New Models of Contracting in the NHS

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Executive Summary

Background

Finding ways to integrate health services to make the best use of resources, reward the delivery of the best outcomes, address demand risk, and catalyse new configurations of providers has become an important policy priority in the English NHS following the publication of the *Five Year Forward View* (NHS England, 2014). This ambition is being realised through various policy developments which entail separate organisations working more closely together. Over the past few years in the English NHS there has been increasing interest in the use of new models of contracting to achieve these aims. These contractual models aim to incentivise providers of health and/or care services to work together to achieve a common aspiration. This report focuses on three such models: Alliance contracting, lead provider contracting and outcome based contracting.

These new models of contracting each differ significantly in the nature of the contractual arrangements they entail. An NHS Alliance agreement between an NHS commissioner and multiple service providers overlays (but does not replace) existing service contracts (NHS Standard Contracts and PMS/GMS/APMS contracts). The Alliance agreement sets out shared objectives and principles, and a set of shared governance rules allowing providers to come together to take decisions. The service contracts to which the Alliance agreement relates may also be subject to payment systems and risk sharing mechanisms which create a collective ownership of risks. In lead provider contracting, NHS commissioners procure under a single contract (an NHS Standard Contract) a set of services. The organisation holding the contract may arrange for a series of NHS Standard subcontracts to be in place with other providers to achieve this. Both the lead provider contract, and the sub contracts, may be subject to a variety of payment mechanisms to incentivise unity of purpose across providers. Outcome based contracting seeks to align incentives across commissioners and providers. This payment arrangement links a proportion of payment to the achievement of defined outcomes. Where the outcomes are shared across multiple providers, this arrangement incentivises providers to work together to achieve system outcomes. Outcome based payments may have varying degrees of relative importance within the contract dependent on the proportion of the overall payment which is dedicated to performance in relation to outcomes.

While there is increasing interest in the use of these models in the NHS, there is a lack of empirical evidence regarding their utilisation in practice.

Aims

This research project aimed to explore why NHS commissioners are choosing new models of contracting, the characteristics of these models, how they are used in practice, and the impact they are having. To meet these aims, the study addresses the following research questions:

1. why commissioners choose particular models of contracting, and what they think such models can achieve
2. in detail the characteristics of these new contractual documents, in particular how outcomes are specified and how financial risk is shared between the parties
3. how the contracts are used in practice, in particular whether the contractual documentation is adhered to, and if not, in which ways it is not
4. the strengths and weaknesses of the different contractual models, both in respect of encouraging cooperation between providers and achieving better outcomes
5. how the NHS Standard Contract is used in conjunction with the new models of contracting, and whether any problems arise in attempting to do so
6. how the new contractual models contribute to reconfiguration of services in local health economies

Design and Methods

The research consisted of three case studies. Each case study focused on a new model of contracting which was being introduced or was in place in a local area in the English NHS. Our case studies consisted of two Alliance agreements (Case Studies A and B). Organisations in the third case study (Case Study C) aspired to put in place a lead provider contractual model. All case studies aspired to use a variety of payment mechanisms to share financial risk between providers, including outcome based payments.

Our main methods of data collection were semi-structured interviews with the management leads for the contractual arrangements in commissioner and provider organisations, and an analysis of the relevant contractual documents. We collected additional data by examining other locally produced planning documents and attending a small number of meetings at which the contractual arrangements were being discussed. There were two stages of data collection,

October 2016 - June 2017 and April 2018 – July 2018. The research period coincided with the contractual negotiations and first year of the contractual arrangements in two case studies. In the other case study the contractual arrangements were in place for the entire research period.

The theoretical framework relevant to the research is derived from economic and socio legal theories. They underpin the relevant theory of contracts, specifically principal – agent theory, transaction cost economics and socio legal models of contractual norms. In addition the analysis draws on empirical evidence relating to the use of these models in the NHS, and in other sectors.

Findings

The development of new models of contracting

Our findings concerning the development of new models of contracting were that the process of negotiation between prospective contractual parties was resource intensive and lengthy, and did not necessarily lead to the agreement of formal contractual arrangements. Commissioners chose these contractual models to incentivise providers to act together to address system-wide issues, with the expectation that they were suitable vehicles to achieve service reconfiguration leading to significant savings. The aim of the service reconfiguration was to achieve a movement of activity from acute services to community based services. The contractual arrangements were considered as a pilot or 'proof of concept' for further contractual arrangements with an increased scope, or alternatively, for different forms of integration which shared financial risk across providers. The development of the contractual model required both significant staff time and the utilisation of legal advice and support from management consultants. This investment was potentially difficult for small contractual parties. The significant investment at the negotiation stage did not necessarily lead to agreement of contractual arrangements. Where negotiations stalled this was related to provider distrust of the underlying financial model, the lack of robust activity data, and more broadly, a lack of alignment of organisations' interests. Additionally, the lengthy period of negotiation risked the model becoming invalidated by changes in the local and national context.

Use of models in practice

We found that the capacity of these contractual models to achieve unity of purpose across providers was limited.

Commissioners aspired to use a broad range of payment mechanisms to incentivise providers to work together. However, these aspirations tended not to be realised in practice. Payment mechanisms to incentivise unity of purpose appeared to have a limited influence on the behaviour of contractual partners. Where payment mechanisms were agreed in relation to outcome measures, the proportion of the relevant service contracts at risk was modest. This reflected the wish of contractual parties to trial payments methods, and a lack of provider appetite for financial risk. In one case study (A), the service reconfiguration agenda had been progressed without agreeing any underlying payment mechanisms. Where arrangements were agreed to share financial gains and losses amongst providers, these were not specified in detail in the written agreement. It was also the case that not all providers participated in risk share agreements. Smaller parties (e.g. third sector, GP federations) were deemed too small to share the financial risks in question. Furthermore, a larger third sector organisation was unable to participate due to constitutional restrictions on spending charitable funds on statutory services.

Where there were pre-existing rifts in interorganisational relationships, primarily between NHS commissioners and NHS providers, these were not remedied by the development of the contractual model. Despite the multi-party nature of these contractual arrangements, negotiations tended to be dominated by binary relationships between the NHS commissioner and NHS provider who was the main recipient of their funding, and which tended to be the organisation at risk of financial losses as a result of the proposed service reconfiguration. On the other hand, the negotiation of contractual arrangements generally improved inter-provider relationships. This was not due to the written contract per se but to improved knowledge, familiarity and trust gained from providers working closely together.

As far as actual behaviour was concerned, both commissioner and provider adherence to contractual undertakings was context dependent reflecting factors such as the financial position of the parties, the wider institutional context, and the existence of established trusting relationships between individuals. In relation to the undertakings of the Alliance agreement regarding commitments to work together, we found these were not consistently adhered to. In one case study (B), where the Alliance members did have clear unity of purpose, we found factors in the local context appeared to be significant. This case study could be characterised as having a history of previous working together as individuals and organisations and modest scale and scope of services under the contract which served to reduce risk exposure and allow internal decision making without reference to governance structures of constituent organisations.

The Alliance model in the NHS

Whilst in industry the Alliance model upholds the principle of equality for all Alliance members, we found that there was necessary divergence to accommodate the model in the NHS. These divergences are necessary to reflect the wider statutory responsibilities of commissioners, however they may also lead to differences regarding the impact and effectiveness of the model in the NHS. Conversely, it was also the case that the inclusion of multiple providers as equal partners in the Alliance was valued by participants. This was particularly the case in relation to the inclusion of the third sector organisations, who were valued as an innovative and independent voice.

Contribution and impact

Findings in relation to the contribution and impact of the contractual models were limited by the extent to which the intent of the contractual models had been realised in the case studies. Only one case study (B – an Alliance) had progressed the contractual arrangements sufficiently to influence the reconfiguration of services and other impacts, such as the achievement of financial savings. In this case the service reconfiguration aims and savings targets had been achieved. The view of the Alliance members was that the Alliance structure was central to the achievement of its aims, in particular that it had enabled the parties involved to focus on 'best for service' and 'best for service user' objectives rather than acting in organisational interests.

Conclusions

Our research suggests that while new models of contracting can play a significant role in facilitating the reconfiguration of services at a local level, and achieving ends key to the integration agenda such as making better use of resources, such contractual arrangements do not address the complex problems that organisations face when they attempt to work together. Consequently, they should be viewed as mechanisms which can help strengthen attempts to work collectively, but cannot overcome significant differences in individual organisations' interests where these exist.

The study has a number of implications for policy and practice. These contractual arrangements cannot influence system design and regulation. The overall aim of agreeing the allocation of financial risk amongst providers is impeded by the payment systems to which providers are subject, and the individual accountabilities of providers for their own financial performance. These elements need to be addressed before the potential of such contractual models can be

realised. Furthermore the legislative framework in relation to procurement does not support inter-organisational co-operation. The findings suggest that the move to alter the procurement requirements as a result of the NHS Long Term Plan may ease this situation although the nature of the proposed 'best value' regime is not yet clear.

In terms of practice, our findings suggest a number of recommendations for commissioners and providers who are considering using these new models of contracting. These include, in the precontractual period, clarifying the position of all parties regarding risk share capacity, considering the resource intensive nature of the contractual negotiations, and investigating and understanding the implications of third sector involvement. It is also recommended that commissioners and providers consider the following when deciding whether to use a new contractual model: issues of scale and scope in the light of findings that modest arrangements may carry practical advantages; the local context, in particular whether organisational interests are aligned and organisations are ready and willing to work together. If an Alliance model is being considered it is recommended that commissioners and providers should consider: the limitations of the Alliance approach in the NHS context; and the level of local support, in particular the existence of enthusiastic local leaders.

Glossary

Accountable care - A term used to describe accountability for using a defined set of resources to provide the best quality of care and health outcomes to a defined population

Alliance agreement - An NHS Alliance agreement overlays but does not replace existing service contracts. It brings providers together around a common aspiration for joint working across the system, setting out shared objectives and principles, and a set of shared governance rules allowing providers to come together to take decisions

AQP - Any Qualified Provider (AQP) is an NHS initiative whereby any registered provider may offer a service at tariff

Better Care Fund - A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities

Block contract - The NHS payment system used for community health services and mental health services under which a healthcare provider receives a lump sum payment to provide a service irrespective of the number of patients treated

Capitation - a means of paying a provider or group of providers to cover the majority (or all) of the care provided to a target population across different care settings, calculated as a lump sum per patient

CQUIN - Commissioning for Quality and Innovation: the performance incentive scheme set out in the contract

HRG – In the NHS an HRG is a standard grouping of clinically similar treatments which use similar levels of healthcare resource. HRGs collate interventions and diagnoses into common groupings in order to support the calculation of Payment by Results tariffs

Integrated Care System – In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve

Joint Venture - a cooperative business agreement or partnership between two or more parties. A Joint Venture can be organisational (i.e. the creation of a vehicle through which to pursue an objective) or contractual (i.e. the parties enter into an agreement to pursue a common objective)

Lead contracting – a contractual configuration where one provider organisation holds a service contract with NHS commissioners and sub contracts part of its performance to other organisations

MCP - The multispecialty community provider (MCP) care model focuses on the integrated delivery of primary care and community-based health and care services, and incorporates a wider range of services and specialists

Memorandum of Understanding (MoU)- A document that records the common intent and agreement between two or more parties. It defines the working relationships and guidelines between collaborating groups or parties.

Monitor – Monitor was the independent regulator of health care provision in England. Monitor became part of NHS Improvement in April 2016

Multilateral gain/loss sharing - Multilateral gain/loss sharing involves multiple providers and one or more commissioners in a local care economy forming a network to identify and distribute financial gains and losses.

NHS England/NHS E - An executive non-departmental public body responsible for directly commissioning primary care and specialist services and overseeing the commissioning arrangements created by the HSCA 2012. From 1 April 2019, NHS England and NHS Improvement are working together as a new single organisation

NHS Improvement/NHS I - An executive non-departmental public body responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. From 1 April 2019, NHS England and NHS Improvement are working together as a new single organisation

PACS – Primary and Acute Care Systems (one of the New Models of Care Vanguard types)

PbR - Payment by Results: the payment system relying on national tariffs for certain HRGs

Vanguards – established as a result of the *Five Year Forward View,* Vanguards were pilots to test new ways of working across sector boundaries

Whole Population Budgets - a simplified version of capitated payments which provides periodic payments for a range of services, initially based on current commissioner spend, according to the size and needs of the population

Chapter 1 - Introduction

Over the past few years in the English NHS there has been increasing interest among healthcare policy makers and local healthcare commissioners and providers in new models of contracting, which attempt to share financial risk between a group of providers, and which, it is thought, may have the potential to improve the integration of services and thereby allow better use of resources (Ricketts, 2014). This report presents the findings of research conducted by PRUComm between October 2016 and July 2018 exploring the use of such new models of contracting in the English NHS. Alliance agreements, lead provider contracting and outcome based contracting were included within the scope of the research. The aim of the research was to explore why commissioners are choosing these new models of contracting, the characteristics of the new models and how they are used in practice, and the effect they are having in respect of encouraging co-operation between providers, achieving better outcomes and enabling the reconfiguration of services. An additional piece of work undertaken in relation to new models of contracting was a review of the literature from other sectors. This separate report can be accessed at the PRUComm website (www.prucomm.ac.uk) (Sanderson et al., 2016).

This report is divided into 13 chapters. An initial introduction briefly sets out the policy context relating to the new models of contracting. This is followed by a discussion of the theoretical framework which underpins the study (Chapter 2), and the empirical evidence regarding the use of new models of contracting, both in the NHS and elsewhere (Chapter 3). We then describe our methods (Chapter 4). The remainder of the report presents the research findings in the light of contractual theory and what is known from the wider literature. We set the scene through an overview of the contractual arrangements in place or under negotiation in each case study (Chapter 5), and situate the case study contractual arrangements within the wider institutional context (Chapter 6). Next, the report examines the written contractual arrangements, focusing on governance (Chapter 7) and payment structures and financial risk (Chapter 8). The report then describes the process of contract negotiation (Chapter 9) and specification (Chapter 10). Finally we discuss the contractual arrangements in practice (Chapter 11) and the contribution of the contractual models in the light of their aims (Chapter 12). The final discussion (Chapter 13) explores the themes which were recurrent across our findings, reflects on our findings in

light of the wider literature and theory, considers the models of contracting within the current and emergent policy context, and makes recommendations for policy and practice.

Policy background

The development of new models of contracting in the English NHS is part of a policy drive to develop closer collaboration between organisations delivering health and social care through a variety of arrangements, such as new shared contractual arrangements or new forms of organisations. As described in the *Five Year Forward View* (FYFV) (NHS England, 2014) an important aspect of current NHS policy is the breakdown of the traditional boundaries which exist between types of care, those between primary care, community services, hospitals, mental health services and social care, in order to create personalised and coordinated health services. In response to the ongoing challenge to the sustainability of the NHS due to demographic pressures, rising demand and expectations and outdated and over stretched delivery systems, 'bold, transformative solutions' should be identified which incentivise high quality integrated services, make the best use of resources, reward the delivery of the best outcomes and catalyse new configurations of providers (Ricketts, 2014).

Integration can occur in many ways. It can take place at various levels, such as a patient (or clinical) level, service level, population level, or regional level. It can occur horizontally between bodies providing similar services, or vertically between different sectors (e.g. primary and secondary care). It can be conceptualised in terms of what is being integrated: services, systems, staff, money, organisations. It can also occur through a variety of forms, such as organisational mergers, contractual agreements, the transfer of staff, or informal agreements to co-operate. This differentiation is reflected in the variety of ways integration across provider organisations is being explored in many ways in current NHS policy. At a system level it is taking place through the formation of networks such as Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) (NHS England, 2017a, NHS England, 2014) through which commissioners and providers take on collective responsibility for resource and population health. At the service delivery level, the New Models of Care Programme (NHS England, 2014) is focusing on developing new ways of joining up and delivering health and social care. As part of this programme Vanguard sites across England are redesigning areas of practice or service delivery by exploring various forms of integration. Examples of the types of integration being explored are the Integrated Primary and Acute Care

Systems (PACS) model based on joining up GP, hospital, community and mental health services, and the Multispecialty Community Providers (MCP) model which focuses on moving specialist care out of hospitals into the community. The Vanguard programme is not prescriptive and local sites are exploring different forms of integration, including using the types of new models of contracting which are the subject of this report (National Audit Office, 2018).

This research focuses on the development of new models of contracting which underpin and facilitate closer working between organisations which are involved in delivering a particular suite of services or services for a particular population. New contractual models such as Alliance contracting and lead provider contracting aim to incentivise providers of health and/or care services to work together to achieve a common aspiration. Like many of the initiatives which are currently attempting to promote integration across providers, new contractual models also give commissioners and providers the opportunity to explore on a limited basis new payment systems and risk sharing arrangements, such as multilateral gain/loss sharing, capitated payments and outcome based payments, which seek to encourage rather than inhibit integration.

There is widespread interest in these new contractual models across the NHS, although the extent to which they have been adopted to date remains unclear. These new models have the potential to facilitate major changes to services for NHS patients, but it is necessary to investigate their characteristics and effects to find out how they are working in practice (Ricketts, 2014).

NHS Contracts and the development of new contractual models

Background

Contracts were introduced into the NHS in the early 1990s as part of the internal market reforms, albeit that they were not legally binding (Allen, 1995). Initially, there was no standard form of contract and the written documents used by commissioners varied considerably (Allen, 2002). There is now a detailed form of standard contract published by NHS England which is mandatory for use by commissioners when commissioning clinical services other than primary care (under the NHS Commissioning Board and CCGs (Responsibilities and Standing Rules)

Regulations 2012). This form of contract was designed for use both with NHS Foundation Trusts and independent providers (in both of which cases it is legally binding), as well as with NHS Trusts (in which case it is not currently legally binding).

Contracts in the English NHS are not simply means to allocate resources to providers, but also act as instruments to improve services (Department of Health, 2009). The NHS Standard Contract has a variety of clauses aimed at achieving specified quality standards and improvements through financial levers, and in addition, there are other financial levers (colloquially known as 'penalties') in the standard contract, and commissioners can impose negative financial levers for breaches of nationally specified events (including 'Never Events') and other aspects of poor quality care.

New models of contracting in the NHS

Following the publication of the FYFV (NHS England, 2014) contractual models to encourage integration have been developed. These have the status of voluntary contractual options to be selected locally depending on which contractual solution is deemed likely to work best given local circumstances. This section describes the lead provider and Alliance models as they may be used in the NHS.

NHS Alliance agreements

An NHS Alliance agreement brings providers together around a common aspiration for joint working across the system. It is not designed to replace or in any way override existing service contracts, such as the NHS Standard Contract. The Alliance agreement sets out a number of shared objectives and principles, and a set of shared governance rules allowing providers to come together to take decisions (NHS England, 2017c). An NHS Standard Contract Template Alliance Agreement was first issued in December 2016, as part of the contract framework for the MCP model, and later reissued (alongside the Accountable Care Organisation (ACO) contract package). This template is available for local adoption but requires input to agree elements such as the local governance structures.

NHS lead provider arrangements

A NHS lead provider arrangement is one in which a single provider entity takes full contractual responsibility, through a service contract such as an NHS Standard Contract, for the delivery

of a range of integrated services for a specific population (NHS England, 2015), and other providers are sub contracted by the lead provider.

Development of payment models

The development of new care models outlined in the FYFV is supported by the development and formalisation of payment approaches which allow financial risk to be shared amongst groups of providers, and which reward the achievement of cross organisational outcomes (Monitor, 2014b). These type of arrangements can be a part of contractual models which involve multiple provider organisations (Monitor, 2015a). The main types of these mechanisms are capitation, multilateral gain/loss sharing and outcome based approaches (Monitor and NHS England, 2015). A brief explanation of each mechanism is given below.

Capitation

Capitation is a means of paying a provider or group of providers to cover the majority (or all) of the care provided to a target population across different care settings (Monitor, 2014a). Payment is calculated as a lump sum per patient, rather than paying for particular treatments or inputs. An alternative approach, Whole Population Budgets, is a simplified version of capitated payments which provides periodic payments for a range of services, initially based on current commissioner spend, according to the size and needs of the population (NHS England, 2017d).

Capitated payments may be made to a single provider which provides all the services for the population, or to a single provider which makes arrangements with a number of providers to deliver the full scope of services (for example, through a lead provider arrangement). If the provider (or group of providers) delivers care to the target population for less that the capitated payment, the financial gain generated is retained. This approach is thought to incentivise providers to deliver proactive care to patients, identify risks earlier and arrange the most effective care to patients. This approach may incorporate other payment mechanisms such as outcome payments.

Outcome based payments

This payment arrangement links a share of the payment to the achievement of defined outcomes (in place of payment for processes such as numbers of episodes of care delivered). Outcome based payments may have many benefits, including: enabling a focus on co-ordinated patient centred care; increasing accountability to ensure best value care; allowing commissioners to define outcomes clearly and contract for those they want achieve; enabling better alignment of patient pathways and care processes with outcomes; and better co-ordination (Monitor, 2015b). Outcome based payments can be linked to many other payment mechanisms, and can be used to incentivise service provision across a number of providers through contractual arrangements which seek to formalise joint working between providers, such as lead provider arrangements and Alliance agreements. Where the outcome payments relate to a contractual arrangement linking providers together, this arrangement incentivises providers to work together to achieve system outcomes. Outcome based payments may have varying degrees of relative importance within service contracts dependent on the proportion of the overall payment which is dedicated to performance in relation to outcomes.

Multilateral gain/loss share arrangements

Risk sharing has previously been permissible on a binary basis (between commissioner and provider) within the terms of the NHS Standard Contract (Allen et al., 2014b) for use during a period of significant service reconfiguration. Multilateral gain/loss share arrangements can be deployed to share financial risk between organisations (Monitor, 2015a). Such arrangements aim to overcome the divisive effect of current payment models. The activity based payment approach of the national tariff may deter acute providers from reducing potentially avoidable acute activity. Block payment arrangements which are commonly used for community and mental health services offer few incentives for providers to increase activity for instance by encouraging transfer of patients from acute to community settings. Multilateral gain/loss share arrangements aim to realign the financial incentives of individual organisations to incentivise the delivery of outcomes for the whole system. It can also protect providers from a sudden loss in revenue or from an unpaid increase in activity. This is achieved by allowing (multiple) commissioners and providers to distribute any savings and losses from system change among themselves, thereby mitigating financial risk and incentivising the achievement of system rather than organisational goals.

The use of new models of contracting in the NHS

The use of new models of contracting in the English NHS, such as Alliance contracting and lead provider arrangements, and the use of associated payment mechanisms, is supported by NHS policy as part of the development and support of local approaches to integrating care locally in recognition of the diversity in population and care delivery across the country (NHS England, 2017a). Most recently, The NHS Long Term Plan (NHS England, 2019) suggested the Alliance model be used to achieve local service integration.

Whilst the extent to which such models are being used is not known (due to the local nature of arrangements), there are indications that they are popular with commissioners. In 2015, The Health Foundation reported that they had identified 25 outcome based commissioning contracts in the English NHS either awarded (9) or being planned (16) (Taunt et al., 2015). A survey conducted in 2016 of clinical commissioning leaders indicated that over half of the respondents thought they were likely to use Alliance contracting over the next 12 – 18 months (HSJ, 2016). Case study examples (e.g. Addicott 2014) indicate that they are being put in place in relation to the provision of complex services which span organisations, and focus on the delivery of services to a specific population (e.g. older people) or as part of a particular care pathway (e.g. cancer).

The following two chapters explore the current evidence regarding these new models of contracting. Chapter 2 examines the theoretical framework which will be used in this report, which is based in legal and economic contract theory. Chapter 3 discusses the available empirical evidence, both outside of the NHS and from the NHS itself.

Chapter 2 - Theoretical framework

In order to fully explore these new contractual models it is necessary to consider them in the light of the theory of contracts. The theory of contracts is based in the context of economic theory, and it is also important to consider contracts in socio-legal contexts. The three main approaches to the theory of contracts which are discussed here are principal-agent theory, transaction cost economics and relational contracting.

Principal-agent theory and the allocation of financial risk

A fundamental characteristic of these new contractual models is the creation of incentives for service providers based on the allocation of risk. A contract is put in place when one party (a principal) desires an outcome but the activities to achieve this must be undertaken by another party (an agent). All contracts carry the risk that the agent will act in their own interests rather than those of the principal (Jensen and Meckling, 1976). While many contracts use monitoring of agent performance against the contract to ensure the agent is acting in the principal's interests (known as a behaviour based contract), the contractual models being explored in this report aim to achieve the alignment of the agents' incentives with those of the principal, through the sharing of financial risk, defined here as uncertainty of outcome, between principal and agent(s), and between multiple agents. Effective risk allocation occurs when risk is allocated to those who can control it, thereby incentivising those with responsibility for the risk to act to mitigate it. In the NHS, payment structures can allocate financial risk between those commissioning and providing services in order to incentivise demand management, improve efficiency, and, through the use of risk share arrangements, encourage providers to work collectively.

Transaction cost theory

Transaction costs are a key concept in contractual theory. Transaction costs refer to the cost of making exchanges, both the ex-ante costs of negotiating, specifying and drafting a contract and the ex-post costs of monitoring and enforcing compliance with that contract (Coase, 1937, Williamson, 1985). Transaction costs vary according to two types of characteristics: *firstly*, those which pertain to the behaviour of people buying and selling the product in question and *secondly*, those which pertain to the product itself and its market. Depending on these

characteristics, different forms of organisation (such as different forms of contract) will be more or less efficient.

In relation to behavioural assumptions, transaction cost theory encapsulates two important notions about behaviour. Firstly, it encapsulates the notion of 'bounded rationality', which refers to the limits of the capacity of individuals to process information when they are making decisions (Simon, 1957). Secondly, opportunism, defined by Williamson (1975) as 'self interest seeking with guile' relates to the possibility that individuals will take advantage of circumstances, such as a lack of knowledge in the other party, in order dishonestly to improve their position. Opportunistic behaviour may include withholding or distorting information (gaming), shirking, failing to fulfil promises and appropriation of others' assets (Parkhe, 1993). Opportunism is thought to be particularly relevant in the NHS where there is likely to be 'information asymmetry', knowledge that agents possess which the principal does not, meaning that the agent has more scope for acting opportunistically. These behavioural assumptions necessitate the agreement of governance mechanisms between contracting parties to 'economise' on the impact of bounded rationality and guard against opportunism (Williamson, 1975).

