be underestimated. Rather than regarding procurement rules or competition laws as burdensome or an excuse for inertia, CCGs could use these tools to refine their ambitions and the technicalities of the contract.

Both transactional and relational approaches have an important role to play

The prime contract and alliance contract models require a high level of trust (which may or may not already exist) among the providers and integrators taking on these contracts. Providers will need to consider how they can build trust, share information and manage financial and clinical risk.

Developing different contractual and commissioning approaches is not a substitute for building good relationships across local stakeholders (which can take considerable time) or addressing conflicts between providers and/or commissioners. A contract is not sufficient to improve relationships and drive service integration, and in some cases may magnify any conflicts and fragmentation. For instance, a fractious relationship between a CCG and acute hospital can carry over in a prime contract to a fractious relationship between integrator and acute hospital, which needs to be brokered by the CCG. In these cases, the contracting vehicle does not address the underlying problem. Traditional contracts operate on measurement, rewards and punishment as drivers of performance, and do not typically require high trust. The models described in this paper demonstrate a more collaborative approach, characterised by shared accountability and a high level of interorganisational trust.



Alliance contracts in particular require providers and commissioners to enter into a single, legally binding partnership. An alliance contract is more likely to wrap around functioning relationships and relies on the strength of these relationships – characterised by high trust and low bureaucracy. The contract (and different payment mechanisms) enables providers to make more substantive change than was possible through informal partnerships. Providers and CCGs will need to have established sufficiently robust relationships in order to agree to such interdependencies and to genuinely share accountability. The contractual vehicle will not build high trust relationships in itself.

The nature of pre-existing relationships might be a factor in deciding the best contractual approach. CCGs might be more convinced by an alliance contract when there is a history of collaboration, trust and commitment between providers and commissioners, with no concerns about quality of provision. Or they may wish to test the market and invite bids from partnerships of providers that are willing to work in such an alliance.

In any case, contractual approaches rely on highly technical levers, based on a transactional approach in order to drive integration. Commissioners and providers should continue to acknowledge, support and promote the relational aspects of integration. The examples we have illustrated here demonstrate how different organisational cultures are coming together in quite complex ways (for example, with new ‘integrators’ in the form of prime or prime provider contracts entering into commissioning and contracting relationships with other local providers). As these organisational cultures are more tightly bound through formal contracts, even more attention needs to be given to ensuring the relationships are healthy and characterised by high trust, and remain so. In Australia, many alliance arrangements are referred to as ‘relationship contracts’. Commissioners should not underestimate the relational aspects of contracting for integration – encouraging collaboration, as well as changes in organisational behaviour and ways of working.

Payment mechanisms and incentives need to be aligned, taking advantage of local flexibilities and capitated budgets

New contractual approaches need to be accompanied by a corresponding realignment in the way that different providers are paid and incentivised. Currently, boundaries and conflicts between providers are reinforced by fragmentation



across payment systems. Providers that are paid for activity can be incentivised to maximise treatment and lower their unit costs. There is little incentive to develop new ways of delivering care, and commissioners must bear the risk of any increased activity. Providers of services where there are no national prices (such as mental health and community services) are instead reliant on block contracts and receive a lump sum payment, thus increasing their demand risk and incentivising providers to limit activity or ‘cream-skim’ less complex cases.

Together, these approaches are driven by perverse and conflicting financial incentives that can carry through into relationships between providers and the care that patients receive. This fragmentation is compounded by the increasing disintegration of commissioning – with CCGs, local authorities and NHS England all taking financial responsibility for different parts of health and social care and relying on different currencies and contracts.

It will be important to take advantage of the flexibility within the system to develop different payment models and pool budgets across commissioners. The 2014/15 tariff guidance is clear that the current pricing regime might not apply in certain circumstances and local variation is possible (Monitor and NHS England 2013). Local variation permits providers and commissioners to define new currencies and agree a price for providing that service. The examples we present here demonstrate how some areas are using the Better Care Fund and pooling budgets across CCGs and with local authorities to overcome fragmentation. Salford has a pooled budget across health and social care, while the CCG and local authority in Lambeth are currently co-commissioning with plans to establish a pooled budget in 2015.