Characteristics of the product, the organisations involved and the institutional context itself are also important in relation to transaction costs. The characteristics of most relevance here are uncertainty and complexity. Uncertainty refers to the extent to which it is possible accurately to predict future circumstances, and is, therefore, related to the complexity of the product and its environment. Uncertainty affects the 'completeness' of the contract (the degree to which it is possible to predict all possible future contingencies), and the difficulty or ease of measuring the products quality, quantity and cost.

A consideration of transaction costs in relation to models which seek to share risk amongst agents, such as Alliance contracting and lead provider arrangements suggests there may be numerous issues to be explored.

Unlike contractual models which have an emphasis on the *ex-post* monitoring of agent performance against the contract, these contractual models emphasise the *ex-ante* elements of the contractual process, namely the agreement of the arrangements to share risk between the principal and agent(s), and between groups of agents. It is therefore likely that the *ex-ante*

process in relation to these models will incur significant transaction costs. In order to align incentives the principal needs to be able to specify current and future requirements, and quantify the performance targets and the appropriate payment structure, and the agent needs to ensure that the targets are reasonable and achievable. Where risks are being shared between multiple agents, those agents need to agree the principles about how risks will be shared.

If payments are to be linked to outcomes, this may be difficult due to the complexity of the nature of health services. For example, the way to achieve the objective might not be clear as the link between action and outcomes is not clear, or because the achievement of outcomes may be out of the direct control of agents. The risk is that outcome measures will not be effective or that outcomes which are hard to measure will not be incentivised. Indeed, the complexity of attributing and measuring outcomes in relation to public services has given rise to concerns regarding the possibility and practicality of using outcome based payment in relation to public services (Lagarde et al., 2013, Perrins, 2008).

Relational contracting

The third aspect of contractual theory relevant to the examination of these new models of contracting in the NHS is relational contracting. While the contract document endeavours to deal with future arrangements, it is impossible to foresee all possible contingencies and eventualities at the outset due to bounded rationality (Simon, 1957). As it is therefore difficult to specify and measure all aspects of agent performance, the contract cannot be 'complete' (Williamson, 1985) or entirely 'discrete' (Macneil, 1978, Vincent-Jones, 2006). In these circumstances, relational contracts might evolve and permit efficient trade (Macneil, 1981).

Theory of relational contracts views certain contracts as relationships over time, rather than discrete exchanges (Macneil, 1978, Macneil, 1981). In relational contracts, adjustments are made to the initially agreed terms during the course of the contractual relationship to deal with unforeseen contingencies (Vincent-Jones, 2006). In contrast with the discrete nature of the complete contract, which is characterised as impersonal, written, specified and measurable, relational contractual elements are not discrete – they are untransferable, informal arrangements, which are subject to ongoing planning and adjustments (Allen, 2002). Every contract is, to a degree, a balance between discrete norms (such as planning, precision and completeness) and relational norms (such as trust, flexibility, solidarity and reciprocity) (Macneil, 1981). Trust in particular is acknowledged to be important as a mechanism which

enables the management of risk where complete contracts cannot be written, due to ignorance or uncertainty about the possible actions of others (Luhmann, 1979, Sako, 1998, Nooteboom, 2002).

The new models of contracting which are the subject of this report are likely to rely more heavily on the existence of relational norms. In situations where the contract encounters high levels of uncertainty regarding the future, reliance on the relational elements of the contract is likely to increase (Macneil, 1978, Williamson, 1985). A 'complete' contract in the NHS context is unlikely because of the inherently complex nature of health care services and a lack of robust data required for proper forecasting and monitoring of activity (Petsoulas et al., 2011). Economic and socio-legal theories of contracting generally, together with empirical evidence on contracting and pricing in the NHS, indicate that the allocation of financial risk is often handled differently from the stipulations of formal contractual provisions (Williamson, 1985, Petsoulas et al., 2011, Macneil, 1978). Empirical evidence also indicates that NHS contracting occurs in the context of mutual interdependences between purchasers and providers, and relies heavily on relational networks and norms (Hughes et al., 2013, Hughes et al., 2011b).

The aim of new models of contracting such as Alliance and lead provider contracting is to secure unity of purpose. A pertinent issue, therefore, where relational norms such as trust are known to be a pre-requisite to successful contracting is the relationship between contractual models and the establishment, maintenance and growth of relational norms. The relationship between the contract and relational norms is contested. Some (e.g. Lyons, 1992, Macaulay, 1963, Sako, 1992) contend that the act of negotiating and writing detailed contracts is inimical to the development of trust between the parties. Furthermore, it is suggested that formal contracts may signal distrust, and encourage rather than discourage, opportunistic behaviour. Others (e.g. (Daintith, 1986, Lorenz, 1999, Deakin et al., 1997) suggest that the use of detailed written contracts does not necessarily indicate a lack of trust between the parties. A third view is that relational norms and the development of well specified contracts may have a complementary relationship, whereby well specified contracts can promote co-operative, long-term, trusting relationships (for example through narrowing risk) and relational contracting may help generate refinement to the formal contract (Poppo and Zenger, 2002).

The Alliance model is particularly interesting in this respect as it attempts to formalise the features of relational contracts as formal contractual terms (Davies, 2008), such as operating on a 'best for project' basis, adhering to unanimous decision making and operating in good faith. The Alliance model therefore seeks to bind parties to the adoption of relational norms. It is important to investigate whether this approach is indeed successful in fostering the adoption of relational norms to sustain a productive contractual relationship.

Chapter 3 – Evidence from the NHS and elsewhere

There is, as yet, relatively limited evidence concerning the operation of Alliance contracting, lead provider contracting and the use of payment mechanisms to share financial risks in the English NHS. Due to the permissive national context relating to the use of the models, the extent to which these models are being utilised by local commissioners, and the impact they are having, is not clear. There is a small number of well-publicised examples of local implementation of new contractual models which have become prominent because of the problems they have encountered (National Audit Office, 2016, Health Service Journal, 2019), however these instances may not be representative.

This chapter seeks to review the evidence which is available concerning the use of these contractual models. Firstly, it summarises the literature concerning the use of Alliance contracting, lead provider contracting and the use of outcome based payments in other settings. Secondly, it summarises the literature concerning the use of the models in the planning and provision of health services in other countries. Thirdly, it reviews the limited evidence which is available concerning the use of the models within the NHS.

Literature from other sectors

This section summarises a literature review examining the evidence regarding the use of Alliance contracting, lead provider contracting and outcome based contracting in sectors other than health. The methodology, and the full results of the review have been published separately to this report (Sanderson et al., 2016).

The review focused on the international evidence concerning the characteristics of the contractual models, the process of their implementation, and their impact. This evidence was drawn from health and welfare services internationally but also other sectors such as construction and defence, where such contracts have been used more extensively. Literature relating to 'pay for performance' in health care, and the USA model of Accountable Care Organisations (ACOs), has been covered extensively elsewhere(Van Herck et al., 2010, Ogundeji et al., 2016, Lagarde et al., 2013), and was excluded from the review.

While unsurprisingly there is a greater volume of evidence regarding the use of these models in other sectors, the literature identified by the review suggests that Alliance contracting, lead contracting and outcome based contracting are in general under researched and under theorised

areas. It is acknowledged that much of the literature is normative in basis, does not consider issues from a theoretical perspective, and does not drawn on empirical evidence (Gallet et al., 2015, O'Flynn et al., 2014, Chen et al., 2012, Buchanan and Klinger, 2007).

Use and Definition of models in other sectors

Alliance contracting

Approaches such as Alliance contracting which aim to overcome the 'adversarial nature' of traditional contracting (Jefferies et al., 2014) have been prominent in the construction industry since the 1990s. The approach of Alliance contracting is thought to have been introduced to the North Sea offshore oil industry in the early 1990s as 'a vehicle to share the risk of complex, costly projects among all the stakeholders' (Gransberg and Scheepbouwer, 2015). The approach is now used in the construction industry across a variety of countries, and is particularly prominent in Australia (Chen et al., 2012).

The contract commonly is based around the development of a shared 'collective ownership of risks' (Rowlinson et al., 2006). This includes a risk/reward shared incentive structure which states the division of financial rewards and penalties according to a fixed pre-agreed ratio between parties to reflect performance against targets. It is based on the principle of 'open book' financial reporting, which refers to openness between alliance partners regarding financial matters. The literature suggests that the 'owner' is a participant in the risk/reward structure. For example in a construction Alliance agreement, the owner would share the construction and design, and share in cost overruns (Department of Infrastructure and Transport, 2011). The development of the relationship between alliance partners is an important part of Alliance contracting, with an emphasis on co-production and relationship-building between the commissioner and the alliance partners. In place of using the written contract to resolve disputes, alliance partners are expected to resolve issues without recourse to the courts for dispute resolution, and contracts may include a no blame/no dispute clause, which excludes recourse to litigation (Rowlinson et al., 2006, Gransberg and Scheepbouwer, 2015, Chew, 2004, Chew, 2007), and unanimous decision making protocols(Davies, 2008).

Lead contracting

There is evidence of the use of lead contracting (termed 'prime' contracting outside the NHS) in defence, including UK Ministry of Defence contracts (Matthews and Parker, 1999, Pryke, 2006, Kebede, 2011, Ndekugri and Corbett, 2004), the construction industry (Bemelmans et al., 2012, Voordijk et al., 2000, Burtonshaw-Gunn and Ritchie, 2004, Rojas, 2008), and

contracts for the provision of welfare services, including employment services contracts in the UK Department of Work and Pensions (Finn, 2011, Finn, 2012, Hudson et al., 2010, Gallet et al., 2015).

The lead provider model, as it is used in other sectors, is based on the belief that commissioners should move away from micro managing complex supply chains, and that moving this responsibility to a lead provider will result in better integrated services (Corrigan and Laitner, 2012, Matthews and Parker, 1999, O'Flynn et al., 2014). Contracts are intended to have a 'black box' approach to allow providers flexibility and freedom in the achievement of outcomes (Finn, 2011).

In common with Alliance contracting, albeit to a lesser degree, the literature concerning lead contracting from other sectors emphasises the development of trusting and co-operative relationships between contractual partners, both between the client and the lead contractor team (Defence Estates and Ministry of Defence, 2003, Kebede, 2011), and within the supply chain (Finn, 2012).

Outcome based contracting

Outcome based contracting is a contractual form which emphasises the achievement of outcomes rather than specifying the processes by which outcomes are to be achieved (Caldwell and Howard, 2014). Often used in conjunction with other contractual models, such as Alliance contracting and lead contracting models, outcome based contracting may have varying degrees of relative importance within the contract dependent on the proportion of the overall payment which is dedicated to performance in relation to outcomes. Outcome based contracting can be differentiated from other forms of contracting due to: the focus on the alignment of goals and incentives across supply chains; increased risk and rewards for suppliers as performance achievement is related to financial bonuses and penalties; an emphasis on the co-production of outcomes through customer/supplier interactions (Selviaridis and Wynstra, 2015). Outcome based contracting is a common approach for 'business to government' contracts such as defence and infrastructure maintenance (Ng et al., 2009, Selviaridis and Wynstra, 2015), but is also a growing approach in 'business to business' contracting (Ng et al., 2009).

Learning from the implementation of models in other sectors

Negotiation and specification of contractual arrangements

The evidence relating to the negotiation and specification of Alliance, lead provider and outcome based contracts suggests firstly, that the process of negotiation and specification of these type of contractual arrangements is likely to be costly and secondly, that there is likely to be a substantial reliance on relational norms to sustain the contractual relationship.

Much of the literature in this regard relates to the negotiation and specification of outcomes where an outcome based payment structure is used. The establishment of outcome based measurement has been found to necessitate the development of new information systems, requiring investment in bespoke data collection and analysis, development of measurement methodologies and monitoring systems (Selviaridis and Wynstra, 2015). It may also demand a more rigorous contract specification thereby highlighting pre-existing issues concerning contract quality, requiring remedial action such as an analysis of the services and outputs which are required from contractors (Hannah et al., 2010, Arthur and Kennedy, 2014, Laurent, 1998).

Whilst contractual theory suggests that the identification and agreement of outcomes is difficult to achieve in relation to public services, much of the literature does not address directly the issue of finding and agreeing outcome measures directly. However, the literature does suggest that the negotiation and specification of outcomes should be seen as an ongoing and iterative process, beyond the contract specification (Arthur and Kennedy, 2014, Hannah et al., 2010, Gelderman et al., 2015). Theory and evidence suggests the transfer of risk through payment mechanisms such as outcome based payments is a significant motivator of behaviour (Martin, 2007). However, suppliers may well be reluctant to agree to contracts linking the entirety of payment to outcomes due to the risk of non-payment, and risk premium payments and rewards linked to milestones may be needed to overcome this (Selviaridis and Wynstra, 2015). Difficulties specifying outcomes, particularly in relation to public services, may further weaken the incentive structure. One example of outcome based contracting in relation to public sector services suggests that outcomes were informally respecified during the contractual period when providers were unable to meet them (Hudson et al., 2010).

Whilst Alliance contracting and lead provider contracting may have similar aims, and draw on the same underlying payment mechanisms, the nature of the contractual arrangements differ significantly. The literature suggests the Alliance model relies on relational norms to steer the contract, and to manage risks which cannot be controlled in the written contract. The reliance on relational norms is explicit in the Alliance contracting model, which is seen as 'a relationship based contractual arrangement' (Love et al., 2010). Many of the success factors identified in the Alliance literature are relational in nature such as developing a leadership enriched culture, establishing top management support, and dedicating adequate resources to this end (Love et al., 2010, Davies, 2008). It is normal practice in the formation of Alliance contracts for the alliance partners to participate in a 'pre-alliance' period after the partners are selected and before the contract commences. During this period the terms of the written elements of the contract are agreed but also partners work together to establish an 'alliance perspective' by undertaking activities which enhance goodwill trust (Langfield-Smith, 2008). An important element in this regard is the acceptance that many issues will be resolved during the performance of the contract, rather than as part of the written contract.

Although it may be expected that lead provider contracting also relies on relational norms to sustain the contractual relationship this is not recognised to any great degree in the literature. This is particularly interesting as evidence suggests relationships between lead contractors and subcontractors can become strained if risk and cost pressure is passed down the supply chain (Matthews and Parker, 1999, Gallet et al., 2015, Finn, 2011). Distrust may occur between lead and sub-contractors due to the perception that lead contractors are profiting from the contracts at the expense of sub-contractors (Gallet et al., 2015, Maddock, 2013, Matthews and Parker, 1999, Finn, 2011).

The literature relating to lead contracting and outcome based contracting suggests that both are susceptible to opportunism. A possible negative effect of incentive payments for outcomes is the encouragement of gaming (Frumkin, 2001, Jacob and Levitt, 2003). Evidence suggests that outcome based contracting, including models which combine lead and outcome contracting, can lead to gaming activities such as 'cherry picking' of easier clients (Hudson et al., 2010), data recording irregularities (i.e. over/under reporting) (Lu and Ching-to Albert, 2006, Caldwell and Howard, 2014), poor quality service (Hannah et al., 2010) and the skimping of service provision (ibid). In relation to lead contracting, there are concerns that the scope for opportunistic behaviour is exacerbated by the 'hands off' approach adopted by the

commissioner. However, the literature did not include any empirical observations relating to this concern. Incentivisation and regulation can also be tailored to mitigate for gaming, such as, for example, requiring providers to accept all referrals in order to prevent cherry picking (Finn, 2011).

The aspects of Alliance contracting which set it apart from other types of partnership working (i.e. the emphasis on risk sharing between all parties and the development of relationships) may reduce the scope for opportunistic behaviour, and there is some evidence that this is successful (Laan et al., 2011). Whilst there may be less opportunistic behaviour within the Alliance contracting relationship, concerns have been raised, in the light of project underruns against the target outturn cost, that there is a temptation at the start of the contractual process for agents to overestimate the costs involved (Love et al., 2010).

It should be noted that, whilst theory and empirical evidence would suggest that these forms of contract incur significant *ex ante* transaction costs, it is not possible, given the weakness of the evidence in this regard, to empirically assess whether these transaction costs are higher than those for other contractual forms. Nevertheless, the evidence indicates that that considerable transaction costs will be incurred in the *ex ante* period, particularly in relation to agreeing payment systems such as outcome based contracting. In mitigation it is argued by some that these transaction costs may be recouped by cost savings created during the life of the contract (Langfield-Smith, 2008). In the case of lead contracting the transaction costs of negotiating and managing sub-contracts can be greatly reduced for the commissioner by moving this role to the lead contractor (Finn, 2011).

Risk and governance

These models appear to be particularly popular in sectors where risk is transferred from the public to private purse, as illustrated by the relatively widespread use of Alliance contracting in the Australian construction industry (Rowlinson et al., 2006). However, it is argued by some that the transfer of risk and accountability from commissioner to provider inherent in these models is in tension with public sector governance objectives including accountability, integrity and transparency (O'Flynn et al., 2014, Gallet et al., 2015, Davies, 2008).

The notion that risk can be transferred from principal to agent is debated, as responsibility for the contract reverts to the principal should the agent fail mid programme (Caldwell and

Howard, 2014). This leads to concerns about a mismatch of risk and accountability, where those parties (assumed to be) carrying the risk are not ultimately accountable for failure. This concern is, of course, particularly accentuated in relation to public services where commissioners have a statutory responsibility for the provision of services to the population, and therefore retain ultimate accountability for service failures (Doerr et al., 2005). One possible response where commissioners retain accountability may be that operational risk transfer may be jeopardised (Selviaridis and Wynstra, 2015), and indeed there is some evidence that this has occurred in the public sector in practice (Hudson et al., 2010).

The literature identifies issues of accountability caused by the 'distance' of the commissioner from the provision of services which may occur when the contractual and payment model aims to transfer responsibility for performance from commissioner to provider. There are fears that lead contractor models can degrade the expertise of the commissioner , thereby weakening its ability to regain ownership and control of the contract should the lead contractor fail (Kebede, 2011, Finn, 2011). The model is thought to risk the increase of information asymmetry between the commissioner and the lead providers, as a result of the transfer of assets, knowledge and skills from commissioner to lead provider (Kebede, 2011). A further reported risk is that the commissioner becomes over reliant on a limited number of organisations who can act as lead providers, resulting in a 'hostage' situation (O'Flynn et al., 2014, Kebede, 2011). The transfer of responsibility from the principal is also thought to weaken commissioners' ability to identify shortcomings in the lead contractor's performance in the first place. Secondly, concerns are also raised regarding the selection of subcontractors, where there is perceived to be a need for the principal to retain an oversight of and control over the subcontractors who are selected for reasons of security (Matthews and Parker, 1999) or to maintain a diverse delivery network (Finn, 2012).

It is argued that Alliance contracting represents a sharing of risk (Arthur and Kennedy, 2014) and therefore does not encounter these issues. However the notion of shared risk is also problematic when considering accountability. Under a traditional contract, specific responsibility and risk is allocated to individual parties, together with the legal consequences for individual failure (Langfield-Smith, 2008). The Alliance contract, however, suggests a collective ownership of the alliance project among partners, and a jointly shared risk, creating potential uncertainty about where accountability lies in the event of under or poor performance of a single alliance partner (Davies, 2008). The nature of public services suggests that the

individual organisation within the Alliance should be held to account for their poor performance, and it appears inappropriate, given the scarcity of financial resources, that an organisation should be unduly penalised for another's poor performance.

These public sector governance risks do not have an evidential grounding in the literature, and indeed may be mitigated by safeguards. Commissioners' distance may be mitigated if commissioners retain a stewardship role (Finn, 2012), or through the imposition of contractual safeguards which allow the commissioner to intervene during the contractual period if the lead contractor fails to meet the minimum performance standards (Finn, 2011). Close relations with the lead contractor post procurement may be achieved through the recruitment of performance managers or similar (Finn, 2012), and/or the establishment of co-located Integrated Project Teams (Kebede, 2011, Defence Estates and Ministry of Defence, 2003, Finn, 2011, Finn, 2012). Issues concerning shared risks may be mitigated by allocating specific risks to specific alliance partners (Davies, 2008).

Overall impact of the models

The literature provides sparse evidence relating to the benefits of these new contractual approaches, and a number of studies conclude that it is difficult to draw any conclusions in this regard due to difficulties with attribution and measurement (Caldwell and Howard, 2014, Buchanan and Klinger, 2007, Henneveld, 2006, Bresnen and Marshall, 2000, Love et al., 2010).

There is some evidence that lead contracting results in a decrease in costs and project completion time (Ndekugri and Corbett, 2004). Evidence from the first two pilot lead contractor construction projects led by the UK Ministry of Defence suggested benefits of over 70% increase in labour productivity, a 25% reduction in construction time, reduced materials wastage and a reduction in through life costs (Holti et al., 2000). The Alliance contracting literature reports that many construction projects were completed within the target costs and timescales using Alliance contracting principles (Gransberg and Scheepbouwer, 2015). However, there is some scepticism regarding reported cost savings in particular in the Alliance contracting literature from the construction sector due to the practice of alliance partners (over) estimating their capital expenditure requirements (Love et al., 2010, Chen et al., 2012). Furthermore any benefits may be due to the implementation of good practice project delivery methods and the identification of good quality contractors rather than any elements inherent in

the contractual models themselves (Bresnen and Marshall, 2000, Buchanan and Klinger, 2007, Davies, 2008).

A further benefit cited for these new contractual models is that they lead to improvements in the quality of services. Chen et al. (2012) found evidence that Alliance contracting led to various benefits such the development of innovations, improved relationships between contractual partner and improvement in non-cost outcomes (such as enhanced reputations and improvement of competitive advantage). The lead provider literature includes a small number of studies that suggest sharing of good practice occurs amongst supply chain members (Lane et al., 2013) and that there is better co-ordination of services as a result of the lead provider approach (Muir et al., 2010).

Evidence from other health systems

The most significant literature regarding the use of a new model of contracting in other health systems is the use of the Alliance model in New Zealand, where Alliance governance models have been used since around 2008. The evidence relating to the use of the model in the New Zealand health system context is therefore discussed below, and shows a mixed picture of the effectiveness of Alliance contracting.

The Alliance model was first introduced in New Zealand as part of the *Better, Sooner, More Convenient* programme, a policy which emphasised the integration of care, and the achievement of efficiency and cost reduction (Lovelock et al., 2017). This programme involved nine pilots aimed at achieving integration across primary care and between primary and secondary care. The main parties in these arrangements are District Health Boards (DHBs) (the statutory local funders of health and social care, and managers of hospital and some community services) and Primary Health Organisations(PHOs) (which co-ordinate DHB funded primary care and GP services which are mostly privately provided). The initiatives in the *Better, Sooner, More Convenient* programme (New Zealand Ministry of Health, 2011) applied Alliance principles to their ways of working. Since 2013 DHBs and PHOs are required to have an Alliance agreement in place, forming 'District Alliances' which use alliance governance principles and pooled funding in order to encourage purchasers and providers to work together (Tebensel et al., 2017). The purpose of the agreements is to encourage leaders of the local system to come together to focus on collaborative whole system service design and delivery, including making decisions about the allocation of resources (Jackson and Gauld, 2018), and

how to address overspends on individual services (Charles, 2017). The use of the Alliance model in the New Zealand context focuses in the main on the adoption of Alliance governance principles to lead decision making, and did not accompany this with the use of payment mechanisms to incentivise co-operation (Charles, 2017, Love et al., 2018, Timmins and Ham, 2013).

In light of the use of the Alliance governance structure in the New Zealand health system for nearly a decade, there appears to be relatively little robust empirical evidence about how they operate (Love et al., 2018). Our review has identified two main sources of evidence. Firstly, an evaluation of two *Better, Sooner, More Convenient* business cases, using mixed method multi-level case study approach incorporating both quantitative data analysis of activity data, a questionnaire of patients and providers, and face to face interviews with clinicians and managers (Lovelock et al., 2014, Lovelock et al., 2017). Secondly, a case study of the use of Alliance governance in Canterbury (Timmins and Ham, 2013), based on interviews with local stakeholders. Both sources note that findings were limited by the relative infancy of the arrangements in question. The evidence presents a mixed picture regarding the operation and effectiveness of the Alliance model, suggesting that local context is an important factor in determining how successful the arrangements are in achieving their ends.

The evaluation of two case studies of the *Better, Sooner, More Convenient* programme (Lovelock et al., 2014), where Alliance governance principles had been put in place, found that trust between alliance members was fundamental to allow the alliance to effectively navigate pre-existing arrangements, strategy development and service redesign, and that the development of trust was a challenging process which took time, a shared vision and commitment. A further publication to the evaluation (Lovelock et al., 2017) noted that the case study alliances had been beset with structural challenges, due to the historical dominance of DHBs in relation to planning, funding and resource allocation, and had, in the limited time available to them, failed to develop trusting relationships and failed to reach agreement over the distribution of resources. Furthermore, decisions made in the Alliance tended to be relitigated and decisions disregarded by senior management in secondary care. The authors concluded that such arrangements should pay greater attention to the contextual realities of their setting.

Conversely it is suggested that within Canterbury's health system, Alliance contracting principles have been used as part of a system wide approach which has resulted the transformation of the system, addressing system wide financial and performance problems, and creating an extensive system of care coordination across hospital, community, social, and primary care, in which emergency medical admissions, lengths of stay, and readmissions fell (Timmins and Ham, 2013, Mays and Smith, 2013). The system adopted an alliance governance structure, and was also reported to put in place a gain/loss share agreement for some services (Mays and Smith, 2013). Alongside this was a general remodelling of payment mechanisms on a system basis, replacing activity based payments with bottom-up budgeting (Mays and Smith, 2013).