Permission for local variation presents an opportunity to experiment with payment systems that promote integrated care by moving away from case-based payment towards capitation, and defining new currencies that explicitly reward important elements of integrated care, particularly care co-ordination. It has been used to agree the currencies required for mental health and community service block contracts and, more recently, to modify the national tariff rules or bypass them altogether for acute and emergency services. For example, Heart of England NHS Foundation Trust has been paid according to a locally agreed ‘risk-sharing’ agreement with the commissioner for two years (Calkin 2013). Importantly, this agreement further reduces the ‘incentive to admit’ from A&E under the Payment by Results tariff.



Commissioners should use the more flexible national context to consider ways of reducing financial fragmentation, ‘aligning budgets’ with local authorities and NHS England, co-ordinating how they commission services locally according to shared aims and objectives. This could be a step towards a more formal pooled budget (through a Section 75 agreement), where commissioners combine their budgets into a single fund (Ham and Walsh 2013). Commissioners could then use this pooled budget to fund providers on a capitated basis, covering the full range of services for a whole population. This allows commissioners and providers to collectively design a range of interventions for this population, including prevention and targeting those at greatest risk of unnecessary admissions and treatment. Recent initiatives, such as the Better Care Fund, may provide more opportunities for increasing financial collaboration. Innovations in payment mechanisms (using the opportunities and flexibilities described by new Monitor guidance) can then flow down the supply chain and not be limited to the contract between the commissioner and the integrator.

A capitated budget would seek to align financial incentives and allow providers to collectively manage the distribution of activity and funding across the system. The capitation payment would be based on the agreed contract value (as discussed earlier), adjusted over time according to population projections and/or any ambitions to reduce overall spending for the service.

The transfer of financial risk onto providers can introduce strong incentives to limit activity or cut corners on quality. To address these concerns, commissioners could build risk-sharing terms into the financial incentives of the contract (ie, a proportion of the overall budget is dependent on the providers collectively achieving the agreed quality and outcome measures). Our five examples all introduced a degree of risk-sharing through the contract, with a proportion of the budget to be released only after stipulated outcomes have been achieved.

The focus should be on building governance and organisational models

The contractual and payment models described here all point to increased risk-sharing across providers. Commissioners need to focus on developing appropriate and ambitious outcomes for the contract (engaging with the public and providers to do this), but leave the solutions to providers. The contractual model itself will not necessarily guide how providers should manage and share this risk. Instead,



providers must establish an organisational model and/or collaborative governance arrangement to manage the flow of money, develop and monitor services, and hold each other to account for their contribution to meeting outcomes and other terms of the contract.

Shared governance frameworks currently lag behind new contractual models, instead evolving to meet the needs of emergent interdependencies. Early evidence from accountable care organisations in the USA also indicates that shared governance arrangements are not yet mature enough to manage the interdependencies of the contracts (Addicott and Shortell 2014).

CCGs should not be prescriptive about these organisational and governance models. Providers themselves are best placed to establish structures and processes that will best achieve the objectives of the collaboration. In some cases, such as a typical alliance contract, there is a requirement for a leadership team and a management team, and a stipulation that decisions need to be unanimous across all members of the alliance.

New provider partnerships will need to establish a legal framework and terms of reference setting out how they will work together, make decisions and manage risk. Commissioners are transferring greater responsibilities and risks onto providers, which frequently do not have a track record of working together. The scope and other terms of these contracts also presents a challenge for managing risk at the boundaries (either based on population or disease groups) as patients move in and out of the contract remit. Such an approach is inherently risky, particularly as providers take on large budgets and shift money around the system. In more complex partnerships (involving financial risk and complex flows of money between providers), greater consideration will need to be given to how this is managed in order to protect the interests of all partners. They will need to form a legal entity to manage these relationships, with a formal 'agreement' or memorandum of understanding that sets out expectations and defines how interdependencies will be governed and managed in practice.

Absence of any interorganisational governance structures has repercussions for providers' ability and confidence to accept the financial and clinical risk that comes with a capitated budget and an outcomes-based contract. Providers will need appropriate structures and processes in place to monitor spending and performance, as well as mechanisms to hold each other to account.



7 Conclusions

There are major risks as well as potential benefits of using different contractual vehicles to stimulate and support integrated care. The process is long, potentially costly, and might require a level of support that is outside of local capabilities. The experiences reviewed by this paper suggest the need for caution and careful planning in implementing new contractual models. Clinical commissioning groups (CCGs) and other commissioners need to be thorough in considering the appropriateness of a contractual solution for the particular problem they are seeking to solve. There is no magic bullet or shortcut to building trust or nurturing the relationships that are necessary to deliver high-quality and cost-effective integrated care.

These new contractual approaches rely heavily on procurement and supply chain management to design integrated delivery, yet there is limited experience of how to apply these business principles in health care. Emergent research on procurement of health care services attempts to draw parallels with the experience of supply chain management in other sectors (NIHR Health Service and Delivery Research Programme 2012). However, there are fundamental differences between traditional applications of supply chain management and buying and organising health services within a professionalised context (Allen *et al* 2009). We would also urge commissioners and providers to avoid further unnecessary fragmentation of care by segmenting populations through these contracts.

The types of contracts described here are not in themselves a panacea or shortcut – the contract itself will not solve problems, develop integrated services or fix poor relationships. Nor is it a tool to allow CCGs to disengage from strategic commissioning or monitoring the overall performance of care across their area. The examples we have included here instead describe how different types of contracts can formalise pre-existing partnerships, remove barriers to integration and facilitate or support desired behaviours.

Designing and operating novel contractual approaches will require considerable determination, alongside advanced skills in procurement, contract management



and commissioning. The cases we have explored in this paper demonstrate very early experiments to drive innovation through contracting, which have largely relied on the vision of individual teams or leaders, in combination with external legal, procurement and actuarial support. It is unlikely that this approach will be sustainable or replicable across the country, despite the best intentions of commissioners. The cost of developing new contractual approaches is high; the process is difficult and resource-intensive, and is likely to require dedicated teams or programmes to drive significant improvement.

Finally, we would urge Monitor and NHS England to continue their reforms to the payment system to eliminate barriers to integrated care and allow considerable local flexibility in managing payment arrangements. These national organisations are also well placed to gather and share lessons from early innovators, and provide support to enthusiastic but under-resourced commissioners.



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Clinical commissioning groups (CCGs) across England are beginning to think differently about how they work with providers to drive and deliver sustainable integrated care. Some are experimenting with alternative commissioning and contracting approaches, taking advantage of flexibilities including local pricing variation and capitated budgets. But how are new contractual arrangements operating in practice? And what could others learn from how they are being applied?

Commissioning and contracting for integrated care explores how commissioners in five geographical areas are innovating with two broad models - the prime contract and the alliance contract. The case studies cover different population and disease groups (cancer, end-of-life care, musculoskeletal services, mental health rehabilitation, and older people's services). The structure of the model is arguably less important than establishing the terms that hold providers to account for outcomes, stimulate the delivery of patient care across the gaps between service providers, and shift the flow of money between providers. The report highlights the support that CCGs will need with contracting, particularly the financial, legal and procurement aspects.

The report concludes that commissioners should:

- continually engage providers, patients and the wider community to define the problem and identify appropriate solutions
- develop relational as well as transactional approaches
- align payment mechanisms and incentives across providers
- enable providers to develop appropriate governance structures, incorporating decision-making, risk-sharing and mutual accountability.

Using different contractual models to drive integrated care potentially has many benefits but also involves substantial risks, and the experiences reviewed in this report suggest the need for caution. Designing and implementing new contractual arrangements will require considerable determination, and commissioners will need support to strengthen their skills in procurement, contract management and commissioning. National organisations such as Monitor and NHS England have a vital role to play - in continuing to reform the payment system to eliminate barriers to integrated care, and promoting greater local flexibility to manage payment arrangements.

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