Timmins and Ham (2013) report, based on interviews with key stakeholders, that there were high trust relationships between alliance members, characterised by openness and honesty. The possibility for tension between alliance members was noted, particularly with regard to the requirement that the DHB was required to give away some decision making power for the alliance to function. However, in this case it appeared that the alliance governance structures were functioning effectively.

Evidence from within the NHS

An increasing literature focuses on the use of new models of contracting in the NHS, including the underlying payment mechanisms, reflecting their apparent increased usage and popularity. This literature commonly refers to the paucity, or emergent nature, of empirical evidence, and the experimental nature of the use of the contractual models in the NHS setting (Billings and Weger, 2015, Taunt et al., 2015, Collins, 2019, Addicott, 2014, Clark et al., 2015). This lack of empirical evidence is due to the relative novelty of these arrangements, and the length of time required to negotiate the models. In contrast with the paucity of robust empirical evidence, there is a substantial amount of grey literature produced by 'technical advisers' such as management consultancies and legal firms (Corrigan and Laitner, 2012, Acevo, 2015, Hicks, 2017) which aims to support the implementation of these models. Overall, there is a lack of both empirical research, and scholarship which links empirical work with relevant theory, such as contractual theory.

A number of papers rely on case study examples of the use of these models within the NHS (Collins, 2019, Taunt et al., 2015, Addicott, 2014, Clark et al., 2015). Some refer to case study examples drawn from secondary sources (Taunt et al., 2015, Collins, 2019), supplemented with interviews with policy makers and practitioners (Sturgess et al., 2011). The most detailed empirical study is Addicott's review of five case studies (Addicott, 2014) which draws on evidence from three lead provider contractual models and two Alliance agreements, together with policy interviews and interviews with lawyers, to examine how alliance and lead provider contractual arrangements operate in practice. Notably, four of these case studies were at an early stage at the time of the report, either under negotiation or recently signed, limiting learning regarding the operation and impact of the contractual models.

The main areas of learning from these empirical studies, and the other literature relating to the use of contractual models in the NHS is discussed below.

Firstly, the literature warns against an over-reliance on contract as a mechanism to achieve integration. The development of these complex contractual models, and underlying payment mechanisms, can serve as an unhelpful distraction from other efforts to achieve integration (Collins, 2019), and the contractual arrangements should not be viewed as a replacement for the need for strong relationships (Addicott, 2014). Indeed, it is argued that in some cases the use of such contractual models can magnify conflicts (ibid.). Furthermore, it is suggested that close attention should be paid to the local context when these contractual mechanisms are selected, not only regarding quality of relationships, but also for example in relation to the suitability of the service area for the use of outcome based payments (Sturgess et al., 2011).

Secondly, it is suggested that the transaction costs of agreeing the contractual arrangements will be significant, leading to concerns about the capacity in the NHS to meet these costs (Collins, 2019), and suggestions that more should be done from within the NHS to support local implementation (Addicott, 2014, Taunt et al., 2015). There are concerns regarding the difficulties of data collection systems and infrastructures associated with outcome based contracting (Taunt et al., 2015), but also the negotiation of the unfamiliar procurement and legal landscape. It is also suggested that the development of the contractual models may take years (Addicott, 2014) and that payment systems, specifically outcome measures, should be expected to be an iterative and ongoing process (Sturgess et al., 2011).

Thirdly, there are concerns regarding the management of financial risk, and issues of governance and accountability. These concern the aim of transferring risk within the public sector (Collins, 2019). In relation to the use of outcome based payments there are concerns for example regarding the implications of removing money from those who performance badly, and more general concerns regarding the advisability of focusing on splitting of risk in the context of the 'single balance sheet' of public service provision rather than working together to reduce it (ibid).

Consideration of evidence in relation to the use of the contractual models in the NHS

The evidence from the NHS and elsewhere indicates that *ex ante* transaction costs of these contractual models are significant. In particular this appears to be the case in relation to the Alliance model, due to its emphasis on investment in the development of constructive relationships between contractual partners in the precontractual period, and in relation to the negotiation of elements of the contractual arrangement, such as the use of outcome payments, which seek to transfer financial risk from the commissioner to the providers of services. These elements both extend pre-contractual negotiations, and increase the likelihood that outside expertise will required. Additionally, the literature and theory suggests *ex ante* transaction costs will be further increased due to the novelty of negotiating such contractual arrangements in the NHS, and the subsequent lack of in house expertise, sufficient data systems and good quality baseline data. It is interesting in this respect, that the Alliance model appears to have been introduced in New Zealand without any accompanying underlying payment mechanisms in many instances.

Where these initiatives are introduced in cash poor public sector services such as the NHS, the up front investment required of local commissioners and providers may act as a disincentive to the introduction of these models, or alternatively will lead to the introduction of potentially damaging short cuts in the process of contract negotiation and specification. Analysis of the failed 'UnitingCare' lead provider NHS contract in Cambridgeshire suggests that at least part of the failure was due to significant issues not having been resolved during the negotiation period, and misunderstandings regarding the degree of risk to which commissioners were being exposed (National Audit Office, 2016).

There is conflicting evidence regarding how successfully these contractual models and associated payment mechanisms encourage multiple providers to work together. The evidence

from other sectors suggests they may lead to improved co-ordination, improved relationships and sharing of best practice. However it is unclear whether this is due to the contractual models themselves, or result from increased close working which could be achieved through a variety of mechanisms. Indeed, these contractual models encounter many of the relational issues which are acknowledged to be fundamental to existing contractual relationships in the provision of public services (Craig, 1994, Allen et al., 2014a), and therefore do not in or of themselves provide a 'magic bullet' solution to issues which are faced in public service contracting. In particular lead provider contracting may lead to antagonistic relationships within the supplier chain. The mixed evidence regarding the use of Alliance contracting in the New Zealand health system, suggests that local context is an important influence on the functioning of the contractual arrangements. What may be an advantage of alliance contracting, above other contractual forms, is that the need to invest in the establishment of trusting relationships between parties is clearly acknowledged as fundamental to the success of the contract. However, evidence from New Zealand and England suggests that the formation of trusting relationships may still be a lengthy process, particularly in the light of pre-existing structural impediments, such as power relationships between members (Lovelock et al., 2017).

The transferability of cross sectoral learning should be understood in relation to the difference between health and other sectors, relating to both health services as a product, and the wider institutional context in which services are delivered in the NHS. A number of aspects of the new contractual models may be more problematic in health than in other sectors, for reasons relating to economic and contractual theory already outlined in Chapter 2. Issues relating to the identification and agreement of outcome measures are not directly addressed by the cross-sectoral literature, but economic theory suggests this may be problematic to achieve in health where objectives may be multiple, may differ across stakeholders and therefore be hard to identify and measure (Lagarde, Perrins 2008). Opportunistic behaviour, such as withholding information, shirking, or failing to fulfil promises, which was observed in relation to lead provider contracting and the use of payments on the achievement of outcomes, may also assume greater significance in relation to health services where it impacts on public sector principles of equality of provision and outcomes. Unsurprisingly the cross sectoral evidence concerning opportunism is drawn largely from studies of public service contracts e.g. (Hudson et al., 2010, Hannah et al., 2010).

The concerns raised in the literature regarding applicability and fit of these models to the provision of public services, specifically in relation to the governance of risk, are of course

applicable to the NHS and are raised in the NHS specific literature. As the literature indicates, these models are particularly popular in sectors where risk is transferred from the public to private purse, such as the relatively widespread use of alliance contracting in the Australian construction industry (Rowlinson et al., 2006). The transfer of risk may become a less desirable project in relation to services such as the English NHS where despite an increasing diversity of providers, provision is still largely delivered by public sector organisations. Risk transference to the private sector is also problematic for public services where the need for the continuing provision of public services means that risk reverts to the public sector in the case of private sector failure. This risk is illustrated by the collapse of Carillion plc, the facilities management and construction services company who was a major strategic supplier to the UK public sector, which resulted in the commitment of £150 million of taxpayers' money to keep essential services running (House of Commons Business Energy and Industrial Strategy and Work and Pensions Committees, 2018).

The particularities of the institutional context of the NHS indicates there is a significant difference in the operation of some aspects of the models in the NHS. Significantly, the statutory framework in respect of NHS commissioner duties significantly impacts the types of decisions which can be taken collaboratively, and the responsibilities which providers can assume. A further issue relates to procurement. In relation to the Alliance model, in industry common practice is to select of alliance partners without price competition, and on the basis of criteria such as previous working relationships (Love et al., 2010), however the NHS is subject to strict requirements regarding procurement processes in order to ensure the most suitable provider has been chosen.

Whilst the cross sectoral literature is generally positive regarding the potential impact of these models, particularly in relation to cost saving capacity, there is a paucity of robust evidence. The evidence regarding the use of Alliance contracting in New Zealand is mixed, and it is acknowledged the implementation of these models, and the identification of directly related impacts, is a long term endeavour (Mays and Smith, 2013). This lack of evidence, coupled with the questions regarding the differences resultant the application to health services and from the NHS institutional context, suggest caution should be used when lead provider arrangements and alliance agreements are adopted.

Chapter 4 - Study design and methods

Scope of the report

This report examines the use of alliance agreements and lead provider arrangements in the English NHS, together with the associated payment mechanisms, including outcome based contracting, which together attempt to share (some or all) financial risk between a group of providers. PRUComm has undertaken a study investigating how these new models of contracting are being implemented in the NHS.

The research questions have been derived from contract scholarship, the existing literature regarding new models of contracting and relevant NHS policy, and address the aspects of these contractual arrangements which are likely to relate to important issues concerning the operation and impact of these arrangements. The research questions are:

1. why commissioners choose particular models of contracting, and what they think such models can achieve
2. in detail the characteristics of these new contractual documents, in particular how outcomes are specified and how financial risk is shared between the parties
3. how the contracts are used in practice, in particular whether the contractual documentation is adhered to, and if not, in which ways it is not
4. the strengths and weaknesses of the different contractual models, both in respect of encouraging cooperation between providers and achieving better outcomes
5. how the NHS Standard Contract is used in conjunction with the new models of contracting, and whether any problems arise in attempting to do so
6. how the new contractual models contribute to reconfiguration of services in local health economies

Overview of research design

The research draws on three in-depth case studies (case studies A, B and C) to investigate how new models of contracting are being used in the NHS. Each case study relates to a new contractual arrangement being put in place by a Clinical Commissioning Group (CCG).

An additional piece of work undertaken in relation to this area was a literature review the available evidence of the use of alliance contracting, lead provider contracting and the use of payment mechanisms in sectors other than health which sought to identify the characteristics

of these new contractual models and their implementation in other sectors. This is been published as a separate report (Sanderson et al., 2016).

Selection of the case study sites

The use of case studies was thought to be the most appropriate research design for this study as interviews and documentary analysis were informed by the contextual information we were able to gather by concentrating on three specific contractual arrangements. We identified possible case study sites by reviewing a database of relevant media reports and through building on existing research contacts/insights. We shortlisted a number of possible sites by locating publicly available information (most commonly Board papers) to identify a shortlist of contractual arrangements which included a variety of types of contract and payment mechanisms (e.g. alliance agreements, lead provider contracts, outcome based payments etc), also taking into account the variety of types of services subject to those contracts and the value of the underlying service contracts.

Securing access to case study sites

Potential research sites were initially approached by email to the Chief Executive of the CCG. If this approach was successful, we then liaised with the CCG regarding the best way to contact the other contractual parties, and to identify the main contact in each organisation. Each organisation was approached separately to request their participation in the research. The aim was to interview the main individual who had been involved in the negotiation of the contractual arrangement in each organisation. The interviewees consisted of Director level staff and senior managers.

Ethical approval

Ethical approval for the study was granted by the London School of Hygiene and Tropical Medicine internal ethics committee on 25 May 2016. The process of securing the necessary NHS research governance approvals was lengthy. NHS research governance approval from the HRA took 2 months (applied for on 3 June 2016 and granted by the HRA on 26 July 2016), and local research governance approval timescales ranged from twenty days to four months

The timeframe of the research

The research is based on two stages of data collection. The first stage of data collection was conducted between October 2016 and March 2017 (with two supplementary interviews in May

and June 2017). A second stage of data collection took place between April and July 2018. The purpose of the second round of data collection was to gauge how the new contractual models were developing over time. This approach was considered particularly pertinent as the contractual arrangements in two of the case studies (A and C) were under negotiation during the first round of data collection, and therefore the second round allowed the collection of data concerning how the contracts are used in practice, the strengths and weaknesses of the different contractual models and how the new contractual models contribute to reconfiguration of services in local health economies (research questions 3, 4 and 6).

Summary of methods

The field work consisted of three main activities: we analysed the contracts and supporting documents produced in each area; we interviewed the relevant senior managers of the organisations which were party to the contracts; we observed meetings of the contracting parties at which they specified and monitored performance in relation to the new contractual models.

Interviews

The purpose of the interviews was to gather rich data about the reasons for the selection of the contractual model, the process of contract negotiation, and the operation of the contract in practice that it would not be possible to obtain by analysis of the contract documents alone. In the second stage of data collection the interview schedule was amended. This was to ensure that we investigated how the contractual arrangements were developing in each area.

During the first stage of fieldwork we interviewed 20 people (in 17 interviews) across the three case study sites. During the second stage of research we interviewed 8 people (in 7 interviews) across the three case study sites. MS, DO and VM conducted the interviews. Representatives of all contractual (or proposed contractual) partners were interviewed. All interviews were conducted face to face at the interviewees place of work.

Tables 1 and 2 summarise the interviews conducted by case study site.

Table 1 – Interviews by case study site

Case study	Type of contract	No. of interviewees – first stage	No. of interviewees - second stage	Total interviewees
A	Alliance agreement	7	1	8
B	Alliance agreement	7	3	10
C	Joint venture agreement	6	4	10

Table 2 – Interviewees by case study site and organisation

	Case study A		**Case study B**		**Case study C**	
	Stage 1	**Stage 2**	**Stage 1**	**Stage 2**	**Stage 1**	**Stage 2**
Commissioners						
CCG	1	1	2	1	1	1
LA	1		1			
Providers – NHS						
Acute					2	
Community					1	1
Acute/Comm integrated	1					
Mental Health	2		1	1		
GP Federation	1				1	2
Providers – LA					1	
Providers – Third sector	1		3	1		

Use of documentation

We gathered contractual (or draft contractual) documentation. The analysis of contractual documents focused on governance structures, payments structures and the allocation of risk, the specification and monitoring of outcomes, and arrangements for dispute resolution.

We also gathered associated documentation, from all three case study sites. This included board reports, business cases, planning documents and personal communications. These sources were used to add detail to the interview accounts of the contractual arrangements, contractual aims and the impacts of the arrangements.

Meeting observation

We attended four meetings during Stage One of the research (one in Case Study A, one in Case Study B and two in Case Study C) in which contractual arrangements were discussed. The purpose of observing a variety of contract meetings was to supplement the information we obtained from interviews with the parties. Notes were taken during each of these meetings, and were subsequently used to confirm our understandings of the progress of the contractual arrangements and the relationship dynamics between contractual parties.

Analysis of data

Data analysis was conducted with the help of the qualitative research software NVivo. MS and PA agreed the main themes derived from the research questions, the literature on the new contractual models, the theoretical framework and additional themes suggested by the data. These themes were subsequently uploaded in NVivo.

The themes derived from the data analysis were also applied as a framework to analyse the contracts and associated documents. In the case of the Alliance agreements, the two case study contracts were compared against each other and the national Template Alliance contract in order to identify and explore any areas of difference. This analysis is reported in Chapters 7 and 8 of this report.

These themes have been consolidated into five cross cutting themes for the purposes of this report. These themes are: the size and scope of contractual arrangements, costs of pre-contractual period, third sector involvement, relationships between contractual parties and the Alliance model governance structure in the NHS. As Table 3 indicates, these themes are partially reflective of key issues highlighted by relevant contractual theory and the literature review, and partially driven by the research data itself. For example, the analysis of the data suggested the size and scope of the contractual arrangements was recurrently an important factor in relation to development and impact. Similarly the data also suggested the potentially significant impact of third sector providers. The costs of the precontractual period, the relationships between contractual parties and the fit of the Alliance governance structure with the NHS were issues highlighted as relevant in contractual theory and the literature from other sectors, and the NHS itself. The relevance of these themes to the findings is discussed in the summary to each chapter. The themes are also discussed in the Chapter 13 – Discussion and Conclusion.

Table 3: Mapping of themes

Theme	**Relation to theory/learning from literature review**	**Relevant research questions**
Size and scope of contractual arrangements	Management of financial risk Relational contracting	Qu 1. Why commissioners choose these models Qu 6. How the models contribute to the reconfiguration of services
Costs of precontractual period	Transaction costs	Qu 1. Why commissioners choose these models Qu 4. Strengths and weaknesses of the contractual models
Third sector involvement	Management of financial risk	Qu 2. Characteristics of contractual documents (in particular how financial risk is shared) Qu.4 Strengths and weaknesses of the contractual models Qu 5. How the NHS Standard Contract is used
Relationships between contractual parties	Relational contracting Transaction costs	Qu 3. How the contract is used in practice, in particular whether the contractual document is adhered to
Alliance governance structure in the NHS	Management of financial risk	Qu 2. Characteristics of contractual documents (in particular how financial risk is shared) Qu 3. How the contract is used in practice, in particular whether the contractual document is adhered to Qu.4 Strengths and weaknesses of the contractual models

Timeline of development of contractual arrangements during the research period

An important element of scene setting is an acknowledgement of the different stages of development of the contractual models in each of the case studies in relation to our data collection activities (Table 4 below). During our Stage One research period (October 2016 – June 2017) the negotiations for the new contractual models were ongoing in Case Studies A and C. In Case Study B, the new contractual model was in its second year of operation. By the

end of the Stage One research period (March 2017 in Case Studies A and B, and June 2017 in Case Study C), the new contractual arrangements in Case Study A were due to be agreed, and the Case Study C contractual arrangements had been agreed, and the contracts signed.

At the start of Stage Two of our research (April 2018), in Case Study A the Alliance agreement had been in place for a year and had been extended (albeit in a significantly different form), in Case Study B the Alliance had ceased at the end of the three year term, and in Case Study C the contractual model had been largely abandoned.

Table 4: Timeline of development of case study contractual arrangements

Month	**Case Study A**	**Case Study B**	**Case Study C**
April 2016		*Yr 2 of Alliance agreement*	*(Yr 1 of Joint Venture agreement)*
May 2016… *…September 2016*			
Stage 1 research period			
October 2016			
November 2016			
December 2016			Contractual documents signed – backdated to April 2016
January 2017			
February 2017			
March 2017			
April 2017	Contractual documents signed – Yr 1 of Alliance agreement	Yr 3 of Alliance agreement	Yr 2 of Joint Venture agreement
May 2017			
June 2017			
July 2017… *…March 2018*			
Stage 2 research period			
April 2018	Yr 2 of Alliance agreement. Deed of Variation signed.	Alliance agreement extended	Yr 3 of Joint Venture agreement
May 2018			
June 2018		End of Alliance agreement	
July 2018		New Alliance agreement operational	

Chapter 5 - Overview of case studies

The aim of this chapter is to set the scene for each of the case studies. The chapter provides an overview of each case study area and describes the contractual model in place. It also describes the development of the contractual arrangements during the research period. Dealing with each case study in turn, it details:

- A summary of the contractual model and the case study area
- The motivation locally for the adoption of the new contractual model
- The aims of the new contractual model
- An overview of the contractual model at the end of the research period

Case Study A

Summary of contractual model and case study area

Table 5: Summary of Case Study A contractual arrangements

Contractual Model	Alliance agreement
Parties to the agreement	CCG (Commissioner) LA (Commissioner and provider) Integrated acute/community NHS Trust Mental Health NHS FT GP Federation Third sector organisation
Relevant service contracts	Service contracts to deliver services to the over 65 population
Duration	10 year term (1 + 9 year extension)
Value of service contracts	£200 million (year one)
Payment mechanisms of service contracts	Proposed • multilateral risk share agreement • proportion of the service contracts paid on the basis of outcomes • capitated payment mechanisms

The case study area is a health and social care economy, with one CCG, one Local Authority (LA) and one main integrated acute/community NHS Trust. The financial position locally was challenging throughout the research period. Both the CCG and the integrated acute/ community

NHS Trust provider were placed in financial special measures during the research period. In 2016/17, the CCG was required to make a saving of just under 4% of the total commissioning budget of around £475 million. The LA was also under pressure to deliver considerable financial savings.

The case study area has both a growing and ageing population, placing increased pressures on the health and care system. The over 65s group represents nearly 13% of this population, a figure which is expected to increase significantly in the next ten years. Local analysis indicated that the area had a higher rate of admissions, emergency admissions, and emergency readmissions to hospital for patients over the age of 65 when compared nationally.

The Alliance agreement was between the commissioners and providers of social care and NHS funded healthcare services to people aged 65 and over living in the LA area. The commissioner participants in the Alliance agreement were the CCG and the LA (in its role as the commissioner of social care services). The provider participants were the LA (in its role as provider of social care services), an integrated acute/community NHS Trust, a mental health services NHS Foundation Trust, a GP Federation and a third sector organisation.

The contractual arrangement commenced in April 2017, with the intention that the Alliance agreement would comprise a 10-year term, made up of a one-year transition period, followed by a further nine years, with a two year extension option. The Alliance agreement related to various service contracts for the provision of services for the over 65's: firstly, NHS Standard Contracts between the CCG and the Mental Health NHS Foundation Trust, and the CCG and the integrated acute/community NHS Trust; secondly, NHS Standard Contracts between the LA and the integrated acute/community NHS Trust and the LA and the third sector organisation; and thirdly, a service level agreement between the LA as commissioner and the LA as provider. In-scope services included: acute / hospital care; community and out of hospital care; older people's mental health; and adult social care. These service contracts were together worth approximately £200 million in the first year (2017-18). It was intended to develop new payment mechanisms during the first year of the Alliance agreement (termed the 'transition' year). These proposed mechanisms consisted of paying a proportion of the value of the service contracts on the basis of the achievement of outcomes (from Year Two of the contractual arrangement onwards), putting in place a multilateral risk share arrangement and the development of a capitated budget.

The area has a long history of joint working between health and social care predating the Alliance agreement. There is a history of joint working between the LA and the CCG, most recently through the Better Care Fund and the development of an Integrated Commissioning Unit. The area has also established multi-disciplinary health and social care teams, including a model which aims to enhance personalised care for people with long term conditions, and integrated hospital based social work teams.

Why the contractual model was selected

The proposed Alliance agreement model was selected following an iterative process of model development by the commissioners, which sought to balance the commissioners' desire for a contractual model which would transfer appropriate risk to service providers and create the circumstances and incentives to allow them to innovate and profit from success, with commissioners' perception of providers' ability to take joint responsibility for financial risk. This iterative process resulted in a remodelling of the contractual model to one with greater commissioner involvement and oversight than originally intended.

The CCG and LA originally intended to procure a different contractual model: two lead provider contracts, paid through capitation with a proportion paid on the attainment of outcomes, with a supplementary Alliance agreement. A procurement process commenced on the basis of this contractual model using a 'most capable provider' process. This is described in Chapter 6. The selected providers were subject to a capability assessment process to ensure that they were capable of delivering that contract. However during the capability assessment process the commissioners felt that the providers were not adopting a system wide view, particularly in relation to the financial model (the model which projects the financial impact of the proposed contractual model against a projected baseline). At this point in the process, the commissioners altered the model to wrap an Alliance agreement around the service contracts between CCG and providers, and the LA and providers, with an underlying payment model for the service contracts to be developed including outcome payments, a risk share and capitated payments. The commissioners retained the hope that the contractual arrangement would be altered to a lead provider model at a later stage, as this was a model they anticipated would more successfully transfer risk to service providers, and incentivise innovation. As part of the shared commitment to meet the conditions of the capability assessment process it was also

agreed that the commissioners would work together with the providers to develop the system wide financial model.

Aims of new contractual model

The Case Study A contractual arrangement was related to various wide ranging but interconnected aims, spanning improvements of service delivery and service organisation, financial efficiencies and longer term system development goals.

The commissioners hoped the Alliance structure would encourage providers to work together to improve the patient experience by creating a person-centred service model for the over 65 population. Increased joint working would be achieved through more effective partnerships, and the creation of community networks and assets. It was hoped the service model would enable people to take responsibility for managing their own health and wellbeing in the most appropriate setting for them, through the creation of better co-ordinated services which encouraged independent living and incentivised proactive health and wellness management. These changes were anticipated to improve health and wellbeing outcomes.

Potential opportunities identified during the development of the contractual model included the removal of barriers to working in collaboration across organisational boundaries and care settings, the development of opportunities to deliver care in lower cost settings, for example, elective care (increase in day case and outpatient appointments out of hospital) and ambulatory care (increase in day cases), and the promotion of self-care. Table 6 below details specific service aims for the first year of the contractual arrangement.

Table 6: Case Study A - Service aims for the first year of the contractual arrangement

Service aims for the first year of the contractual arrangement
• Creation of a multidisciplinary community hub, strengthening multidisciplinary working with GPs to include links with voluntary groups and third sector organisations in order to provide a responsive, flexible and timely service • Development of individual plans for each service user • Establishment of independence co-ordinators who offer support to service users to ensure services are personalised, co-ordinated, relevant and timely • Establishment of a single point of access and information • Establishment of an integrated independent living team, providing integrated step-up and step-down reablement and rehabilitation

A further aim for the Alliance contractual arrangement related to financial savings. In Case Study A the contractual arrangement was driven by an *'extremely challenged financial agenda in the local health economy and also for the CCG'* (Acute/Community NHS Trust, Case Study A), which needed to be addressed by something *'radically different'*. It was hoped that the service reconfigurations would lead to more effective use of health and social care resources, and economies of scale, facilitating between 10-15% savings in relation to spend on the over 65s age group across the lifetime of the contract. The focus on over 65's (rather than a specific disease pathway) was hoped to have the potential for whole system change, resulting in the kind of significant savings which could lead to financial sustainability for the local health and social care system. CCG financial plans just prior to the commencement of the contractual arrangement estimated that, under the contractual arrangement, CCG savings would begin in 2017/18 with savings of £1.3m in 2017/18 and 2018/19. Detailed benchmarking highlighted a number of specific areas within the acute setting where the area could reduce activity for the over 65s, namely higher rate of admissions, emergency admissions, and emergency readmissions to hospital.

Additionally, the contractual arrangement was seen as facilitating longer term system development goals. Commissioners hoped that the use of the model would, through developing the skills and experience of the provider organisations relating to working jointly to achieve joint aims, aid the transition to a single organisation taking responsibility for achieving the agreed outcomes, such as an Integrated Care Organisation.

Overview of the contractual model during the research period

Year One of the contractual arrangement constituted a 'transition period'. The intention was that this period would be used to agree payment mechanisms and risk sharing for the remainder of the proposed contractual period, and to demonstrate the benefits of the Alliance approach to service transformation. However, at the end of Year One outcome based payments for the service contracts had not been put in place. A multilateral gain/loss share had not been agreed. Plans for capitation had been put on hold. Instead, a bilateral risk share agreement had been set up for the 2018/19 financial year as part of the NHS Standard Contract with the integrated acute/community NHS Trust in relation to non-elective admissions, where £1.5million was at

risk if a reduction in non-elective admissions was not achieved. Payment for non-elective admissions had also been capped.

At the close of the research (July 2018, 16 months after the agreement was signed) the Alliance had been extended for a further nine years. The service contracts which the Alliance agreement relied on had been changed from service contracts relating to the provision of services for the over 65's, to service contracts relating to the general population, reflecting a shift in the focus of the work of the Alliance. This shift in focus was due to firstly, a strategic review of the local health and care economy which recommended that partners come together to deliver system transformation for the whole population and secondly, the requirements of the local STP programme.

The remit of the contractual arrangement had altered at the end of Year One from services for the over 65's to the whole population. Where originally each provider had a service contract for the provision of services for the over 65's, they now had a service contract relating to the general population. The focus of the Alliance was described as being altered to the delivery of specific business cases, to be agreed as part of the health and care transformation plan required by the STP. It was anticipated that each business case would include specific risk share arrangements and outcome or incentive payments. The governance structures relating to the Alliance had also been altered. Following a strategic review of the health economy in late 2017, the governance for the Alliance was consolidated into the wider structures of whole system governance in the health economy. The driver for this move was to reduce the time key players spent in meetings.

Case Study B

Summary of contractual model and case study area

Table 7: Summary of Case Study B contractual arrangements

Contractual Model	Alliance agreement
Parties to the agreement	CCG (Commissioner) LA (Commissioner and provider) Mental Health NHS FT Third sector organisation Third sector organisation
Relevant service contracts	Service contracts to deliver mental health services
Duration	2 year term (+ 1 year extension)
Value of service contracts	£12 million (year one)
Payment mechanisms of service contracts	• multilateral risk share agreement • proportion of the service contracts paid on the basis of outcomes

In Case Study B the new contractual model under investigation consists of an Alliance agreement, a risk share agreement and a small number of financially incentivised outcome based measures. The Alliance agreement related to service contracts for the delivery of services and support for people with severe mental health problems. The Alliance model was part of a contractual approach intended to address the current unsustainable service, which had issues regarding bed based services which were over budget, subject to increasing demand, and thought to be proving limited outcomes for service users. Previous reviews of these services had indicated that service users were not experiencing outcomes commensurate with the level of investment in services. The contractual arrangement focused on the use of rehabilitation inpatient beds or residential placements in the LA area by approximately 200 existing service users (a quarter of whom were inpatients in the Mental Health Trust, and three quarters supported in Local Authority social care placements) and new patients who were assessed as having complex mental health needs.

The Alliance agreement was in its second year of operation when the data collection commenced in October 2016. The two year initial period was subsequently extended for a further year. Parties to the agreement were the CCG and LA ('commissioner participants'), and providers, comprising the LA, a Mental Health NHS Foundation Trust, and two charitable

organisations. The LA had a role as both commissioner of social care services but also as a provider of social care services either through direct delivery or through subcontracts. The Alliance agreement related to service contracts funded from the CCG and LA pooled commissioning budgets (using a Section 75 partnership agreement) worth approximately £12 million in first year, for which the CCG was designated the lead commissioner. The Alliance agreement related to four NHS Standard contracts, between each Alliance provider and the CCG, including the LA for the delivery of adult social care services.

Anticipated savings were built into the financial plan for the contractual arrangement, and a quarterly reconciliation process took place to accommodate variations against plan and any mutually agreed shifts in activity between the providers. The Alliance agreement referred to a small gain/pain share agreement consisting of a small number of financially incentivised outcome based measures (with payments available worth around 1% of the value of the service contracts). It also contained agreement about how any gain/loss pool relating to performance against the financial envelope would be managed.

All the Alliance members had previously worked together on service improvement initiatives. The Alliance members were drawn from a wider formal group of service providers who were committed to working together, using co-production, to bring about improvements. This group had set up an earlier multi-disciplinary initiative to provide open access early support to people with mental health needs.

Why the contractual model was selected

In Case Study B, the contractual arrangement was seen as a development of the partnership working which already existed between all contractual partners. The selection of the Alliance model was the result of co-production practice in relation to the commissioning and delivery of services and support for people with severe mental health problems. The Alliance agreement was identified by the CCG as a model which would support changes to the setting in which care was delivered and achieve financial savings, and without resorting to 'salami slicing' individual organisations' budgets (Mental Health NHS Trust, Case Study B). The CCG anticipated that using an Alliance agreement would bring providers together and incentivise them together to achieve transformational outcomes. The Alliance model was also seen to be

advantageous as it enabled integration without needing to engage in complex formal processes such as moving staff between organisations.

The CCG identified the providers who would participate in the development of the contractual arrangement through a process which did not involve open competition. This is described in Chapter 6.

Aims for the model

An earlier review of inpatient rehabilitation services concluded that services should be redesigned in order to deliver personalised, recovery-based community based services. It was hoped the contractual model would minimise the need for inpatient rehabilitation and residential placements, based on an agreed threshold and eligibility criteria for rehabilitation services. The underlying principle was to ensure that people experienced more personalised opportunities to be supported in the community, at home where possible, with tailored packages of support to meet their needs, thereby reducing reliance on hospital and 'institutional' types of care.

Table 8: Case Study B - Service aims for the contractual arrangement

Service aims for the contractual arrangement

• Achieve overarching aims of helping service users experience improved physical and mental health, experience increased self-determination and autonomy, and participate in daily life on an equal footing with others through:
  • Review of each service user by multi-agency support team
  • Development of refreshed individual personalised support packages
  • Agreement of Alliance rules for assessment of applications for personal budgets or funded care packages
  • Agreement of Alliance thresholds for discharge from the service
• Resulting in minimisation of need for inpatient rehabilitation and residential placements (including reduction of referrals to residential placements by 50%)

It was hoped that the Alliance approach would encourage a collective approach to decision making which would result in service changes to reduce the use of residential placements by 50%, and increase the achievement of a number of outcomes, such as increasing the number of people in employment, voluntary work, education or training. It was further hoped the model

would deliver savings of approximately 25% (c£2.8m) from Year Two of the contractual arrangement.

Overview of the contractual model during the research period

In Case Study B the contractual arrangements was in place for the entire research period until it ceased at the end of June 2018 after an additional two month extension on its anticipated three year term.

At the end of the research period, a new Alliance agreement was put in place, commencing July 2018. This new agreement had an initial seven year term, with the option to extend for a further three years. The new Alliance agreement was between the same group of providers as the initial Alliance and related to NHS Standard Contracts between the CCG and each provider. The value of the service contracts was much larger than those relating to the original Alliance and encompassed most of the NHS and social spend on adults with mental health problems in the area. It was anticipated that pain/gainshare payments on the basis of performance against outcomes would be developed. A bilateral risk share agreement between the CCG and the Mental Health Trust in anticipation of volatility of bed usage in the early stages of the Alliance was in place, with the intention to establish a wider risk share from Year Three including all partners.

The intention of the new Alliance is to work together to achieve radical improvements to community services, such as the expansion of early accessible support and urgent care on a round the clock basis. The LA and CCG aim to achieve approximately 14% efficiency savings over the initial seven year contractual term. It is very early days for this Alliance agreement, and therefore this report does not attempt to examine the new arrangements in detail.

Case Study C

Summary of contractual model and case study area

Whilst the commissioner in Case Study C had aspirations to establish a novel arrangement based on a lead provider contractual arrangement, at the time of the research a largely conventional contractual arrangement was in place, which did not seek to involve multiple parties. Despite the conventionality of the arrangement in place, Case Study C has been retained in this report firstly, due to the aspiration during the fieldwork period to implement the wider contractual arrangement by April 2018 (within the timescale of the fieldwork), and secondly, to provide information about the challenges encountered by contractual partners when negotiating these models.

Table 9: Summary of current and proposed Case Study C contractual arrangements

Current

Contractual Model	Joint Venture agreement (to develop and deliver community adult healthcare services and locally commissioned GP services)
Parties to the agreement	Community NHS Trust GP Federation
Relevant service contracts	Service contract between Community NHS Trust and CCG for adult community services Subcontract between Community NHS Trust and GP Federation
Duration	2 year term
Value of service contracts	£20 million (year one)
Payment mechanisms	Proposed • proportion of the service contract paid on the basis of outcomes

Proposed

Contractual Model	Lead Provider model (currently Memorandum of Understanding in place)
Parties to the agreement	CCG LA Community NHS Trust Acute NHS Foundation Trust (1) Acute NHS Foundation Trust (2) GP Federation
Relevant service contracts	Service contracts for adult out of hospital care and social care services

Duration	Not agreed
Value of service contracts	Unknown
Payment mechanisms	Proposed • proportion of the service contract paid on the basis of outcomes • development of a capitated payment mechanism

The case study is based in an area that is healthy and safe. Its population was generally wealthy and it boasted good health outcomes. However during the research period the CCG experienced considerable financial difficulties, resulting in a deficit of around £15 million. The contractual arrangements in the case study relate to the provision of adult out of hospital care and social care services. The contractual arrangements were motivated by the commissioner's long standing strategy to move more care out of hospital and into community settings, and related to the development of a delivery model to incentivise providers to work together to meet the needs of the patient, treat people as close to home as possible and prevent avoidable hospital admissions, reduce length of hospital stay and reduce delays to discharge and provide access to urgent care in the community.

There are two groupings of contractual arrangements under investigation in Case Study C. Firstly, there is long term aim of the agreement of a lead provider contractual arrangement with a population based/capitated payment mechanism with outcome payments for the provision of adult out of hospital care (community services) and social care services. These plans involve the CCG (Commissioner), the LA (Commissioner and provider), a community NHS Trust (provider), a GP Federation (provider) and two acute NHS Foundation Trusts (providers).

When the research commenced it had not been possible to reach agreement with local providers about this proposed model, so a second arrangement, consisting of different numerous contracts and schedules were put in place to underpin the future development of the contractual arrangement. These arrangements do not constitute an innovative model of contracting, but a stage in the process of moving towards such a model.

Firstly, a Joint Venture agreement, for an initial two year term, was signed in December 2016 and backdated to April 2016, between the community NHS Trust and the GP Federation for the development and delivery of community adult healthcare services and local commissioned

(GP) services. Secondly, this Joint Venture agreement related to an NHS Standard Contract between the CCG and the community NHS Trust for the adult component of the community block contract, also signed in December 2016 and backdated to April 2016. The term of this contract was for an initial five year period, with an option to extend for a further five years. The contract was subject to yearly 'refreshes', with changes signed as contract variations. The contract was worth approximately £20 million in the first year, and was for almost all of the community NHS Trust's services. Thirdly, a subcontract (NHS Standard Contract Subcontract) between the community NHS Trust and the GP Federation had been signed in December 2016 for the provision of a small number of services (GP services to an inpatient unit, GP work in a walk in centre and rapid response team).

It was intended that the scope of services included in the Joint Venture agreement, via the NHS Standard Contract, would increase over time to include firstly, locally commissioned (GP) services, secondly, third party services (small contracts for services such as hospice care, community transport, support services for primary care), and thirdly various acute services (currently provided by the two acute NHS Foundation Trusts).

This contractual arrangement did not contain outcome based payments when it was signed, and essentially mirrored existing payment arrangements. It was intended that a proportion of payment would become dependent on achievement of specified outcomes at some point during the contract period.

A wider group of parties signed a Memorandum of Understanding (MoU) committing to the development of a contractual arrangement for the provision of adult out of hospital care and social care services. The signatories to the MoU were the CCG, the LA, the community NHS Trust, the GP Federation, and two acute NHS Foundation Trusts. This arrangement, for the provision of adult out of hospital care (community services) and social care services, was expected to include a lead provider arrangement, a population based/capitated payment mechanism and outcome based payments.

There was not a significant history of past partnership working between the parties to the Joint Venture agreement or the signatories to the MoU beyond involvement in the local STP and as the main bodies involved in proving health and social care to the local population.

Why the contractual model was selected

The contractual model under negotiation in Case Study C was the result of a lengthy iterative process which took place over several years, during which there were changes in national policy as well as considerable staff turnover in the local organisations' respective leaderships.

The original proposal from the CCG was the formation of a single organisation taking responsibility for achieving the health outcomes for the population. The formation of a single organisation comprising the services of the community NHS Trust and some LA services which delivered both health and social care was also then discussed. However these proposals were rejected due to concerns about the financial underpinnings, lack of support from the local GPs, and difficulties of integrating health and social care services in two different LAs.

The commissioners (CCG and LA) agreed to commission a single service contract for integrated Out of Hospital Health and Social Care for adults using a 'Most Capable Provider' process. This took the form of a lead provider contractual arrangement with a population based/capitated payment mechanism and a proportion of the contract paid on the achievement of outcomes. The procurement process is described in Chapter 6.

The commissioners identified a group of four providers who were then invited to participate in a Most Capable Provider assessment process. During the procurement process, both the LA and the two acute NHS Foundation Trusts withdrew from the proposed contractual arrangement. The LA was concerned that the adult social care resources would become 'lost' in the wider health and care system. The two acute NHS Foundation Trusts were not sufficiently happy with the arrangements being proposed, particularly the viability of the financial model being proposed.

The subsequent proposal in Case Study C was for a two party joint venture agreement (between the community Trust and the GP Federation) with the other parties, including the CCG, as 'MoU partners' who were not party to the formal Joint Venture agreement. The Joint Venture agreement was chosen as it was a way of joining partners together while avoiding the creation of a separate legal entity, which was thought to bring issues associated with VAT. The advantage of the joint venture agreement was that it was a *'legal vehicle that will give you some sense that we're in this together'* (Community NHS Trust, Case Study C). It was seen as

offering the opportunity for significant service reconfiguration, to address the need to *'achieve a satisfactory solution for community services'* (CCG, Case Study C), and leading to moving resources out of hospital into the community.

The signatories to the Joint Venture agreement and the transformation partners were continuing to work together (through the MoU) on the development of a wider contractual arrangement which would involve all partners. However, the Acute Trusts and the LA had not given a firm commitment to entering into a contract.

Aims of the contractual model

The various contractual arrangements in Case Study C underpinned wide ranging aims relating firstly, to the development of a wider contractual model, secondly, to service redesign aims of the current contractual arrangement (the Joint Venture agreement), and thirdly to the service redesign aims of that wider model once established (Table 10).

The most specific and clearly articulated aims of the contractual model (the Joint Venture agreement and the negotiations of the MoU transformation partners) in this period were the achievement of 'transition activities' which would enable the establishment of the wider contractual arrangement. The aims in this respect were reaching agreement regarding how to work together to redesign clinical pathways, the review of payment mechanisms and the development of a capitated payment mechanism, the review and development of an outcomes based payment model, and the agreement of success criteria and trigger points and a performance framework. It was envisaged when the Joint Venture agreement and MoU were signed that the wider contract would be developed and implemented by April 2018.

In terms of the service aims of the current contractual arrangement, the parties to the Joint Venture agreement, and the wider provider group of 'Transformation Partners' were responsible for the development and implementation of five redesigned health and care pathways.

The parties to the Joint Venture agreement had a small number of aims separate to the transition work with the MoU signatories. These were to develop close working relationships between the community NHS Trust and the GP Federation, to focus on achieving best value for money operational performance and to co-operate to deliver patient focused care.

There were a series of more generalised service redesign aims for the eventual wider contractual model. These included meeting the needs of the patient, treating people as close to home as possible and preventing avoidable hospital admissions, reducing length of hospital stay and delays to discharge, and providing access to urgent care in the community. Whilst is was indicated that it was hoped this model would achieve financial savings, these remained unspecified at this stage.

Table 10: Case Study C - Service aims of current and proposed contractual arrangement (Joint Venture agreement and MOU between transformation partners)

Service aims for the current contractual arrangement
• Development and implementation of five redesigned health and care pathways: cardiology frail elderly diabetes respiratory care end of life care

Service aims for the longer term contractual arrangement between MOU partners
Development of an adult out of hospital care and social care services service which: • meets the needs of the patient • treats people as close to home as possible • prevents avoidable hospital admissions • reduces length of hospital stay and delays to discharge • provides access to urgent care in the community.

Overview of the contractual model during the research period

In Case Study C at the end of the research period, the contractual arrangements had not been developed as anticipated.

The two year initial term of the Joint Venture agreement between the community NHS Trust and the GP Federation came to an end in March 2018. This was renewed for a further three years, to reflect the remaining term of the NHS Standard Contract between the CCG and the community NHS Trust. The NHS Standard Sub contract between the community NHS Trust and the GP Federation was still in place. It had been intended to move Locally Commissioned Services and some third party contracts into the NHS Standard Contract between the CCG and the community NHS Trust but this had not taken place.

Although outcomes had been identified, payments on the basis of outcomes relating to this contract had not been put in place.

The MoU was in place during the entire research period, but by the end of the research, however this was deemed to be inactive. The MoU signatories were not meeting to progress the development of a wider contract arrangement with a population based/capitated payment mechanism for the provision of adult out of hospital care (community services) and social care services as was originally intended.

Overall, therefore, while the written contracts were still in place, the intent behind the contractual model and plans for its future development appeared to be largely abandoned.

Summary

This chapter considers the case studies together, and draws out some of the key themes which will be returned to later in this report. Table 11 summarises the key information about the contractual arrangements.

It is clear from the overview of the case study contractual models in this chapter, that the three case studies are diverse. The scale (value of associated service contracts) and scope (breadth of services and populations covered and duration of contractual arrangement) of these arrangements is an important theme which will be returned to throughout this report.

Each of the proposed contractual arrangements focuses on the provision of services to a particular population (Case Study A – the over 65's, Case Study B - people with severe mental health problems), or a particular service (Case Study C - adult out of hospital care (community services) and social care services). The use of the models to focus on a particular population or service is in line with other examples cited in recent NHS policy literature (Addicott, 2014). However, the contractual arrangements differed greatly in scale and scope. The anticipated value of the service contracts in Case Study A was £200 million in Year 1, compared with £12 million in Case Study B. The Joint Venture agreement in Case Study C related to a service contract worth £20 million. The scope of the services involved also differ, whilst the Case Study A Alliance agreement relates to services delivered to the over 65's (an estimated 50,000 people), Case Study B focused on an initial 200 service users, plus some new users. However both of the case studies were ambitious in terms of the anticipated savings which it was hoped the models would achieve were quantified: Case Study A hoped to achieve 10-15% over the

life of the contract, whilst Case Study B hoped to achieve 25% over the life of the initial two year term.

Table 11: Overview of contractual arrangements by case study

Case Study	Model	Services	Length of contract/ date commenced	Participants	Value of service contracts	Payment mechanism
A	Alliance agreement	Health and social care services to the over 65s	10 year term (1 year Transition Period, and 9 year OBC period, with 2 year extension option). 1st April 2017	-CCG (commissioner) -LA (commissioner and provider) -Integrated acute/community NHS trust -Mental health services NHS FT -GP Federation -Third sector organisation	£200 million (Year 1)	Proposed- Capitation with proportion of payment on basis of outcomes. Multilateral risk share
B	Alliance agreement	Mental Health	2 year term, with 1 year extension. 1st April 2015	-CCG (commissioner) -LA (commissioner and provider) -Mental health services NHS FT -Third sector organisation -Third sector organisation	£12 million (Year 1)	Monthly payments based on forecast activity with proportion of payment on basis of outcomes. Multilateral risk share
C	Joint venture agreement/ MoU for further contractual model	Adult out of hospital care and social care services	2 year JV agreement leading to wider contract, for 5 years, with 5 year extension option. JV signed December 2016	Joint venture agreement -community trust -GP federation - 'MoU partners' for development of lead provider model - Acute NHS FT - Acute NHS FT - LA - CCG	£20 million (Year 1)	Proposed – proportion of payment on the basis of outcomes (relating to JV agreement) Proposed - population based/capitated payment mechanism and with proportion of payment on basis of outcomes

In all three case studies the commissioners hoped that these new contractual arrangements would be transformative. They were perceived as a significantly different model of contracting. A common distinction was made between what was referred to as the 'transactional' dialogues of traditional contract negotiations, and the 'transformative' or more forward looking and strategic nature of these models, which would result in better outcomes for patients, and would achieve the improved integration of services. Particular emphasis was given to allocating

financial risk to providers as a means to incentivise them to find innovative solutions. All three case studies proposed, or had agreed, payment models which sought to share financial risk across partners, consisting of linking payments to outcome based measures, multilateral risk share arrangements and capitation. The evidence and theory already cited in the earlier chapters of this report suggests that the specification and agreement of such arrangements will be a challenging element of production and implementation of these contracts. The negotiation and specification of these elements of the contractual arrangements is described in Chapters 9 and 10. Chapter 11 meanwhile focuses on how the payment mechanisms were used in practice.

In all our case studies the new contractual arrangements which were in place or under negotiation were perceived as a stage in a journey towards a further, more integrated, and more ambitious, contractual model. Contractual partners in Case Studies A and C described an iterative, pragmatic process in which a number of alternative models were proposed and rejected. This process was largely one of downscaling the ambition of the contractual model in relation to the amount of risk which was allocated to providers to manage jointly, and seeking to find a model in which sufficient commissioner oversight could be retained. Case Study B differs from Case Studies A and C in this regard as the Alliance model which was put in place was that which was anticipated at the outset of the contract procurement process. Interestingly the successful use of this model in the Case Study did serve as the precursor to a wider, more ambitious Alliance arrangement which had been established by the end of the research. The notion that the models were a way of piloting ways to work together before rolling them out on a wider basis will be returned to in Chapter 13 - Discussion and conclusions.

This iterative approach to achieving integration reflects the idea that providers can learn how to work together effectively to manage risk jointly. Contractual theory and the findings of the literature review of evidence from the use of the models in sectors other than health suggest relational norms such as flexibility, solidarity and reciprocity will be necessary to enable the continuation of the contractual relationship in the light of uncertainties. The overview of the case studies indicates differences in the nature of the relationships between the contractual partners (or proposed contractual partners). The theme of the relationship between relational norms and the formal contract appears throughout the report, and will be returned to in the Discussion chapter.

All three case studies include partners from outside the NHS, reflecting the use of such contractual arrangements to secure integration across health and social care providers. Case Studies A and B also include smaller third sector organisations. This reflects the general drive in current NHS policy to include relevant diverse partners from across health and social care in the planning and provision of services for the population. This report explores the implications of for these parties of being involved in a contractual arrangement in which commitment to the joint endeavour must be balanced with individual accountabilities outside the NHS environment. A further issue in this regard is the relative size of these diverse contractual parties, with vast organisations such as NHS Trusts and LAs sharing a table with smaller partners from the third sector. This relates to two themes of the third sector involvement, and the application of the Alliance governance structure to the NHS. Both these themes will be returned to at various points throughout the report, and considered more fully in the Discussion chapter.

Chapter 6 - Fit of New Models of Contracting in the wider institutional context

This chapter situates the case study contractual models in relation to the wider institutional context in the NHS. While, since the publication of the Five Year Forward View strategic plan (NHSE, 2014), the principle of cooperation has been elevated to become the preferred mechanism governing the supply of health care services, this is situated in the context of a residual legislative framework which favours competition. This chapter examines this wider institutional context, together with factors raised in relation to the earlier discussion of the relevant contractual and economic theory and the cross sectoral evidence in Chapters 2 and 3. The aspects of the wider institutional context discussed here in relation to the case study contractual arrangements are:

- Procurement of new contractual models
- Fit with other NHS initiatives
- Input from national regulatory bodies

Procurement of new contractual models

Background

The literature review of the evidence regarding the use of these contractual models in other sectors (described in the Chapter 3 of this report) indicated a tension the need to establish trusting close working relationships based on co-production inherent in the Alliance model, and the requirements of procurement processes in the NHS. While it appears that in other sectors the Alliance model is procured without competitive process, the regulations in the NHS place certain requirements on commissioners in respect of the competition procurement of health care services.

Procurement in the NHS is subject the Public Contracts Regulations 2015 (PCR 2015) which came into force in April 2016 (replacing The Public Contracts Regulations 2006). The procurement processes for the contractual arrangements in the three case studies took place before the PCR 2015 came into force, and the implications of this will be discussed below. Additionally, procurement is subject to the secondary legislation introduced by the Procurement, Patient Choice and Competition Regulations (No. 2) 2013 (PPCCR 2013) pursuant to the HSCA 2012.

The PPCCR 2013 suggest that competitive tendering is to be the preferred method of procuring clinical services. However there is some latitude to commissioners as to whether to procure services competitively, and a number of factors should be taken into account when commissioners decide on a procurement approach. Most pertinent in giving commissioners latitude is Regulation 5 which stipulates that commissioners can award a contract to a particular provider without running a procurement process if "the services to which the contract relates are capable of being provided only by that provider".

Under PCR 2015 meanwhile, the procurement of health services above a certain threshold fell under a so-called Light Touch Regime (LTR). This did not apply to the contractual arrangements under investigation in our case studies, but is described here for completeness. This allows health care commissioners to have considerable flexibility in designing their own procedure, for instance by deciding the contract award criteria, splitting contracts into lots or carrying out market engagement. However there is also a requirement to openly advertise and follow a transparent procurement process where the contract value exceeds the relevant threshold. Commissioners are required to advertise the procurement opportunities by publishing contract or Prior Information notices in the Official Journal of the European Union and Contracts Finder, to make all documents available in advance of the procurement, to publish contract award notices and to include standstill periods. Moreover, the tailor-made procurement procedures under the LTR ought to be relevant, reasonable and proportionate and should not breach the equal treatment and transparency principles.

Procurement processes relating to the case study contractual arrangements

The procurement processes for the contractual arrangements in the three case studies took place before the PCR 2015 came into force. In the PCR 2006 Regulations health care services fell under a so called 'Part B' provision which meant that commissioners were able to award a contract without advertising where there was no cross-border interest (DH, 2016).

In all three case studies the commissioners had chosen not to follow a competitive tendering process, and had chosen instead to follow a 'Most Capable Provider' process. This is a process whereby commissioners do not need to advertise the contract opportunity if, having carried out a market engagement/assessment exercise, the commissioner can determine that competition is absent for technical reasons and there is therefore only one provider (or group of providers)

capable of delivering the contract. If this is the case and no reasonable alternative or substitute exists and the absence of competition is not the result of an artificial narrowing down of the parameters of the procurement, then the commissioner can enter into negotiations with that provider and there is no need to advertise the contract opportunity (NHS England, 2017b).

Case Study A

In Case Study A the CCG and LA originally intended to procure two lead provider contracts, paid through capitation with a proportion paid on the attainment of outcomes, with a supplementary Alliance agreement. A procurement process commenced on the basis of this contractual model using a 'Most Capable Provider' process. In this case all the providers of services for the over 65's in the CCG/LA area were evaluated against a set of criteria that had been developed by the commissioners, to identify the most capable providers. The selected providers signed a letter of intent to say that they were willing to work together. These selected providers were then subject to a capability assessment process to ensure that they were capable of delivering that contract.

Case Study B

In Case Study B, the CCG identified the providers who would participate in the development of the contractual arrangement through a process which did not involve open competition. The group of providers was restricted to existing providers within an existing informal provider alliance in the area and based on the need to achieve improvements to the outcomes experienced by people using inpatient rehabilitation beds. The CCG had an original proposition based on the use of the alliance model, which they presented to the group of relevant providers. The providers discussed amongst themselves who was best placed to contribute and a number stepped back at this stage. The remainder of the providers developed the contractual model in more detail with the CCG.

This procurement approach was justified on the grounds that this was a highly complex service transformation that requires providers who have demonstrated prior commitment to the collaborative work already underway in the area, and have demonstrated an ability to be able to work on a collaborative basis to deliver integrated personalised care.

Case Study C

The commissioners (CCG and LA) originally intended to commission a lead provider contract for integrated Out of Hospital Health and Social Care for adults using a 'Most Capable Provider' process. The initial step was to identify from the group of providers who currently delivered Out of Hospital Health and Social Care, a smaller group of providers according to a range of pre-set criteria. These criteria were to identify and evidence existing capabilities that would allow them to come together as a group, to provide the most effective, integrated, transformed, service delivery for Out of Hospital (physical) Health and Social Care. The commissioners identified a group of four providers who were then invited to participate in a 'Most Capable Provider' assessment process. The assessment aimed to assess and measure evidence of the progression of joined up and integrated working. Failure to meet the criteria at key gateways would trigger either the start of a competitive procurement process, or the formation of an Alliance agreement.

Participation in new models of contracting and future competition

Participation in new models of contracting which require collaboration between different organisations, particularly the Alliance model, necessitates the close sharing of information between organisations which may carry implications regarding conflict of interest and competition law. As will be addressed more fully in Chapter 7, the NHS Template Alliance Agreement addresses the potential for conflict in relation to issues of transparency, namely that an Alliance member may wish to take part in a competitive procurement process which may bear some relation to the information that has been shared in the course of collaboration between Alliance members. The Template Alliance agreement suggests that the onus is on the provider to demonstrate that the information it has required does not preclude the commissioner from running a fair competitive procurement in line with legal obligations, and the commissioner retains the right to exclude potential bidders to comply with procurement and competition legislation if necessary.

There was only one procurement reported in the case study sites which was relevant to this issue. This was the procurement of a new Alliance agreement in Case Study B at the end of the research period. As the overall value of the service contracts was over £500 million for the proposed ten year duration commissioners were required to follow the EU Light Touch Regime procurement process (LTR) as described above. In this instance, the prior knowledge of the

existing Alliance provider organisations was not deemed to have carried any implications regarding conflict of interest and competition law, and the existing Alliance provider organisations responded to the expression of interest as a single group, and were successfully selected. It was reported that in practice the implication of their previous Alliance work together in this case was that the provider alliance members needed to disassociate themselves from the commissioner during the application process, who they had previously been working closely with in the initial Alliance.

Fit with other NHS initiatives

New models of contracting exist in a complex landscape of initiatives aimed at increasing integration to better meet patients' needs and to respond to financial pressures. We asked interviewees to describe the relationship between their new contractual model and STPs and Vanguards, which were the other emergent arrangements for progressing the integration and partnership working agenda at the time of the research.

Vanguards, established as a result of the *Five Year Forward View* (NHS England, 2014) as part of the New Care Models Programme are test beds to develop new ways of working across sector boundaries, intended to establish new 'products and frameworks' which would subsequently be rolled out more widely (Checkland *et al.*, 2019). Examples of the types of integration being explored through the Vanguards are the Integrated Primary and Acute Care Systems (PACS) model based on joining up GP, hospital, community and mental health services into a single organisation or an integrated network sharing the risk for the health of a defined population and the Multispecialty Community Providers (MCP) model which focuses moving specialist care out of hospitals into the community through working as a single organisation or integrated network.

STPs, envisioned as vehicles for local cooperative, place based planning, bring together NHS and other organisations into local partnerships based on natural communities, existing working relationships, patient flows, and taking into account the scale needed to deliver services, transformation and public health programmes (NHS, 2015, p. 6). STPs have no statutory or contractual basis and all existing organisational accountabilities remain. STPs cover geographical areas with an average population size of 1.2 million people with memberships from local partners, consisting of (multiple) CCGs, NHS providers, Local

Authorities and other health and care services, dedicated governance structures and programme management support from constituent organisations (NHS England, 2017a).

In considering the relationship between the case study contractual arrangements and STPs, interviewees generally acknowledged that the initiatives were concerned with the same direction of travel, but that there were instances of tension between them, potentially due to issues of scale. The new contractual arrangements were generally understood by interviewees to have clear resonance with the parallel creation of STPs. It was acknowledged that these new contractual models and STPs were part of the same continuum. The general direction of travel of both initiatives was therefore thought to be 'entirely compatible' (CCG, Case Study C). The Case Study B CCG commissioner saw the Alliance agreement as reflecting a locally chosen solution to the same issues addressed by STPs. In Case Study A, it was also suggested that STPs were a further enabler of the agenda which had already commenced with the adoption of the new contractual models:

> *'We're always clear there was a journey from over 65's and then it would be extended, we're now [with STPs] talking about the contracted journey to an accountable care system' (Acute Trust, Case Study A)*

However, some interviewees found the practicalities of the connection between the two more problematic, with instances of tension between them, potentially due to differences in scale. Interviewees in Case Study A reported that the STP diverted resources from the negotiation of the alliance agreement, as the alliance agreement only represented an element of the STP agenda. There were reports of disagreements about the way the two fitted together in practice. One particular issue was the difference in the focus of integration efforts experienced in Case Study C as dissonance between the 'pathway' approach of the proposed contractual model and the system focus of the STP.

Interviewees in Case Study B saw less connection between their Alliance and the STP programme than the other case studies. This could be due to the fact that, firstly unlike the arrangements in Case Studies A and C, the contractual arrangement in Case Study B was already in place when STPs were announced, and therefore there were no ongoing parallel negotiations. Secondly, in Case Study B, the contractual arrangement was for a smaller, more distinct area than the proposed arrangements in Case Study A and C, where the more general nature of the services addressed by the new contractual model meant that overlap with the STP was more pronounced.

Interestingly, by the end of the research, the relationship between the contractual arrangement and the work of the STP had shifted significantly in Case Study A where it had been recommended that the Alliance be consolidated into the wider governance structures of the local system, and consequently the Alliance had been moved to sit within the governance structure of the STP. This shift is described more fully in Chapter 5.

The issue of fit between the new contractual models and the Vanguard programme was less pressing than the fit with STPs, because none of our case study sites was involved in the Vanguard initiative. There was an acknowledgement that these contractual models were addressing the same agenda as the Vanguard programme, and some interviewees self-identified the new contractual models as 'vanguards'. Indeed, one view was that those developing these new contractual models were undertaking the same work as the 'Vanguards' but were doing so without extra financial support:

> *'So we're not a Vanguard. We've had no promised funding. No pots of money had contributed to this, other than our own. And that's been a real hindrance, but probably been a blessing as well, because we can get on and do it, because if you're a Vanguard, for instance, there's an enormous amount of overhead, in terms of reporting back up the tree to demonstrate what you're doing. But I would still take the money because I think we could do so much more.'(CCG, Case Study A)*

The opportunities for transferable learning from the Vanguards were highlighted in Case Study C, where it was reported that Vanguards models had been studied to aid the development of the local new contractual model and longer term plan for increased integration. Equally though others reported that the Vanguard programme had not resulted in the expected transferable benefits, specifically in relation to the development of standard contractual arrangements to support integrated working:

> *'We have spent a huge amount of money with the Lawyers, and that's partly because the National Vanguards were supposed to sort out all of this and they didn't. So every organisation at the moment is getting VAT advice, is, you know, getting [legal firm's] or other Lawyers' advice around what joint venture agreements should have in them. I think that's been a completely unnecessary spend.' (NHS Community Trust, Case Study C)*

Support from national regulatory bodies

While the new contractual models investigated in this study were initiatives which were locally identified and developed, NHS England and NHS Improvement were also engaged in supporting the development of local contractual arrangements, specifically those that were deemed to be 'complex'. The experience of our case studies suggested that the contractual arrangements were subject to national involvement and advice, in particular in relation to assessing the risks involved.

During the first data collection period of our research NHS England and NHS Improvement introduced the Integrated Support and Assurance Process (ISAP) (in November 2016) which risk assesses large and complex contractual arrangements that commissioners intend to put in place (NHSE&NHSI, 2017). The process aims to ensure proposals represent a good solution in the interests of public and patients, to streamline the assurance process of complex contracts, to ensure a system view is taken in appraising the potential consequences of contract award and to identify, understand and mitigate the risks. Examples of complex contracting arrangements include, but are not limited to, commissioning systemically significant new care models, such as multispecialty community providers (MCPs), primary and acute care systems (PACS) and any accountable care collaborations that result in significant changes in local health systems. Contracts with population-based budgets or significant levels of payment conditional on outcomes may also need to go through the ISAP.

The negotiation and specification of the original contractual arrangements in our case studies were not subject to this regime as it had not been introduced. At the end of our research the new contractual arrangement in Case Study B (outside the scope of this research) was subject to a 'shadow' ISAP process in which the process was run by the local region of NHS England and did not require sign off at a national level. While the case study contractual arrangements were not subject to the ISAP regime, it was reported that national regulatory bodies retain oversight of the contractual arrangements, assessing the arrangements in relation to the risks they presented, and offering advice when arrangements were at a formative stage. For example, in Case Study C, Monitor (now part of NHS England/Improvement) intervened in early discussions regarding the possibility of forming an Accountable Care Organisation, in order to ensure the NHS providers were fully aware of the financial risks of the payment mechanisms of the model. Case Study B, meanwhile, reported that Monitor had concerns about the relationship between commissioner and provider in their Alliance, particularly to ensure that the underlying NHS Standard Contracts should tie the organisations and agreement to provide

services together if the Alliance agreement were to fail. This concern appears to be reflective of the timing of the development of the Alliance agreement in Case Study B, which co-incided with the development of the NHS Alliance template. Such issues have now been given clarity by the national Template Alliance agreement and associated guidance.

Summary

This section has examined the fit between the new models of contracting and the wider institutional context.

The review of literature from other sectors, and the current policy context in the NHS indicate that commissioners may experience some difficulty adhering to procurement regulation while maintaining the ethos of co-production, cooperation and close working relationships which new contractual models rely on. Our findings suggest that commissioners were keen to procure these models without resorting to competitive procurement processes. It is notable that if the procurements had taken place after April 2016, the commissioners may have needed to follow the Light Touch Regime, which requires advertisement. Competitive procurements may create of adversarial relationships between providers and commissioners, create administrative burdens and incur additional transaction costs.

An important finding relates to the tension between co-operation and competition in the current institutional context, as illustrated by potentially detrimental repercussions for providers of collaboration. This relates specifically to implications of sharing of 'competition sensitive information' between collaborators which might later impinge their ability to compete. Although this issue is highlighted in relation to the Alliance model here, it relates to all initiatives which require close inter-organisational co-operation. In this case, the issue appears to be exacerbated in relation to both the Alliance principles of transparency and openness, and the close knit nature of the provider landscape for health and care services, where it is likely a small number of local providers will be competing and collaborating together across a spectrum of local services and initiatives (Porter et al., 2013, Jones et al., 2013).

Our findings regarding the degree of fit between the new models of contracting and other initiatives to achieve integration in the case study areas indicate that local experiences in this regard were mixed, with some tension between the scale and scope of contractual arrangements and the system wide focus of STPs.

These issues are explored further in Chapter 13 – Discussion and conclusions.

Chapter 7 - Written contractual arrangements – governance

The following chapter discusses elements of the written contracts which were in place, or existed in draft form, at the time of the field work in each case study. Elements of the contractual arrangements which set out specification of performance, monitoring, payment and dispute resolution are important as statements of parties' intentions at the time the contract was made regarding the most likely and important eventualities which may occur during the life of the agreement (Allen, 1995). The aim of the written contract is to specify, as far as possible, all future matters concerning the contractual relationship at the outset (Macneil, 1978). Aspects of the written contractual arrangements which are considered are:

- The relation of the new contractual arrangements to the NHS Standard Contract
- Governance arrangements for the new contractual model including transparency and conflicts of interests
- Role definition for commissioners and providers
- Arrangements for dispute resolution

These aspects are important as they deal with key aspects of contractual relationships. The relationship of the new contractual arrangements to the NHS Standard Contract is important as NHS commissioners must use the national standard contract with all providers of care to NHS patients (except GPs). Therefore, an urgent issue is to understand how these new models of contracting dovetail (or do not dovetail) with the national standard contract. The governance arrangements, definition of respective commissioner and provider roles, and arrangements for dispute resolution are important statements of how the contractual parties intend to act in relation to the key aspects of their contractual relationship.

Details of the agreements regarding payment mechanisms are also important in this regard as they describe how parties intend to share financial risk between them. Due to the complexity of these arrangements, payment mechanisms are discussed separately in the next chapter (Chapter 8).

We follow up the discussion of the written contract in this chapter and Chapter 8 with a description of how such issues were dealt with in practice by the contractual partners during the life of the contractual arrangements in Chapter 11. While the contract document endeavours to deal with future arrangements, it is impossible to foresee all possible

contingencies and eventualities at the outset due to bounded rationality (Simon, 1957). In these circumstances, the relational elements of the contract might evolve and help facilitate efficient trade (Macneil, 1981). These include adjustments made to the initially agreed terms during the course of the contractual relationship to deal with unforeseen contingencies (Vincent-Jones, 2006). It is important therefore to examine both formal (written) and relational (unwritten) aspects of contracts. It is particularly likely that the relational aspects of the contracts will be important in our case studies as they concern long term contractual relationships in which, economic and socio-legal analysis demonstrates, parties do not plan and specify their contractual relationships completely, instead addressing issues in the contractual relationship such as the resolution of disputes during the life of the contract (Beale and Dugdale, 1975).

The main body of this chapter is concerned with the written Alliance agreements in Case Studies A and B. As indicated in the introduction to this report, the adoption of Alliance agreements in the NHS is supported by the NHS Standard Contract Template Alliance Agreement for Virtual MCP/PACS models (version 2, December 2016). Both our case studies followed this NHS Template closely, and therefore this chapter refers in the main to the Template agreement, referring only to the case study Alliance agreements where they differ significantly from the Template.

Also in this chapter, we give a brief overview of the written contractual arrangements in Case Study C, focusing on the relation to the NHS Standard Contract, governance arrangements and arrangements for dispute resolution. The purpose of this overview is to ensure that the arrangements in place in Case Study C are understood, despite the fact that no new model of contracting was put in place in this case study site.

The Alliance agreements (Case Studies A and B)

Relation to NHS Standard Contract

It is mandatory that NHS commissioners hold NHS contracts with providers. It is therefore important to establish how these new contractual arrangements relate to the NHS Standard Contract, and any problems arising in using these new contractual models in conjunction with the NHS Standard Contract. The experiences of our case studies suggest that these new contractual arrangements may entail the adoption of NHS Standard Contracts by providers who previously did not hold them, incurring changes to contractual terms as a result which may cause potentially significant operational issues around remuneration and activity payments.

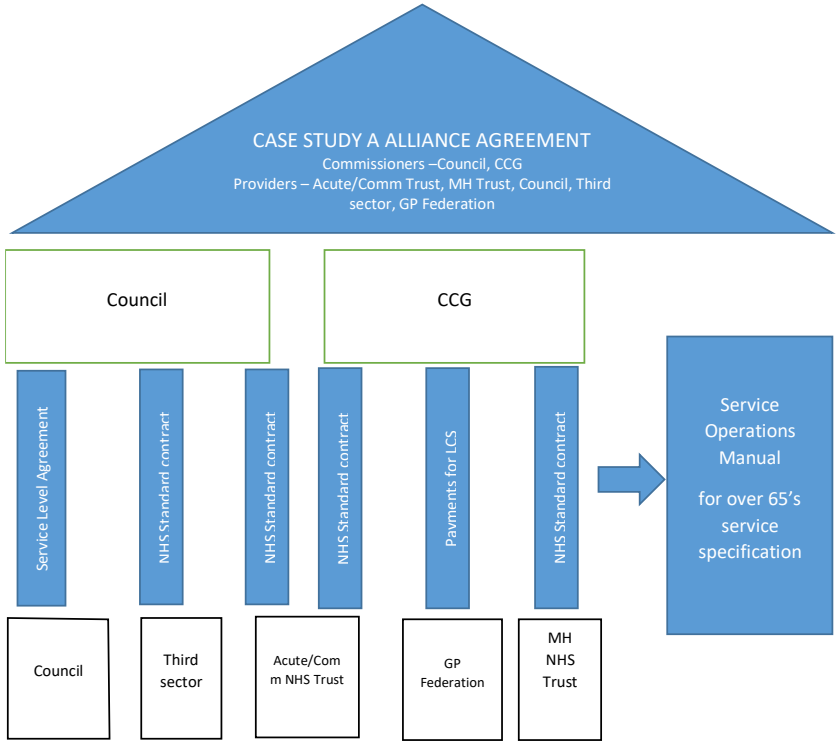
The relationship between the Alliance agreement and the NHS Standard Contracts is that the Alliance agreement describes how parties work together in a collaborative and integrated way, and the NHS Standard Contract describes how services will be provided. Alliance agreements are therefore 'wrapped around' numerous bilateral NHS Standard Contracts for the services subject to the Alliance agreement. Figure 1 summarises the contractual arrangements in place in Case Studies A and B. In both case studies, the detail of service provision and budgets for the services which the Alliance related to were contained in a document called the 'Service Operations Manual' (SOM). Changes in service provision were detailed firstly in the SOM. Both Alliance agreements stated that where the Alliance deemed it necessary, individual NHS Standard Contracts would be altered to reflect changes in service provision and shifts in the share of work.

The hierarchical relationship between NHS Standard Contracts and Alliance agreements is that the NHS Standard Contract should always take precedence. The implication of this is that in the case of conflict or inconsistency between the NHS Standard Contract and the provisions of the Alliance agreement the terms of the service contract (i.e. The NHS Standard Contract) will always prevail. We found that the Case Study B Alliance agreement erroneously states that it would take precedence over the NHS Standard Contract. This may be reflective of the fact that the Case Study B contract was drawn up while the NHS Template Alliance agreement was being finalised.

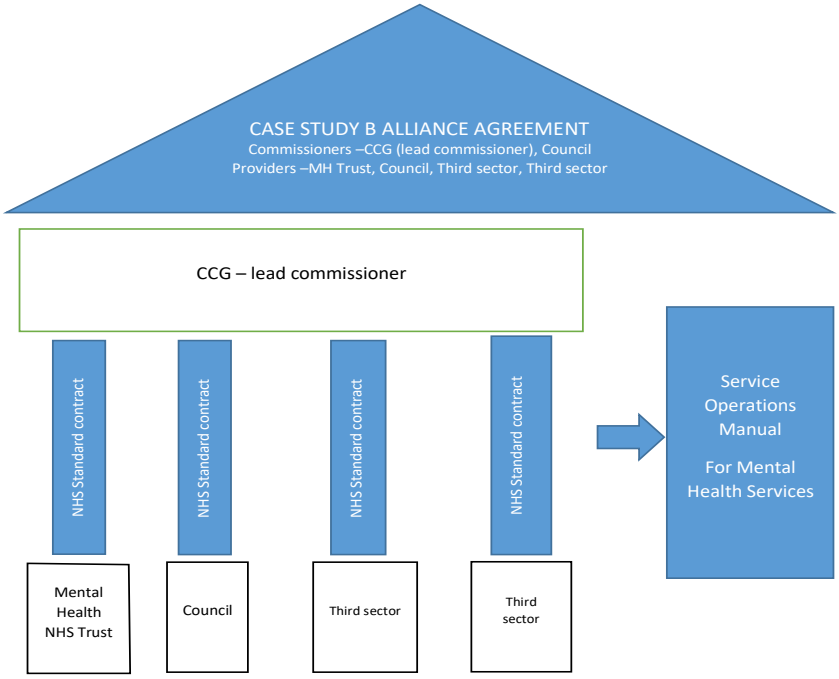
In Case Study A, in which both the CCG and the LA were commissioners, and the LA was also a provider, the LA had chosen to adopt the NHS Standard Contract for contracts under the umbrella of the Alliance agreement. This had been instigated early on in the process when the LA and CCG were anticipating the eventual adoption of a single integrated health and social care contract held by a lead provider, delivered through a series of NHS Standard subcontracts. In Case Study B, the lead commissioner CCG already held all the service contracts (NHS Standard Contracts) prior to the establishment of the Alliance, so this issue was not encountered. The NHS Standard Contract had been chosen as the default in Case Study A as the LA was not obligated to use its own Terms and Conditions and the NHS was. The main reported implication of this was for the third sector provider who was moved from the standard LA contract to an NHS contract.

Figure 1: Overview of contractual arrangements in Case Studies A and B showing relation between Alliance agreement and NHS Standard contracts

Case Study A



Case Study B



The third sector provider was particularly concerned about the implications of this change in relation to differences in contractual terms, which were under investigation at the time of the interview, in particular whether there would be a change to the payment of the London Living Wage (which was a standard element of the LA contract) and whether payments would change from three months in advance (LA contract) to one month in arrears (NHS Standard Contract), thereby potentially causing significant cash flow issues.

Governance of the Alliance

Governance structures are significant as they describe how the contractual parties agree to make decisions during the life of the contract. Alliances are based on a collaborative and collegiate model, incorporating unanimous shared decision making, open book accounting, and undertakings that partners will work together to resolve issues without recourse to the courts. When this model is transferred to the NHS setting, the nature of the NHS Alliance agreement is necessarily that each organisation remains sovereign, reflecting the primacy of the NHS Standard Contract or other service contract, and the statutory responsibilities of public sector commissioners and providers.

The NHS Template Alliance agreement seeks to formalise relationships between contractual parties by referring to a number of general principles which NHS Alliance governance structures should support: the commitment of partners to work together, to take responsibility for making unanimous decisions on a best for services basis, take collective ownership of risk and reward and to adopt 'an uncompromising commitment to trust, honesty, collaboration, innovation and mutual support' (Clause 7.1).

The governance of the Alliance rests within a tripartite structure, consisting of a board with membership from each member (Alliance Leadership Team), and a more operational body also with membership from each member (an Alliance Management Team) and leadership from a dedicated Alliance Programme Manager. The Alliance Leadership Team provides strategic direction to the Alliance, manages risk and holds the Alliance Management Team to account for the performance of the alliance. The Alliance Management Team is responsible for managing the Alliance and the delivery of the services. The Alliance Programme Manager, who is appointed by the Alliance Leadership Team (ALT), project manages the Alliance. The governance bodies described in both Alliance agreements largely mirrors those suggested in

the Template Agreement. Figure 2 summarises the governance structures of Case Studies A and B.

Decision making

The general undertaking in the Alliance agreement is that all members should take responsibility for making unanimous decisions on a best for services basis (NHS Template Alliance Agreement, 7.2). Specific undertakings regarding the unanimity of decision making in the Template indicate this is subject to qualification due to the particularities of the NHS context.

Under the terms of the NHS Template Alliance agreement, the governance structures of the Alliance must have members with delegated decision making authority on behalf of their organisations. However, due to the ongoing sovereignty of member organisations, the governance structures of the Alliance are unable in law to bind any Alliance member. The Template agreement designates the ALT as a forum for discussion of issues, with the *aim* of reaching consensus among the Alliance members (Schedule 3, Part 1, 2.2). The written contract does not demand that all decisions are unanimous, and the agreement requires the ALT to develop a protocol to address circumstances in which a member decides not to adopt a decision reached by the other members.

The case study Alliance agreements differ in how they deal with the need for unanimous decision making. The draft agreement for Case Study A follows the NHS Template Alliance agreement and states that matters put to a vote by the Alliance Leadership Board should be passed unanimously and where this is not possible, and 'the nature of the matter is such that the Board must come to a decision', the matter can be decided by a majority vote. The Alliance agreement in Case Study B, which was agreed prior to the issuing of the NHS Template Alliance agreement, is aligned with the principle of unanimous decision making without further distinction suggesting that each member of the Alliance Leadership Team will have an equal say in decisions.

Furthermore, the statutory responsibilities of commissioners necessitate situations in which the commissioner may make decisions independent of the rest of the Alliance. These 'reserved' matters include: any matter which requires the Commissioner to invest further monies; any

matter upon which the Commissioner Participants may be required to submit to public consultation or may be required to respond to a Local Healthwatch organisation, decisions regarding inclusion of parties in the Alliance, and the termination of the Alliance; and a further requirement that the Alliance should implement the commissioner decisions in relation to reserved matters as if it were a decision of the Alliance Leadership Team.

Whilst these arrangements are necessary, they mark a departure from the Alliance model. The implications of this will be discussed at the end of this Chapter, and in the Discussion chapter of this report.

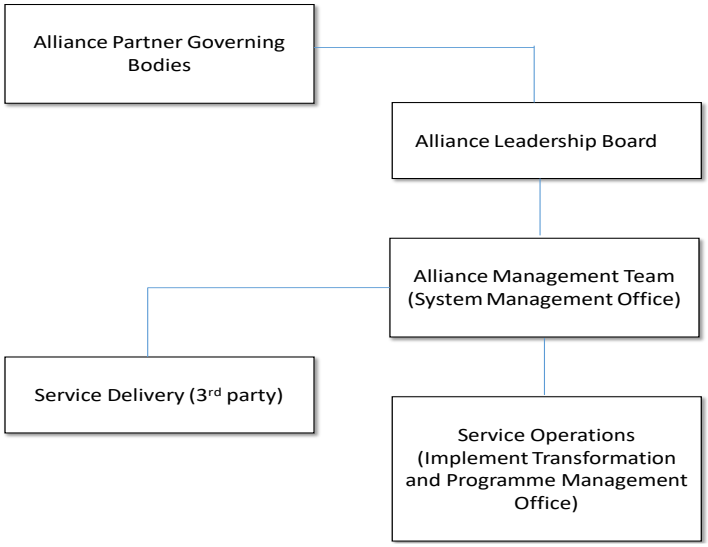
Transparency and conflicts of interest

A central principle of Alliance contracting relates to transparency, and in particular the concept of open book accounting. The desire to achieve an open sharing of information between Alliance members clearly carries with it the potential for conflict of interest and the infringement of competition law, and implications regarding the freedom of Alliance members to bid for further contracts.

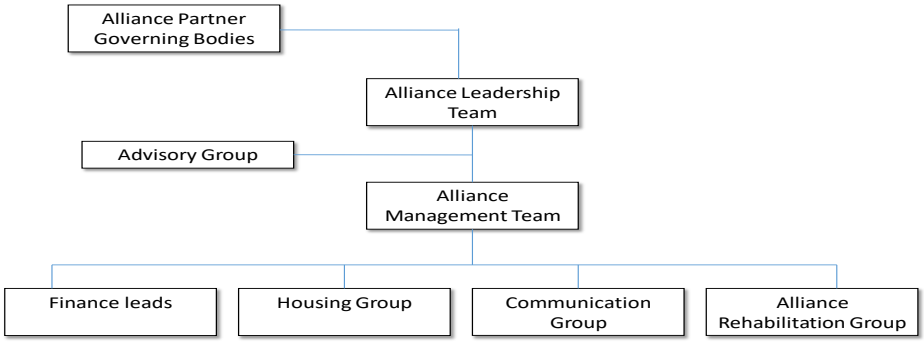
The Template Alliance agreement details the general undertaking that members will establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information, subject to competition law compliance. As previously discussed in Chapter 6, the NHS Template Alliance Agreement addresses the potential for conflict in relation to issues of transparency. This is a particular issue in relation to the sharing of sensitive information between providers, and the possibility that provider members may wish to compete in a competitive procurement process which may bear some relation to the sensitive information which has been shared. In these situations the NHS Template Alliance Agreement suggests that the onus is on the provider member to demonstrate that the information it has acquired as a result of its participation in the Alliance does not preclude the commissioner from running a fair competitive procurement in accordance with the commissioner's legal obligations (Clause 10.7). Furthermore, the Template Alliance Agreement also states that commissioners reserve the right to exclude potential bidders to comply with procurement and competition legislation if necessary (Clause 10.8).

Figure 2: Governance arrangements in Case Studies A and B

Case Study A



Case Study B



Additionally, there are potential conflicts of interest pertaining to the position of Local Authorities as both commissioner and provider members of Alliances. The Template Alliance agreement states in this regard that it is for the Alliance Leadership Team to develop and approve a protocol for addressing actual or potential conflicts of interests among its members (Schedule 3, Part 1, 8.2). The draft Agreement in Case Study A highlights the potential for conflict of interest due to the status of the LA as both commissioner and provider, and the need to ensure that dual roles are appropriately identified and managed. The document suggests a broad approach whereby conflicts of interest must be declared in writing, and then will be dealt with by the Alliance Strategic or Management Boards.

Roles of commissioners and providers

The Alliance model, as it is used in industry, is characterised as a partnership model based around a unified team. However, it is also acknowledged that this notion is, in reality, tempered to a degree by the residual differing interests of principal and agent (Jefferies et al., 2014).

The NHS Template Alliance agreement highlights various ways in which the roles of commissioner and provider members will differ, which are largely related to the statutory responsibilities of commissioners. Both the Case Study A draft Alliance Agreement and the Case Study B Alliance Agreement take the opportunity to further differentiate between the roles and responsibilities of commissioners and providers to reflect local concerns. The Case Study B agreement outlines the different roles of commissioners and providers, in which commissioners should establish an environment which encourages collaboration, provide leadership, link to other relevant services, and consider decisions in a timely manner. Providers, meanwhile, are identified as (among other roles) managing risks in performing services, providing cost reports, implementing performance recording, working co-operatively, and unlocking enhanced value for commissioners and the public (Clause 7, Case Study B Alliance agreement). The draft contract for Case Study A details still more specific responsibilities allocated to commissioners and providers. The commissioner participants are identified as having responsibility, for example, for establishing a maximum affordable financial envelope; managing the performance of third party providers contributing to the delivery of the Services; providing subject matter experts to ensure continuity in the management of system controls; and clearly articulating performance standards, the scope of services and associated technical requirements, and known risks. Provider participants meanwhile are identified, in addition to the responsibilities contained in Case Study B contract, as having responsibility for managing

system demand; and delivering services in accordance with performance standards, the Financial Plan, the scope of services and associated technical requirements and known risks (Clause 8, Case Study A draft Alliance Agreement).

Dispute resolution

Contractual documents were reviewed to identify the arrangements for dispute resolution. The arrangements for the resolution of disputes is a key issue in contractual relationships, and is of particular interest in relation to Alliance contracting, as it is a key area of difference between alliance contracting and other more traditional forms of contract. In the Alliance model as it is used in industry, unlike traditional contracts, Alliance partners are expected to resolve issues without recourse to the courts for dispute resolution, and contracts may include a no blame/no dispute clause, which excludes recourse to litigation and unanimous decision making protocols.

The NHS Template Alliance Agreement outlines a dispute resolution process by which any disputes will be resolved through the Alliance governance structure, rather than through the standard NHS dispute resolution procedure. If the issue cannot be resolved through this internal governance structure, it can be referred to an independent facilitator. If the independent facilitator cannot resolve the dispute, the most senior Alliance governance body can terminate the Alliance, or alternatively agree to disagree. The Case Study A draft Alliance Agreement and the Case Study B Alliance agreement largely follow the procedure outlined in the Template Alliance Agreement. The significance of this process is that the Alliance agreement suggests parties should resolve disputes largely without resource to any outside decision maker. Whilst an independent facilitator can be involved, the issue, if unresolved, is then referred internally to the Alliance again. This process differs from the arrangements for dispute resolution in the NHS Standard Contract whereby external bodies, such as NHS England/Improvement take a mediation role, followed by a final stage binding 'expert determination' by an independent expert if mediation fails (NHS England and NHS Improvement, 2018). The significance of this Alliance agreement dispute resolution process, particularly in relation to the issue of formalised relationality will be discussed in the summary to this chapter, and more generally in the discussion chapter of this report.

The Template Alliance agreement also addresses the action to be taken in the case of member 'non compliance' where an Alliance member acts against Alliance principles and the interests of the Alliance. In such instances of wilful default, if the member refuses to amend their

behaviour, the other members may ultimately exclude that individual or organisation from the Alliance. The Template agreement anticipates that any situation that warrants exclusion from the Alliance is also likely to result in a decision by the commissioner to terminate the associated Service Contract.

What happened in practice when there were disputes between parties in our case studies will be discussed separately in Chapter 11 below. The extensive literature concerning all types of contract indicates that parties' behaviour may well deviate from formal processes stipulated in written contracts.

Case Study C

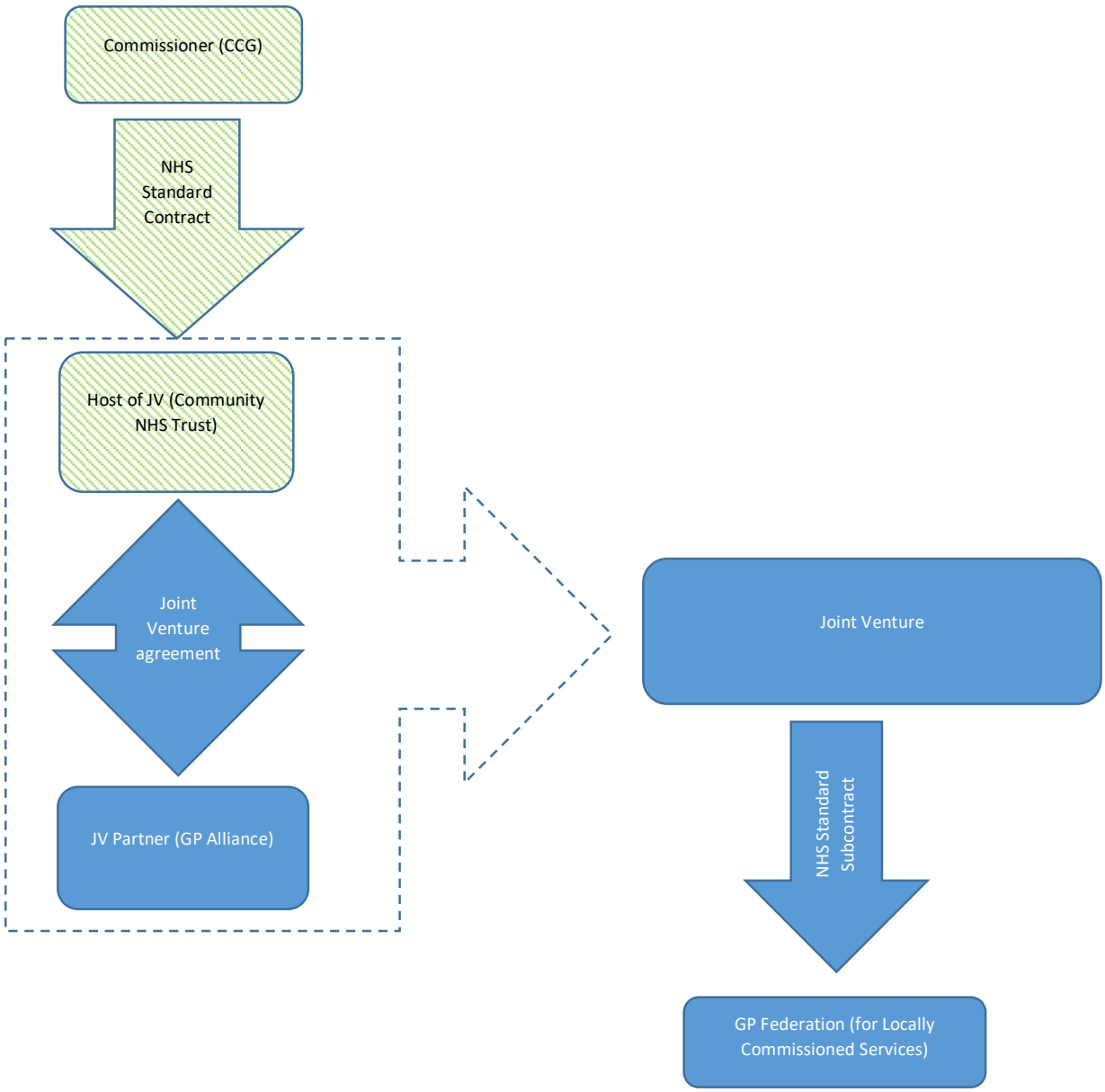
There were two contractual agreements in place in Case Study C. Firstly, the Joint Venture agreement, and secondly, a Memorandum of Understanding relating to the development of a wider contractual arrangement. Neither of these written documents is of direct interest to this report. Firstly, the Joint Venture agreement did not constitute an innovative contractual model which attempted to share (some or all) financial risk between a group of providers. Secondly, although the proposed wider contractual arrangement is of direct interest to this report, the written document representing this endeavour, the Memorandum of Understanding, is not, in itself, of interest because it is not a formal contract. This chapter, therefore, provides only a short description of the formal situation in Case Study C in order to ensure that the arrangements in place in Case Study C are clearly defined.

Relation to NHS Standard Contract

In Case Study C, the NHS Standard Contract was supplemented by other contractual documents to structure the Joint Venture arrangement (see Figure 3 below). The NHS Standard Contract was between the CCG and the community NHS Trust (the 'host' of the Joint Venture agreement). This NHS Standard Contract was for the development, integration and delivery of community adult healthcare services and local commissioned services in the area. The Joint Venture agreement, between the Community NHS Trust and the GP Federation, and the MoU, between the group of wider contractual partners, were documents relied on in the NHS Standard Contract. Contained within the Joint Venture agreement was a subcontract between the community NHS Trust and the GP Federation for the provision of some services by the GP

Federation (this took the form of an NHS Standard Sub-Contract for the Provision of Clinical Services 2016/17).

Figure 3: Overview of contractual arrangement in case study C



Governance structures

The governance structures of the Joint Venture agreement (Figure 4) were not as complex as those of the Alliance agreements, and are not of direct interest to this report as they do not relate to the type of new model of contracting of interest here: namely this Joint Venture agreement is a bilateral rather than multiparty agreement, and it did not seek to share any significant financial risk between the two parties.

Figure 4: Governance arrangements in Case Study C

Summary

This chapter has examined the written contractual documents associated with the contractual models in our case studies in terms of their relation to the NHS Standard Contract, their governance arrangements, including issues relating to transparency and conflicts of interest, definition of commissioner and provider roles, and arrangements for dispute resolution.

As the agreement of the new model of contracting in Case Study C had not yet been concluded, the extant written contractual documents relating to the interim arrangement were briefly discussed here for clarity but are not of direct interest to this report, as they did not constitute a new model of contracting as defined by the scope of this report.

The analysis of the written contractual documents for the Alliance agreements of Case Studies A and B raises a number of issues. In general, arrangements in the written contract reflected the particularities of the statutory responsibilities of NHS commissioners, and indicate how the model is amended to suit the NHS context.

Whilst the Alliance model, as used in industry, reflects a need to ensure the equality of all Alliance members, the NHS Alliance agreements reflect the differing statutory responsibilities of NHS commissioners and providers, particularly regarding commissioner 'reserved matters'.

These refer to areas where decision making or action cannot be delegated or shared such as duties regarding commissioning, public consultation and relating to budgetary constraints. In these instances the commissioner is not obliged to act within the confines of the Alliance agreement and take decisions on a unanimous, best for service basis, and indeed the other parties to the Alliance are required to abide by the commissioner decisions. Both the case study Alliance agreements also chose to flesh out in further detail differences in roles between commissioner and provider members, further highlighting the differences between their responsibilities.

The differences between the roles of commissioners and providers in Alliances will be discussed again in later chapters, in particular in relation to the negotiation of contractual arrangements in Chapter 9.

Both the Template Alliance agreement and the draft Alliance agreement in Case Study A depart from the principle of unanimous decision making which appears to be an element of the model as it is deployed in other sectors, allowing the possibility that in some circumstances another method of reaching agreement, such as majority rule, may be sufficient. Both this departure, and the existence of commissioner reserved matters, represent a significant difference in the adaptation of the Alliance model to suit the NHS setting. The implications of this in relation to the empowerment and engagement of individual organisational members and the commitment to negotiating win/win solutions will be returned to in the final discussion chapter.

Two further significant issues emerged from the analysis of the written contract.

Firstly, as already discussed in relation to the fit of the models in the wider institutional context in Chapter 6, the written Alliance agreement indicates the tension between increased provider collaboration and the requirements of competition legislation.

Secondly, a set of issues related to the implications of the move to an NHS Standard Contract from a Local Authority service contract for the third sector provider in Case Study A. It appeared this move had potentially significant implication in relation to changes in terms and conditions. This issue will be picked up again in relation to the negotiation of contractual arrangements, and the provision of legal advice to smaller providers, particularly third sector providers in Chapter 9. The role of third sector organisations in these new models of contracting is a key theme which has emerged from the research, and will be discussed again in Chapter 13 - Discussion and conclusions.

Chapter 8 - Written contractual arrangements - Payment structures and financial risk

The agreement of appropriate payment structures which share financial risk amongst multiple parties are important to new models of contracting, as mechanisms with potential to incentivise the achievement of cross organisational outcomes. The main types of these mechanisms associated with new models of contracting in the NHS, such as Alliance and lead provider contracting, are capitation, multilateral gain/loss sharing and outcome based approaches (Monitor and NHS England, 2015).

As described in Chapter 5, all three of the contractual models we researched intended to use payments structures which shared risks and rewards amongst multiple parties. This chapter discusses elements of the written contracts which specified the payment structures which had been agreed by the contractual parties. As discussed in the previous chapter, it is important to analyse both the written contract and how the contractual relationship is conducted in practice, and this approach is also taken in relation to the analysis of payment structures and the allocation of financial risk. This chapter therefore analyses the written formal agreements regarding payment structures and financial risk, and Chapter 11 describes how these matters were dealt with in practice.

Our analysis of payment structures and arrangements regarding the allocation of financial risk within these new contractual models encompasses the main elements of these arrangements:

- how providers were to be paid
- whether the contractual arrangements included any payments on the basis of outcomes
- the use of financial penalties and rewards
- the use of multilateral gain/loss sharing agreements
- any general undertakings regarding the sharing of financial risk between parties

We reviewed the descriptions of payment structures in the contractual documentation, and we supplemented this information with interviewees' descriptions of the payment structures where this was required to gain clarity.

Our main findings resulting from this analysis is that the written contract did not specify payment structures which would enable the sharing of financial risk in two cases studies (A and C). One case study (B) specified the general principles for the allocation of financial risk

and specific mechanisms regarding outcome based payments. However there was a failure to specify in advance how financial risk relating to changing activity and finance flows would be managed amongst providers. Where outcome based payments were used or proposed these were modest in value compared to overall value of the service contracts.

Case Study A

The intent in Case Study A was to agree a multilateral risk share agreement, pay a proportion of the service contracts on the basis of the achievement of outcomes, and eventually, put in place a capitated payment mechanism.

The draft Alliance Agreement for Case Study A did not specify any of these mechanisms, and, indeed, these arrangements remained under discussion at the point the agreement was signed. The written agreement instead recognised that significant developmental work needed to be undertaken before new payment mechanisms could be agreed, and specified the timescale to achieve agreement of these new mechanisms. The Alliance dedicated the first year of the contractual arrangement to 'transition' work which would allow a change in payment mechanisms from second year of the contractual arrangement. The draft Alliance agreement stated that in Year One the pre-existing payment structures for the service contracts would be preserved, with providers being paid as previously, albeit that separate NHS Standard Contracts would be established for over 65's and under 65's elements of services.

As outlined in Chapter 5, the Alliance model was subject to change after the first year of the contractual agreement. A Deed of Variation noted that it had not been possible to achieve all the objectives of the transition period. This Deed, signed at the end of the first year of the contract, stated that the ambition of the Alliance was to move to payment for Alliance services on the basis of a whole-population capitated model by the conclusion of the contractual term (a further 9 years). It also stated that both outcomes payments and agreement of risk share arrangements were possible future mechanisms.

Case Study B

The Alliance agreement in Case Study B specified a number of payment mechanisms.

The Agreement laid out broad principles underlying the financial mechanisms: that transactional costs will be minimised; that there will be cost transparency between provider Alliance members (subject to compliance with competition law and the need to ensure non-

disclosure of commercially sensitive information); that definitions of costs will be agreed in advance by all Alliance members; that value for money must be demonstrated for cost and non-cost outcomes; and that none of the contractual partners will incur unreasonable profits or losses.

There were two ways in which financial risk was allocated within the contractual arrangement. Firstly, in relation to the outcome based element of the service contracts, a formal gain/pain share arrangement relating to performance against outcomes was in place. The second element of risk share relates to the wider financial risks of the Alliance.

Payments relating to performance against outcomes

The Alliance agreement specified a gain/pain regime in respect of performance against outcomes which consisted of 'gainshare' payments from the commissioner Alliance members to the provider Alliance members and 'painshare' payments from the provider Alliance members to the commissioner Alliance members. This arrangement, worth approximately 1% of the value of the service contracts (£140,000), constituted the only performance related payment mechanism in the contractual arrangement. The ratio of payment for both the gain and pain share was initially approximately 40% each for the LA and the NHS Foundation Trust, and 10% each for both third sector providers, although this was expected to change over time as activity changed. This apportionment was based on the proportion of the relative value of each provider's service contract as determined at the start of the Agreement. A modifier totalling 2% of the available gainshare could be applied at the discretion of the commissioner, where it was deemed there had been poor practice in relation to investigating and learning from clinical incidents.

The agreement states that the outcome based payments in relation to the service contracts were not in operation for Year One of the contractual arrangement. In Year Two gainshare payments were funded from CQUIN money. The amount at risk through painshare in the event of underachievement on performance was equal to the gainshare. If applicable, painshare payments were to be paid by providers to the Alliance commissioners through a dedicated fund, which provider Alliance members agreed to set up should a painshare payment seem imminent.

Risk sharing arrangements

Additionally, the contract documentation addressed the wider financial risks of the Alliance, namely how any gain/loss pool would be managed between the commissioners and providers, and between the group of providers.

There are a number of broad principles contained in the Case Study B Alliance Agreement (as summarised previously) which indicate the degree of risk Alliance members are exposed to, and the ways in which these are mitigated. These principles concern agreeing a 'fair' allocation of risk between Alliance members, for example stating that no Alliance member will derive unreasonable advantage or suffer unreasonable disadvantage, and that shifts in activity between the Alliance providers which are in line with the Alliance plans will be reconciled in line with Alliance principles and in a way that participants consider fair. The Alliance agreement explicitly recognises that the risks associated with shifting activity in the service model rest with the Mental Health NHS Foundation Trust, who will experience a decrease in activity should the Alliance be successful. However the written contract does not address specifically how this risk should be shared apart from in the spirit of the general principles detailed above.

Any overspend against the funding envelope (which included the savings expected from the Alliance) was deemed to be a matter resolved by the providers in the Alliance. The contract does not specify how this loss pool would be shared between providers, and therefore it appears that this would be agreed between Alliance partners when the situation arose. Commissioner Alliance members will reconsider the financial envelope, if additional demand exceeds the activity and financial plan by 10% or more and all Alliance members have fully utilised opportunities to reduce demand in the system.

In relation to the distribution of an underspend (a 'gain pool'), the agreement states that in Year One of the contractual arrangement, any cost reductions would be returned to the commissioners to set against the pump priming costs of the Alliance. In subsequent years, cost reductions would be managed by mutual agreement of the Alliance Leadership Team according to the following principles: firstly, money will be used for local residents with severe and enduring mental health problems and complex life issues; and secondly, if money remains, 50% will be returned to the commissioners for redirection to other priorities and 50% made available to Alliance providers for use in related local services. Where an underspend relates to demand which is lower than expected or is easily manageable within budget, the Alliance

governance bodies will seek ways to expand the Services to other cohorts of people rather than treating the underspend as a 'gain pool'.

Case Study C

In Case Study C it was intended that that wider, aspirational contractual model would use both capitation and a proportion of payment on the basis of outcomes to share financial risk between providers. These intentions are recorded in the Memorandum of Understanding, which described activities which should take place in the two year 'transition' period which included the development of a capitated payment mechanism including an outcomes based payment model.

Whilst it was acknowledged that these payment mechanisms, and indeed the contractual arrangement itself were aspirational, the MoU also referred to the intent that the Joint Venture agreement would put in place payment on the basis of outcomes for the delivery of community adult healthcare services and local commissioned services. At the start of Year One of the Joint Venture arrangement the payment schedule reflected existing PbR and block payment arrangements and payment flows.

Payment on the basis of outcomes

The Joint Venture agreement anticipated that all community services would transition on an incremental basis to outcome based payment over the two year term, with 1% of payments in the second half of Year One of the contract paid on the achievement of outcomes, rising to 2% in the first half of Year Two and 3% in the second half of Year Two.

Additionally, CQUIN payments totalling approximately £350,000 (to meet provider costs to support the development and infrastructure required to deliver the wider contractual arrangement) were payable on the achievement of transition milestones. These milestones included the development of payment mechanisms including the development of a capitated payment mechanism based on a fixed payment, an outcome based incentive payment and a contingency.

Risk sharing arrangements

In the main, where the allocation of financial risk was specified in the Joint Venture agreement this concerned how financial risk would be allocated between the commissioner and the parties

to the Joint Venture agreement. Issues covered in this way related to the specification of parameters and tolerances for changes in activity and financial performance against indicative activity plans and planning assumptions. As these arrangements did not relate to sharing risk amongst multiple providers they are not of direct interest to this report.

The agreement indicates the circumstances in which the parties to the Joint Venture agreement can benefit from savings made, for instance to use for approved business cases for investment to expand the service or to invest in alternative services which deliver the aim of the JV or the contractual arrangement anticipated to come from the work of the parties to the MoU. Provision is also made to protect the parties to the Joint Venture agreement from some of the financial risks associated with service redesign. For example, if there is a reduction in inpatient beds the parties to the Joint Venture agreement can negotiate the transfer of funds to care for those patients.

Summary

The written contractual documents indicate a significant discrepancy between the aspiration of contractual parties to use payment mechanisms which share risks and rewards between multiple providers, and the arrangements which were specified in practice.

In two of our case studies, the written agreements broadly focused on the process by which these mechanisms would be agreed in the future.

In some instances the written documents did detail agreements which had been reached. In two case studies (B and C) it had been agreed that a proportion of the service contracts would be paid on the basis of outcomes. There are a number of significant factors relating to these payments. Firstly, these payments represented only a very small proportion of the value of the service contracts (1-2%). Secondly, in Case Study B, the payments were to be drawn from CQUIN money, and therefore payment was already subject to satisfactory performance prior to the introduction of these specific outcome measures.

The Alliance agreement of Case Study B specified how financial risk was to be shared in much greater detail than the other two case studies. Whilst acknowledging that one particular provider was likely suffer financially as a result of the work of the Alliance, the written documents relied on general principles regarding how such risks would be shared in practice. This is indicative of the approach of alliance contracting model, which uses express contractual terms to bind contractual partners to particular behaviours and principles in their contractual

relationships which will then be applied when addressing issues that arise in the contractual relationship. It is important to examine how these sort of general behavioural undertakings are operationalised in practice. The example of how the contractual parties in Case Study B shared financial risks in practice will be discussed in Chapter 11.

Chapter 9 – Negotiating the contractual arrangements

This chapter of the report details how the contractual arrangements were negotiated in the three case studies. Negotiations consisted of multiple layers: the negotiation of the terms of the agreement itself, the associated financial and service model, and the underlying payment mechanisms. This chapter is concerned with the *process* of negotiation (e.g. resources involved), while issues relating to the *nature* of the negotiations (e.g. concerning the specification of the multiple layers of the contractual arrangements) are discussed in Chapter 10.

The negotiation of these contractual arrangements is significant for a number of reasons. The examination of the negotiation, specification and monitoring of contracts in practice is important because it is misleading simply to analyse the formal provisions of the contract alone, as actual practice often does not comply with contractual rules (Macneil, 1981). Negotiation is a relational aspect of contracting, allowing flexibility and other relational norms.

Transaction cost theory suggests that contractual models that seek to share financial risk between multiple parties will incur significant *ex-ante* costs, in other words the models are likely to require substantial input in terms of searching, collecting information and negotiating before the contract is agreed**.** The literature regarding the use of alliance and lead provider contracting and the use of outcome based payments in other sectors (Sanderson et al., 2016) suggests this is also the case in practice. It is therefore pertinent to examine the process of negotiation in practice to understand the transaction costs which were incurred in our case studies.

The foregoing chapters have illustrated that in two case studies, A and C, the agreement of the contractual arrangements was problematic: the nature of the contractual model was altered during the negotiation process, and arrangements to share financial risk among multiple parties were not agreed. This chapter and the next (which focuses on the specification of aspects of the contract) seek to find out why the agreement of the contractual arrangements proved difficult in these local contexts.

An additional focus of this chapter is on the relationships between parties to the new contractual arrangements during the negotiation of the contractual arrangements. Contractual theory emphasises that where it is difficult to specify and measure all aspects of agent performance, relational aspects of contracts might evolve in which adjustments are made to the initially agreed terms during the course of the contractual relationship to deal with unforeseen contingencies. In contracts with pronounced relational norms parties rely on flexibility, solidarity and reciprocity. As described in Chapter 2, contractual theory also suggests that the contractual process can itself help build constructive relationships between contractual parties. This is a particular area of interest regarding the negotiation of the Alliance contractual arrangements, where it is conventional to use the 'pre-contractual' period to develop the working relationships and form an Alliance perspective between the parties to the agreement. It is therefore pertinent to discuss the relationships between the parties during the period of negotiation, and also, particularly in relation to the Alliance agreements (A and B), to understand the process that was undertaken in the negotiation period to build relationships.

Aspects of the negotiation of the contractual arrangements which are examined in this chapter are:

- The resources which were reported to be used
- The involvement of regulatory bodies
- Relationships between contractual partners during contract negotiations
- Third sector involvement in negotiations

Resources used

Across all three case studies, interviewees reported that the development of the new contractual models had been a time consuming process, requiring investment in significant dedicated resources. These related to firstly 'buying in' external support, specifically the provision of legal advice and the use of management consultants, and, secondly, the dedication of 'internal resources', specifically staff time. The dedication of resources to the contractual negotiations was a significant commitment to all contractual parties, but which was potentially particularly difficult for the smaller contractual partners.

Provision of legal advice

As described in the introduction to this report, NHS template Alliance agreements are available for adoption by localities. These models had been utilised in Case Studies A and B. Case Study B reported that when they began developing their Alliance agreement the national template was not in place. However the existence of template agreements is not intended to remove the need for the provision of tailored legal advice to each contractual party, and the amendment of the template agreements locally to reflect local circumstances (NHS England, 2016). Contractual parties in all three case studies had used internal legal support (where this was available) and external support to facilitate the drawing up of the agreements.

Legal support was not shared across the contractual parties. This is standard practice in contractual negotiations due to potential conflicts of interest, but was noted to be costly for the smaller of the contractual parties. The exception to this was a sharing of legal advice between the Council and CCG in Case Study B where both parties were pooling funds. An associated issue which was raised was the perceived duplication of legal advice on issues associated with VAT, which incurred unnecessary cost to individual organisations.

Use of management consultancies

All three case studies reported the involvement of consultancy firms (and in one instance an NHS Commissioning Support Unit) in the development of the new contractual models. The case studies all reported using consultancy firms with specialism in the development of such new contractual models. These agencies were used to provide briefings concerning the previous use of this type of contractual arrangements in similar setting, develop the case of change, model the baseline position and estimate the scale of the potential financial opportunity, support the identification of outcomes, and to facilitate the development of inter organisational relationships. In Case Study A organisational development support also included workshops facilitated by a consultancy to establish productive working relationships between contractual parties. This focused on the establishment of principles for working together, agreement of leadership arrangements and arrangements for the negotiations.

It was also reported that the consultancies had supported the commissioners in line with their general duty to involve individuals and the wider community, in public involvement events which served to gather views and opinions to feed into the development of outcomes.

In the main these costs were borne by the commissioner. In Case Study A, however the integrated acute/community NHS Trust also commissioned a management consultant to produce an independent financial model.

Use of internal resources

Contractual parties in all three case studies reported that the negotiation of the contractual arrangements had drawn significantly on staff time over a prolonged period. This was particularly the case in Case Studies A and C where the contractual model was revised, and negotiations proved difficult to progress. However, in Case Study B, where the original proposed contractual model was successfully agreed, interviewees also reported that negotiations had required substantial input from all contractual parties.

> *'So there was a lot of time spent negotiating the contract. It was probably nearly a year, 18 months, from start to finish. The amount of time that it took was enormous. It was a huge commitment from all of the organisations and particularly the voluntary sector organisations committed so much time and resource, not just at our level, but at management – at operational management level as well. And the negotiations for the contract were slow, not because everybody didn't want it, but because we were dealing with five separate organisations, who each have their own internal governance, who each have their own internal structures that for large, statutory organisations, are not the easiest to manoeuvre….So, we had to work hard to share those risks, and to really motivate each other to keep going. Because it was the right thing to do, and it is the right thing to do, but you couldn't detail every scenario on paper, and that's what made the contracting bit more difficult, I guess.' (Council, Case Study B)*

In Case Study A dedicated resources had been put in place, consisting of a dedicated central team consisting of the Programme Manager, supported by around six other dedicated staff based in provider organisations. In the other two case studies, the negotiations had been managed within individuals' existing workloads.

The contractual negotiations were both lengthy and intensive.

In Case Studies A and C the development of the contractual models had begun in 2014, and contracts were due for signature in April 2017 and December 2016 respectively, a period of two - two and a half years. In Case Study B (the only contract operational when research commenced) the negotiation of the Alliance agreement had taken eighteen months. The length of this pre-contractual period presented its own challenges, particularly in Case Studies A and C, in the context of changing personnel:

> *'It's been a huge commitment and it's still a huge commitment. So, if others were to look at the same, I would say, "Do not underestimate the – not just the brainpower needed, but the commitment, and the energy, and the drive, and the perseverance." So my particular Chief Officer came in, in August 2015 and she inherited this. I think the previous team had worked on it for a year before that.' (CCG, Case Study C)*

Eventually in both Case Studies A and C the local context and national context had changed, whilst first the contractual arrangements themselves, and then payment mechanisms, were being negotiated, to the extent that both contractual models were substantially remodelled by the end of the research period, without some of the issues under negotiation (e.g. payment models) ever being resolved (see Chapter 11).

In both Case Studies A and C the lengthy process of negotiation, involving the development and subsequent rejection of detailed plans for provider led contractual models, had left some of the provider participants frustrated and fatigued, with a reported loss of engagement among staff involved in service delivery in Case Study A. The acute/community NHS Trust in Case Study A had found the process of negotiation particularly disheartening, largely due to their disappointment at the change from a provider led contractual model to a commissioner/provider Alliance during contractual negotiations, and the apparent invalidation of the previous agreements which had been reached:

> *And they've got some new people now, but it still feels commissioner driven, our Chief Exec, you know, is quite a strong voice from the Trust, but it's still kind of strongly commissioner driven. And I think on the transformation agenda, what's happened now is it's back to being commissioner driven, and it's just like, so painfully slow. It's actually really quite frustrating, because we made a lot of progress and now it's kind of the ball's in their court. We're producing business cases as part of the kind of the*

STP process, and I'm like, "Well, we did all this work for [the original provider led contractual model], why isn't it in there?" (Director, Acute/Community NHS Trust, Case Study A)

A number of factors appeared to negatively impact the time taken to agree the contractual model. Firstly, negotiations were hampered by difficulties of specification which will be explored in the next chapter: refining the financial modelling, the service model and the payment mechanisms. Secondly, the multiparty nature of the contractual arrangements provided a natural 'drag' on the speed of the process. Decisions had to be referred back to each organisations' own governance structure for approval, slowing progress. Furthermore, thirdly, decision making was complex in relation to the large statutory organisations which needed to consider decisions relating to the contractual model within the context of a much wider infrastructure and service portfolio.

The data suggests the negotiation of the contractual models also required an intensity of input from each of the contractual parties. In Case Study A, for example, it was reported that, in the months immediately before the contract was due to be signed, contractual parties were meeting on a weekly basis. The resources required to negotiate the new models of contracting in the case studies were significant for all contractual parties. This has implications for all organisations who may be considering entering into such arrangements, however it is likely to be a particularly difficult issue for smaller contractual parties. This was the case for the third sector organisation in Case Study A. This was a local branch of a national charity, in which management posts were funded in relation to budgeted projects within little spare capacity to undertake unfunded work. In order to aid this organisation's participation the Alliance provided limited funding, which the third sector provider hoped would continue throughout the life of the contract in order to subsidise their ongoing input to the service transformation work. The role of third sector providers in these new models of contracting is a key theme of this research and will be explored further in the remainder of this chapter, and returned to again in the final discussion of this report (Chapter 13).

Relationships between contractual partners during negotiations

The establishment and maintenance of trusting relationships between contractual partners is an important enabler of the successful negotiation of contractual agreements. As explored in

Chapter 2, the theory of relational contracting together with empirical evidence of contracting in the NHS, suggests that contracting in the NHS occurs in the context of mutual interdependences between purchasers and providers, and relied heavily on relational networks and norms.

The Alliance model of contracting seeks to build good working relationships between Alliance partners. This process begins in the negotiation period, with the open sharing of information between contractual partners, the use of co-production techniques, and the use of relationship building workshops. However, the context in which these contractual models were being negotiated, in which significant savings were required from NHS provider participants by NHS commissioners, in particular those providing acute services, strained relationships between these contractual parties.

In all case studies there was significant work to foster good relationships between contractual parties in the precontractual period. However, this organisational development work took place within the context of difficult relationships between the CCG commissioner and the NHS provider organisations providing acute services in Case Studies A and C. The most significant drag on the establishment of good relationships were the differences in organisational interest between the CCG and the providers, relating to the need to achieve savings, particularly by shifting services away from acute services. The providers perceived the contractual model as a vehicle to for the CCG to extract savings from them to enable the CCG to attain financial balance:

> *'It's starting to realise these efficiencies and savings that the CCG are dictating that needs to be achieved to meet their financial balance. I mean essentially, that's what it comes down to, it's their financial balance. "Don't care how you do it, just get there."'*
> *(Director, Mental Health Trust, Case Study A)*

In both these case studies the NHS provider organisations were dissatisfied (and suspicious) at the commissioner decisions to switch from a provider led to a commissioner led model. In Case Study C, the main acute providers had withdrawn from the proposed contractual model during negotiations, leaving the remaining NHS provider organisation (the integrated acute/community NHS Trust) fearing they would be required to achieve greater savings as a result. In Case Study A, despite the emphasis on the establishment of an Alliance vision, and the establishment of a dedicated Alliance governance structure to steer the negotiations, the interviewees in NHS provider organisations felt discussions were steered largely by residual

organisational interests, and decisions taken on a 'best for organisation' rather than 'best for service' basis:

> *'I think the Board isn't functioning as a Board. I think we currently got – and you witnessed it with us, organisations thinking of – trying to think across, but generally thinking of self-preservation of their organisations. I think because we aren't close to signing, some of those parallel lines are continuing, so therefore, the resolution is fudged.' (Mental Health Trust, Case Study A)*

A particular challenge for contractual partners was the agreement of financial risk share arrangements. Inherent in the task of service reconfiguration is that at least one contractual partners will suffer financially for the proposed service reconfigurations to work. This ran counter to organisations' individual accountability to NHS Improvement for their financial position, and NHS providers were understandably concerned that they would be held accountable for their bottom line, while losing control of the recovery plan:

> *'You know you've got a control total, you've got to hit it, and if you're not in a legal entity, the cost pressure, if there is one, sits on your organisational bottom line. So therefore Monitor is requiring you to demonstrate what your recovery plan is, but of course, you're not running it anymore because it's sitting in an Alliance.' (Mental Health Trust, Case Study B)*

Unsurprisingly, the implications of a removal of funding was cited as a key challenge, such as when this funding was tied to a fixed cost such as a ward, or when (as was the case with the Mental Health Trust) a provider was funded by multiple CCGs, and financing services was the result of cross-subsidy (e.g. pooled commissioner resources to fund a single ward).

This dynamic was exacerbated when organisations faced significant financial challenges, as illustrated in Case Study A where both the CCG and the Acute Trust were in deficit, and struggled to work together to plan a joint financial model:

> *'But I think the challenge is the special measures and the financial situation, and I think when you've got a CCG and an Acute Trust that are in the situation they're in, I'm not sure how that can be overcome that easily, because each person's being told sort your bottom line out and that's really difficult to achieve, isn't it? Where we've been for decades is pushing things around the system, the point of this is to manage a system together and understand where the pinch points are. But the challenges are still the*

same and you get to crunch point, don't you? And someone has got to take that pressure.' (LA, Case Study A)

Interestingly, the same dynamic was not reported between the NHS commissioner and NHS acute provider (a mental health trust) in Case Study B, despite the need to achieve savings. This may be because firstly, the magnitude of savings required was smaller in Case Study B, and secondly, because the Alliance objectives were set as part of a co-production approach.

Third sector involvement in negotiations

In contrast with the strained relationships between the CCGs and NHS providers of acute services, the third sector providers were seen as a wholly positive force during negotiations. A number of advantages to third sector involvement were proposed in Case Studies A and B, which both included third sector membership. Firstly, it was felt (both by the third sector providers themselves and others) that third sector organisations were an innovative force, providing solutions for service issues. Secondly, they provided an independent, critical voice which challenged established dynamics between the NHS commissioner and provider, and between the NHS and LA. The equality of parties in Alliances, in which all members have a vote, enabled the third sector organisations to challenge much larger providers through their equal seat at the table. Importantly this seat at the table extended to all issues under negotiation, whether they directly affected the third sector organisation or not:

'We don't worry about it, you can be sitting across a table from the Head of, you know, [NHS provider] who might be on X amount a year or whatever, it means nothing. He's an opinion, the same as ours, and we voice our opinions when we're there. And it's never been a problem, you know, from the beginning they said, "You're equal partners, and you each have a right to a say in the negotiations."' (Third sector organisation, Case Study A)

In both case studies third sector organisations were acknowledged to have had a substantial impact on negotiations. The third sector organisation in Case Study A was characterised as 'the single biggest, most positive contributor to bringing it together and making progress' (Acute Community Trust, Case Study A). In Case Study B, one of the third sector organisations chaired the Alliance Board, and was noted to have committed a great deal of time to the negotiations.

Summary

This chapter has outlined the process of negotiation, and touched on key themes which will be returned to again in the report, including in the final Discussion chapter.

A key theme concerns *ex-ante* transactions costs. It is clear that contractual parties felt the negotiations were a significant undertaking. The pre-contractual negotiations required investment in external help, and substantial internal commitment. Arguably, the agreement of significant service reconfiguration to achieve savings is inherently complex, regardless of the contractual model deployed. However, it is also important to note that, in Case Studies A and C, despite significant investment in the precontractual period, no agreement was reached on key issues. This issue is explored further in the next chapter which looks at the process of specifying the contract, and returned to again in the final discussion. Blocks to organisational working are discussed in the final chapter in the context of NHS policy.

This chapter also highlighted the significant role third sector organisations can play in the Alliance model. The role of the third sector in relation to the contractual arrangements in practice will be discussed in Chapter 11, and again more generally in Chapter 13 - Discussion and conclusions.

A further key theme is the sometimes difficult relationships between CCGs and NHS providers of acute services. This issue will be picked up again in Chapter 11 in relation to the contractual arrangements in practice, which will explore the impact these contractual models had on the relationships between contractual parties during the life of the contract. In particular the chapter will address the capacity of these contractual models to assist the development of trusting and productive inter-organisational relationships.

Chapter 10 – Specifying the contractual arrangements

This chapter, like the foregoing chapter, is concerned with the negotiation of the new contractual models. However whereas the previous chapter focused on the *process* of negotiation itself (the resources utilised), this chapter focuses on the *nature* of the negotiations.

Aspects of the specification of contractual arrangements which are considered in this chapter are:

- The specification of financial models
- The definition of the scope of the contractual arrangements
- The specification of payment mechanisms (agreement to share risk and payment on the basis of outcomes)
- The ongoing negotiations to agree financial models, scope and payment mechanisms in Case Studies A and C

It is important to examine the challenges of specifying the contractual arrangements. Contractual theory (as explored in Chapter 2) suggests contractual models which emphasise the agreement of arrangements to share risk between principal and agent(s) and between groups of agents will necessitate resource intensive pre contractual negotiations, in lieu of *ex-post* monitoring of agent performance against the contract. Furthermore, the inherently complex nature of health services coupled with a lack of robust data for forecasting and monitoring of activity, can make it difficult to identify and measure outcomes, and link them to performance or to agree the distribution of financial risk (Petsoulas et al., 2011). In situations where the contract encounters high levels of uncertainty regarding the future, it is expected that the contract will increasingly rely on relational norms (Macneil, 1978, Williamson, 1985).

As described previously in both Chapter 5 and Chapter 8, in Case Studies A and C the contractual arrangements did not progress as originally envisaged. In Case Study A while the Alliance agreement was signed, mechanisms to share financial risk among the parties to the agreement were not agreed. In Case Study C, the original lead provider contractual arrangement was delayed following the withdrawal of two acute NHS organisations and the LA, and the service contract to which the Joint Venture agreement related essentially mirrored pre-existing

payment arrangements, with the exception of a very small element of payment on the basis of performance against outcomes. It is important in the light of this lack of progress to explore the specification of contractual arrangements in these case studies.

Specification of financial models

Failure to agree financial model in Case Studies A and C

In Case Studies A and C there was a failure during negotiations to agree the financial model (the model which projects the financial impact of the proposed contractual model against a projected baseline). The failure related to NHS acute service providers' mistrust of the financial model proposed by the CCG.

In Case Study A, there was disagreement between the CCG and the two NHS providers (an integrated acute/community NHS Trust and a mental health services NHS Foundation Trust) about whether savings in the CCG's financial model were attainable:

> *'We could not produce a financial model that sufficiently evidenced we could make the level of savings…. So, I think that whole financial modelling was another key work stream and if I'm honest, it was always clear to me that we were never going to close that gap completely. I think it's impossible, without something seriously radical.' (Integrated Acute/Community Trust, Case Study A)*

The other NHS provider who stood see a reduction in activity and income as a result of the model, the Mental Health NHS Foundation Trust, suggested that the commissioner financial model was 'fundamentally flawed', and had not been adequately stress tested. Stress testing refers to a risk management technique in which the potential impact of unlikely, although plausible, events or movements in a set of financial variables is tested.

A similar dynamic was observed in Case Study C, when distrust of the financial model was a factor in the withdrawal of one of the two acute NHS Foundation Trusts from the contractual negotiations:

> *'However, what happened, in practice, was that there was a problem with transparency, not with will, with actual transparency, in some of the calculations that the CCG had done, in terms of how they had calculated our baseline. We couldn't quite reconcile that.' (NHS Foundation Trust, Case Study C)*

In recognition of the lack of robust underlying data, this provider subsequently led the development of improved modelling of costs across pathways. This lack of agreement regarding the financial model inhibited the further specification of other aspects of the contractual arrangement such as payment mechanisms, which were not agreed before the contractual agreements were signed.

Agreement of financial model in Case Study B

In Case Study B the negotiations resulted in the agreement of a financial model. As described in Chapter 5, the parties to the Alliance agreement were committed to the development of the contractual model, including developing a financial and service model which would achieve the 23% savings required by the commissioners. Despite some concerns about the accuracy and robustness of statutory sector financial and activity information systems, and the consequent robustness of the financial model, the financial model had been agreed.

There is a number of factors which may have contributed to the successful agreement of the financial model in Case Study B. Firstly, providers had been involved in the development of the financial model through a process of co-production. Secondly, the relatively modest value, scope and duration of the Alliance agreement, allowed a 'piloting' approach and the adoption of a 'can do' attitude:

> '*I think also its strength, what the size allows you to do is kind of get on with stuff below the radar a bit, which is going to be much more different in the wider alliance, you know. So there were things that we could kind of just reshape through the conversation and kind of test them and say "Well actually, you know, let's just give it a go". And that definitely allowed us to I think deliver some changes that maybe Medical Directors and clinicians might have been more kind of cautious on but we've kind of proven the concept now.' (Third sector provider, Case Study B)*

The imbalance of risk and likely disadvantage from the service reconfiguration work, fell on a particular organisation (the Mental Health NHS Foundation Trust), just as it had fallen on the providers of acute and mental health services in the other case studies. In Case Study B however, this imbalance was thought to be mitigated by general undertaking to share underspends between the provider parties to the Alliance:

'So, in the end there were, kind of, two levels, which really was a, kind of pragmatic agreement to just get it done, because we were right at the deadline, which was that any underspends within the Alliance would be used. First call on those would be to offset any overspends that any partner had. Because it wasn't a legal entity, if I had an overspend because too much activity was happening and happening somewhere in [this organisation's] service, there was no legal entity to charge that back to, right? So it was on my bottom line. So basically the first call was 'Well if there are any underspends elsewhere in the Alliance they go to helping our partners who've got overspends to pay off'' (Mental Health NHS Trust, Case Study B)

Defining the scope of the contractual arrangement

Across all three case studies the imposition of boundaries across services and the population in order to define the remit of the contractual arrangement was both a difficult process and one which was felt at times to be not in the spirit of the development of system wide integration.

In Case Study A, contractual partners experienced difficulties separating the services and budget for the over 65's from those for the under 65's. While this division had initially been adopted because the provision of services for this population had been identified as having scope to achieve significant gains in terms of service improvement and savings, the contractual parties found that agreeing the financial and service boundaries around this population was an unhelpful distraction:

'One of the things that was flagged up was, we spend an awful lot of time arguing about money amongst ourselves, amongst each player, particularly been the CCG and the Acute Trust. And we should have one single set of data, and separating under and over 65 is an overhead that's unnecessary' (CCG, Case Study A)

Challenges of a similar nature were also experienced in relation to the more distinct service area in Case Study B, which concerned a small group of service users with severe mental health problems, concerning lack of clarity regarding the inclusion of particular teams, and their costs in the financial model and the eligibility criteria for service users. In fact, the final agreement of eligibility criteria in Case Study B occurred after the start of the contractual arrangement.

Specification of payment mechanisms

In all three case studies the intent was to agree a variety of payment mechanisms to share risk between contractual parties.

Multilateral gain/loss share agreements

In Case Study A, the lack of agreement of the financial model prevented further specification of payment mechanisms, including the agreement of a multilateral gain/loss share arrangement. It was noted that agreement had not been reached at this stage about smaller financial matters such as legal fees, and that risk discussions were broad brush:

> *'You know, we tried – we're trying to launch into risk share. We're figuring out how we would – the principles of – you can do all of that stuff, you can say what the principles are, but when it comes down to actually agreeing, if you don't know what you're sharing, you get stuck. So, the focus has to be on that financial model and where the gap is and how that gap is going to be sorted*.' *(Council, Case Study A)*

A risk share was agreed in Case Study C, but this was essentially a binary agreement between the CCG and the community NHS Trust about who would benefit from savings.

In Case Study B, as described in Chapter 8, the Alliance partners had agreed arrangements regarding the sharing of losses and gains between the contractual partners. However, these arrangements appeared in the Alliance agreement to be underspecified, relying on the adherence to general principles. The agreement of arrangements to share risks among the contractual parties (those relating to individual provider's gains and losses resulting from the redistribution of activity) was described as an issue which 'only really blew up at the end' of the negotiations, with the realisation that not all the providers would be willing or able to share these financial risks. Specifically, the third sector parties considered themselves unable to return money to any overspent parties due to constitutional restrictions on spending charitable funds on statutory services. The general principles that were put in place that none of the providers would take a surplus if others were struggling were considered sufficient by the Mental Health NHS Foundation Trust which was the organisation which was anticipated to suffer financial losses as a result of the work of the Alliance. In actuality these risks were to be shared between the Mental Health NHS Foundation Trust and the Local Authority.

Specification of outcomes

All three case studies had identified outcomes, and the process of doing so was reported in general to be fairly straight forward. However, measuring these outcomes, and agreeing performance thresholds was reported to be a more difficult process. Two case studies (B and C), agreed the linkage of payments to outcomes, however these payments were very modest in relation to the value of the service contracts.

Identification of outcomes

All three case studies had identified and agreed the outcomes which were pertinent to the work associated with the new contractual arrangement.

In Case Study B outcomes were agreed collectively by Alliance members (providers and commissioners) through a process of negotiation. Both Case Studies A and C had identified outcomes with the help of an external consultancy, and with consultation with the public. In A, around 100 outcomes were identified through this process, and subsequently agreed by service providers. These were largely outcomes which were already recorded to reduce duplication and the time consuming and costly development of new indicators. The identification of outcomes in Case Study C followed a similar process to that in Case Study A, identifying outcomes across all the services which it was anticipated would fall within the scope of the wider contractual model involving the transformation partners in the longer term. A smaller number of outcome indicators had been agreed to be piloted in Year One by the parties to the Joint Venture agreement.

Measuring and monitoring outcomes

The agreement of the measuring and monitoring systems for the selected outcomes was a more complex piece of work than the identification of outcomes. The measurement and monitoring of outcomes was more complex. This complexity was across a number of areas. Firstly, there were issues of definition, such as the need to choose measures of 'outcomes' and avoid the substitution of proxy measures, such as outputs or counts of activity. There were also concerns regarding the 'measurability' of outcomes, particularly relating to 'soft' measures in respect of patient satisfaction. Secondly, there were challenges associated with conducting the measurement of performance against the outcomes, such as developing a baseline for outcomes, addressing issues of time lag where the outcome measure was measuring a new

initiative or remodelled service, and agreement of weightings and performance expectations. Thirdly, there were practical issues to be resolved to ensure that financial and information systems were in place across organisations to be able to pull the necessary information together and report the same information.

The expectation was that measures will be developed during the life of the contract.

Linking outcomes to payments

All case studies originally intended to link these outcomes to payments. Arrangements linking outcomes to payments were only agreed in Case Studies B and C. As will be discussed in Chapter 11 in relation to the contractual arrangements in practice, payments on the basis of outcomes were in fact only made in practice in Case Study B.

It appears that the reticence regarding the linking of payment to outcome was not due to problems of negotiation or specification, but due to the avoidance of financial risk. As these performance payments were made out of the service contracts' value (i.e. they were not made from 'new' money), if a target was missed, the providers would be paid less. In Case Study C the proportion of the service contract which was paid on the achievement of outcomes was kept deliberately small in order to limit risk exposure to providers in the event of underperformance against outcomes.

Case Study B had specified payment on the basis of outcomes in detail. A Schedule to the Alliance agreement detailed a small number of overall performance outcomes and, within each of these, subareas which each detail further subsidiary outcomes. Each performance outcome and sub area was allocated a weighting and a modifier. Outcomes which were chosen, including those which were financially incentivised had been subject to a process of evaluation asking: whether the outcome and its measure help achieve the overall outcomes; whether the attachment of a financial incentive would encourage a change in behaviour to meet the outcomes and avoid perverse incentives; whether the measure was feasible and verifiable and not open to manipulation; and whether the collection of data was justifiable without becoming a drain on resources or distraction from delivering services.

In interview it was reported that this approach was deliberately modest, and was seen as a helpful experience which would build towards a future wider contractual arrangement:

'There was mutual agreement very much including with the Commissioners that we would try some outcomes, and we would make sure that we built a small Payment by Results element to the contract, with the pain share/gain share, but it wouldn't be something that was going to drive behaviour too much at this stage' (Third sector provider, Case Study B)

The ongoing negotiations to agree financial models, scope and payment mechanisms in Case Studies A and C

As discussed in the previously, the negotiation of the contractual arrangements in Case Studies A and C did not result in the agreement of models to share financial risk. Instead the development of such mechanisms became an aim of the first year of the contractual arrangement. However, these additional negotiations did not result in the agreement of models.

Case Study A

When we revisited the case study at the end of the Year One of the contractual arrangement, it was reported that the Alliance partners had not agreed any new payment structures in this period, and had not reached an agreement about the sharing of financial risk between providers. The CCG stated the root cause of this failure was the financial position of the local health economy where a lack of any budget surplus across organisations made the agreement of risk share arrangements very difficult.

A number of wider changes had happened in the intervening period which altered the remit of the Alliance. The health economy had been subject to a strategic review with the recommendation that partners come together to deliver system transformation for the whole population. Furthermore, the local STP required local areas to develop health and care plans. The focus of the Alliance was described as being altered to the delivery of specific business cases, to be agreed as part of the health and care transformation plan required by the STP. At the time of the second period of data collection, the Alliance had agreed to deliver a business case for a new out of hospital model of care, which was focusing on the delivery of services for the over 55's population. It was anticipated that each transformation programme would include specific risk share arrangements and outcome or incentive payments.

Case Study C

In the 'transition period' (the year after the Joint Venture agreement was signed), activities were due take place to progress the intended wider contractual model involving the transformation partners who had signed the Memorandum of Agreement. These included a review of the payment mechanisms for services; the development of a capitated payment mechanism based on a fixed payment, an outcome based incentive payment and a contingency; and the development of an outcome based payment model.

These activities did not take place. The reasons for not progressing arrangements in relation to payment mechanisms were multiple. From a commissioner perspective, the worsening financial position of the CCG had dampened its appetite for such arrangements. In this environment there was no additional money available to dedicate to the payment of outcomes, and funds would need to be top sliced from the value of the NHS Standard Contract for the payment of outcomes. The CCG felt such an arrangement would be detrimental to the community NHS Trust, as it would jeopardise the payment of a proportion of their contract for which they were currently guaranteed payment through the Block arrangement.

Additionally, there had been a changes in leadership in the CCG which had weakened commissioner support for the development of outcome payments, and indeed for the proposal contractual model and its aims for service transformation. The CCG now felt the model was not sufficiently transformative in its aims, and not aligned to national policy concerning the integration of health and social care.

The parties to the Joint Venture agreement (community NHS Trust and GP Federation) were keen to progress the arrangements, including in relation to payment by outcomes, but could not do so without commissioner support. Outcomes had been identified, and providers collected data relating to the measurement of performance against them, but these were not linked to payment.

Summary

This chapter has considered specification of financial models, the scope of the contractual arrangements and the specification of payment mechanisms.

Contractual theory and the literature from other sectors suggests that specification, particularly in relation to outcome based payment, is going to be difficult. In actuality in our case studies,

these issues were largely unexplored. Firstly, as already discussed in Chapter 9 in relation to the negotiation of the contractual arrangements the difference in organisational interests between the CCG and the NHS organisations who would stand to 'lose' as a result of the service reconfigurations, stymied further discussions regarding the specification of multi-party payment mechanisms, such as payment on the basis of outcomes, and risk share agreements. Secondly, while the existing theory and evidence suggests that the specification of outcome measures and the associated payment structure would be a difficult and iterative process, outcomes in our case studies were not linked to payment mechanisms in a significant way, thus negating much of the need for detailed specification in this area. However, whilst potential difficulties regarding the specification of financial models and payment mechanisms were not fully explored, there were still concerns about the quality of the underlying data regarding existing activity and financial flows. This was triggering remedial work.

A recurrent theme in this report is significance of the impact of the size and scope of the contractual arrangements. The experience of Case Study B, suggests that the relatively small size of the Alliance agreement (in terms of service area, population, value and contract duration) conferred advantages in progressing negotiations and reaching detailed agreements. While significant financial risks were still associated with the contractual arrangement, it was used essentially as a 'pilot', allowing the testing of approaches. The issues associated with the size and scope of contractual arrangements are returned to in Chapter 13 – Discussion and conclusions.

Difficulties were experienced defining the boundaries of the contractual arrangements, both technical difficulties of defining which services, teams and service users should be included and excluded, and also concerns regarding the lack of coherence with the wider drive for integration. This indicates a tension between a service/population group focus which is conventionally associated with new models of contracting in the NHS, and the need to adopt a whole system approach to achieve integrated service provision. It is noteworthy, that by the end of the research period, both Case Studies A and C had moved away from the development of partnership working which involved focusing on specific service pathways and populations. This change in focus is outlined in Chapter 5 and is also returned to in Chapter 13 – Discussion and conclusions.

Finally, the findings regarding these negotiations, including the continued lack of progress in Case Studies A and C during the first year of the contractual arrangements suggests that a significant issue relates to the acceptability of transferring financial risk to provider organisations through the use of payments on the basis of outcomes, where this would potentially result in significant loss of income. This issue is also returned to in the final discussion chapter.

Chapter 11 – Contractual arrangements in practice

This chapter discusses the how the contractual arrangements operated in practice in the three case study areas. Aspects of the contractual arrangements which we asked the interviewees to describe are: how the money was allocated between parties in practice, and how financial risk was managed; how the monitoring of outcomes was working in practice; how disputes between contractual partners had been resolved in practice.

Our analysis of the operation of the contractual arrangements in practice within these new contractual models encompasses the main elements of these arrangements:

- Payment structures and financial risk in practice
- Monitoring and payment on the basis of outcomes in practice
- Informal management of risk
- Sharing of financial risk between commissioners and providers
- Dispute resolution in practice
- Alliance governance in practice

It is important to examine what was happening in practice as contractual theory in this regard suggests that contractual parties may in practice ignore the written contractual documents to be more flexible in the face of events. Research has shown that the operation of contracts in the NHS tends to entail flexibility, and there may well be changes in the terms of the contractual relationship which are at odds with the written document signed by the parties. For example, research on NHS contractual governance which investigated the first few years of the standard contract indicated that actual allocation of financial risk deviated in practice from that set out in the contractual documents, and thus national pricing rules were not always followed (Petsoulas et al., 2011). This indicates that research should investigate how NHS contractual mechanisms, including financial levers to allocate risk, are working in practice.

Payment structures and financial risk in practice

We asked how the money was allocated between parties in practice, and how financial risk was managed. This data relates to Case Study B only, as this was the only case study which used payment structures and financial risk to share risks between multiple parties.

In practice in Case Study B, the provider organisations exercised constant vigilance in relation to changes in activities against the business plan for the contractual model. They monitored financial flows frequently to reconcile resources between providers in line with activity and to fully understand performance against the business plan and the budget.

A key agreement in the written contract regarding the allocation of financial risk was the general principle that any savings or cost pressures would be shared across the provider Alliance members. It had been agreed that no provider would take a surplus if the other providers were struggling, and instead overspends would be offset between provider organisations. As noted in Chapter 10 in relation to the specification of the contractual arrangements, the two third sector providers were considered ineligible for this commitment as they were unable to return money to any overspent parties due to constitutional restrictions on spending charitable funds on statutory services. Whilst this was not specified in the written agreement, the understanding was that only the Mental Health NHS Foundation Trust and the LA were subject to this commitment. This principle was in fact adhered in the first year of the contract, when provider participants netted off over/under spends at the financial year end of Year 1 of the contractual arrangement. As had been anticipated at the outset, the Mental Health NHS Foundation Trust were overspent as a result of the model, and to rectify this the LA gave money back to the Mental Health Trust, instead of putting the money against their own overspend.

However it was not clear whether parties to the Alliance agreement would always honour these general undertakings regarding the management of financial risks. While the agreement states that providers should look within their own organisations to offset an overspend, it was suggested by the Mental Health NHS Foundation Trust that they would not cut any other service to offset an overspend incurred because of Alliance work. Their reasoning behind this was, firstly as an organisation which provided services for multiple commissioners, it would not be defensible to cut a service funded by another commissioner to address an Alliance issue, and secondly, that the situation amounted to commissioners asking providers to fund the costs of transition. This position was not tested in practice during the research period.

Monitoring and payment on the basis of outcomes in practice

There was little indication across the three case study sites of how the monitoring of outcomes and payment on the basis of outcomes was working in practice. Where outcomes had been

linked to payments (in Case Studies B and C) it appears that, firstly performance against outcomes was not financially incentivised due to the small proportion of the overall payment which had been linked to them, and secondly, there was an inclination to pay the full amount regardless of performance. This latter issue constitutes post-hoc adjustments to the terms of the contractual agreements in order to manage the financial risk to which providers were exposed.

Case Study B

As described in Chapters 8 and 10, in relation to the specification of payment mechanisms, the proportion of the service contracts paid on the achievement of outcomes was modest (approximately 1% of the total value), and was not intended to drive provider behaviour. The use of payment on the basis of outcomes was seen by providers and the commissioner as a way of trialling the system. Additionally, the incentive element was kept small because of the limited contractual length and the need to achieve savings.

Where it was found that performance targets against outcomes would not be met, the Alliance members agreed to remodel the targets. It was reported that one of the targets in particular, which related to increasing the engagement of service users in the world of work and the wider community, had not been met. This outcome was challenging both in terms of collecting the information and attainment of the target, which was thought to have been set at a too ambitious level. It was reported that in this instance, the outcome was recalibrated during the life of the contractual arrangement, partly due to a wish to recognise the positive outcomes which were being achieved in this area.

Case Study C

In Case Study C there was evidence of post hoc adjustment regarding the allocation of financial risk. In Year One of the Joint Venture agreement, the Joint Venture partners were due to pilot six outcomes. The outcomes proved difficult to measure, and much of the local work was difficult to quantify. Furthermore the Community NHS Trust disputed the outcome based payment formula, and argued that a smaller proportion of the contract should be subject to meeting the outcomes. This resulted in a very small proportion of the contract, equating to around £19,000 being linked to outcomes. It appeared that the Trust was issued with a ‘credit note’ for this amount regardless of performance against the outcomes.

Informal management of risk

Interestingly, in Case Studies A and C it was suggested that contractual parties had progressed arrangements to share risk on an informal basis. These examples are interesting as they suggest that participation in the contractual agreement had improved relationships between contractual parties to the point they were willing to share risks without an encompassing contractual structure.

The Case Study A CCG suggested that the close collaboration between Alliance partners during Year One of the contractual arrangement, both to progress the service model and during negotiations around payment structures and the allocation of financial risk, had led to an understanding among Alliance partners which constituted a 'more informal management of risk':

> *But what we do recognise is actually we can risk manage. So understanding each other's risks to our financial position, and help each other manage those risks, you know? If I do something here, how does it impact here? All that 'oh if you do that here, that will help me here' type thing. So that's something we're pursuing more actively. How do we manage the risks to each other in the system rather than how do we have a [slush] fund that we can dip into if we go in, if we have a problem. We don't have that luxury. So the next best thing is just to make sure the risks don't eventuate, or reduce and minimise the risks to ourselves. And actively manage the system together (CCG, Case Study A)*

This 'informal' approach to risk management and associated development of a system wide perspective, was not consistently reflected in the behaviour of providers. From the CCG commissioner's perspective one impediment was the unwillingness of the providers to adopt a system wide perspective. This was related in particular to the behaviour of the integrated acute/community Trust, who the CCG regarded as making insufficient efforts to reduce entry to hospital services through their own community services.

A similar phenomenon was reported in Case Study C where, it appeared that informal arrangements for the sharing of risk existed between the Community Trust and GP federation who had signed the Joint Venture agreement. The community NHS Trust was directly funding a small number of small initiatives through the GP Federation, such as a pilot of self-referral to musculo-skeletal services, which were aimed at reducing admission to acute services, in order to build trust with the GP Federation.

Sharing of financial risk between commissioners and providers

A cross cutting theme of this report is the operation of the Alliance governance structure within the NHS, specifically the tension between the equal partnership envisaged between members of an Alliance, and the different roles and responsibilities of NHS commissioners and providers and inherent power relations. This tension has previously been discussed in relation to the written contractual governance arrangements discussed in Chapter 7, and in relation to the negotiations between commissioners and NHS providers regarding financial models described in Chapter 9.

In relation to both Alliance agreements (Case Studies A and B), the perceived lack of risk sharing between commissioners and providers was a source of tension. Whilst acknowledging that the commissioner would argue that they held some risk, at least politically, some providers held that the provider/commissioner dynamic in the Alliance led to an unhelpful power differential:

> *'But personally I feel that it would've been better if they shared some of the risk, particularly because we rely on them to deliver what we need to do, so. And it would be much more straightforward and, in a way, there is that power differentiation.' (Third sector organisation, Case Study B)*

This dynamic was exacerbated by the existence of largely binary relationships between the CCG commissioner and the larger NHS Trusts in both case studies, particularly in Case Study A, where financial risk was predominantly held by either commissioner or a single provider:

> *'[The CCG] and us hold all the risk, and then they'll just put in all together with us holding the biggest risk. That's not a risk share in my book' (NHS Trust, Case Study A)*

Alliance governance arrangements in practice

As described in Chapter 6, Alliance agreements adhere members to a number of important governance principles, based on a collaborative and collegiate model of joint working, involving equal decision making rights and internal dispute resolution processes. This section discusses how these undertakings were enacted in practice in the two Alliance case studies.

Dispute resolution in practice

Interviewees in Case Study A were able to describe a number of issues which had been encountered in the pre-contractual period, ranging from issues of the scope of the contractual

arrangement (e.g. defining which services and customers were included) to issues concerning the power and influence of individual Alliance members. These issues had been addressed through discussion between alliance members within the internal governance structure of the Alliance. In one case (concerning the power and influence of individual alliance members) the issue had been taken to an externally facilitated Organisational Development workshop for resolution.

Case Study B interviewees were able to tell us of their experience of dispute resolution during the life of the Alliance agreement. It had not been necessary to instigate the dispute resolution clause in the Alliance agreement. Issues had been encountered which required resolution, however interviewees did not consider these to constitute 'disputes'. Significant issues cited were challenges regarding the necessity of the provision of high cost placements, which particularly related to one provider, disagreements about whether to instigate a contractual clause allowing renegotiation with the commissioner (in the face of spiralling costs), and how to address escalating costs affecting a single Alliance member.

Members of both Alliance agreements (A and B) were clear that the point of the Alliance was to resolve disputes:

> *'But the aim of the no dispute is that actually, when it comes to making a decision, everyone agrees. So you've done the work before it gets to that making the decision' (CCG, Case Study A)*

> *'If this was just about a contract then we wouldn't be getting very far, because if you're looking to clauses to resolve disputes, then you've probably failed already' (CCG, Case Study B)*

This approach was supported by Alliance members, who identified advantages as being able to achieve sustainable change through discussion and agreement of decisions, and being able to avoid 'railroading' of decisions by the more powerful members of the Alliance.

In Case Study B the Alliance had been in operation for three years by the end of the research, and therefore this case study presents the richest findings regarding the operation of the contract in practice. Interviewees felt strongly that a critical factor in the success of these discussions was the relationships between Alliance members, including a history of working together prior to the formation of the Alliance which had led to pre-existing trusting relationships between individuals, which were strengthened further by close working during the Alliance:

'We'd known each other for some time though, as people and organisations, because we'd done all the work with the [local collaborative initiative] and the [local group]. I think it would be different if we'd come cold to it. I think that's one of the problems that other Alliances may find if they're trying to pull together people who haven't worked together before' (Mental Health Trust, Case Study B)

It was acknowledged there was tension between Alliance members, particularly in relation to managing the balance between the interest of the Alliance and the interests of organisations, and that there had been some candid discussions between alliance members, but also that relationships had been strengthened by their duration: 'we all laugh about it. We're fairly at ease with each other now' (Third sector organisation, Case Study B). A further area we asked interviewees to describe was how poor performance was dealt with in the new contractual arrangements. In Case Study B (the only case study which had experience of performance within the contract at the time of the Stage One data collection) there were no issues of poor performance which had been encountered at this stage. It was acknowledged there had been some initial teething problems, but that these were not the fault of a single alliance member:

'Where there was poor performance where there were people maybe not as signed up to the philosophy and the vision, and let's be honest, we were pulling people from different organisations and planting them into a team, we hadn't been able to do the cultural change work that we would've wanted to do, you know, before we pressed the green button. So that's been a real learning for us taking forward.' (LA, Case Study B)

Alliance decision making

The parties in Case Study B, whilst generally very positive about their participation in the Alliance, had found the Alliance governance structure, which is based around reaching consensus across all parties, to be inherently slow, lending itself to *'lots of meetings, bureaucracy, slowness, possibly inertia'* (Third sector provider, Case Study B), and risking progress at the pace of the slowest member. Notably, as discussed in Chapter 7, the Case Study B Alliance agreement deviated from the terms of the NHS Template Alliance agreement in requiring all Alliance decisions to be unanimous. This principle was cited by some parties as lengthening the negotiation process, whilst it was also noted to be a powerful way of creating equality between Alliance members.

As described in Chapter 2, contractual theory suggests that the Alliance model is particularly interesting as it formalises the relational norms as express contractual terms. The experiences in our two Alliance case studies suggest that the impact of this formalisation differs in relation to the local context.

In Case Study A the experience of parties to the Alliance agreement, particularly in relation to the lack of agreement regarding the financial model between the NHS commissioner and the NHS provider organisations, indicate that the general undertakings regarding how the Alliance partners would work together had not noticeably influenced relationships. Undertakings in this regard included making decisions on a best for service basis, taking collective ownership for risks and rewards, and adopting an uncompromising commitment to 'trust, honesty, collaboration, innovation and mutual support'. Whilst in interview the CCG suggested the negotiation of the Alliance agreement had improved relationships and had powerful 'symbolic' value, the view of the provider members was generally more cynical about the impact the Alliance had had on the development of relational norms such as trust and reciprocity. The majority view was that the general undertakings regarding the establishment of relational norms between parties in the written agreement, did not override organisational interests in practice, and were not seen as serious commitments by the parties to the agreement:

> *'And ideally, you move from having those two different perspectives to one. But it doesn't happen overnight and if you've got different people and different personalities that's really challenging. This is why you can have all the visions and principles that you want. You read our Alliance agreement, it's fab. It's got all the best principles and the way we should behave and you know. But in reality, when it comes down to negotiating a pound sign, it's, you know, it's slightly different.'* (LA, Case Study A)

In contrast, the operation of the Alliance agreement in practice in Case Study B suggests that the general undertakings of the Alliance agreement had been adhered to, for example undertakings to work on a best for service basis had been upheld despite the negative impact on individual parties. This behaviour could be attributed to the formalisation of relationship rules of behaviour in the Alliance agreement, however success occurred in the context of pre-existing relational norms between the parties to the agreement, who had a history of joint working both on an organisational and individual level. Furthermore, it should be noted, as described earlier in this chapter, that it was not certain that parties to the Alliance agreement would always honour these general undertakings.

In Case Study B one interviewee argued that the use of the Alliance agreement as a means to secure unity of purpose was a distraction from the need to develop constructive working relationships.

> *'But, so yeah, most of it comes down to that and being able to find a mutual solution. And the time that's actually spent on that is minimal, compared to trying to get a shiny contract, or you know. So, that's a big issue. So anyone that's starting it tomorrow, I would say focus on the maturity of your relationship first and then try and do a shiny document, yeah.' (Mental Health Trust, Case Study B)*

Summary

This chapter was concerned with the operation of contractual arrangements in practice. Due to the lack of agreement of contractual arrangements in Case Study C, it has concentrated largely on the experience of the Alliance arrangements in practice in Case Studies A and B.

A number of significant conclusions can be drawn from the findings, which relate to the key cross cutting themes of the research, specifically the operation of the Alliance agreement governance principles in the NHS, the establishment of relational norms and third sector involvement.

Firstly, in line with findings of other studies of the allocation of financial risk in the NHS (Petsoulas et al., 2011), there was evidence (in Case Study C) of post hoc adjustments to contractual agreements regarding the allocation of financial risk between commissioner and provider and an instance of payment regardless of performance. Significantly, however, there was also evidence (in Case Study B) of Alliance provider members honouring agreements to share financial risks between them. These actions, and discussions of likely future behaviour with interviewees, suggest that the allocation of financial risk in practice is dependent on factors in the local context, such as relationships between contractual partners, rather than adherence to contractual undertakings regarding the allocation of financial risk.

The other conclusions which can be drawn from the chapter relate to the operation of the Alliance governance arrangements in practice.

Elements of the Alliance governance arrangements were adhered to in practice. In particular decision making and dispute resolution arrangements were followed, observing principles of equality. This was found to be a valuable, albeit time consuming, process, particularly in neutralising power imbalances between Alliance members during the negotiation process, by

allowing smaller non statutory bodies, such as the third sector, a seat at the table. However, the undertakings of the Alliance agreement were insufficient to mitigate the structural inequalities between Alliance members in practice, specifically those between commissioners and providers, and between large statutory organisations and smaller contractual partners, which manifested in relation to the allocation of financial risk.

The third conclusion relates to the impact of the Alliance agreement on the development of relational norms. This issue is pertinent in light of contractual theory concerning the relationship between contracts and the establishment, maintenance and growth of the relational norms between contractual partners, which are thought to be a prerequisite for successful contracting. Our findings suggest that the experience of working together in an Alliance can increase relational norms between Alliance partners, aided by the governance structure and general undertakings regarding how Alliance members will conduct their relationship, however the agreement itself appears to have limited impact in relation to the establishment of such norms in the face of structural inequalities between Alliance members.

These conclusions will be examined further in Chapter 13 – Discussion and conclusions.

Chapter 12 – The contribution of new models of contracting

This chapter explores the contribution which the new models of contracting made in each case study area during the research period. At both stages of data collection, we asked interviewees what had changed as a result of the new contractual model. We asked whether the anticipated benefits had been achieved, what the impact had been on the reconfiguration of services and whether there had been any unanticipated changes.

Firstly, this chapter describes, on a case study basis, the impact of the contractual arrangements in light of the anticipated aims at the outset of the contractual process. Secondly, it describes, across all three case studies, the ways in which the contractual arrangements had influenced working relationships between contractual parties.

Areas of impact which are considered are:

- Service reconfiguration
- Outcomes – related to care and financial
- Other impacts identified by interviewees

The findings in relation to the contribution the new models of contracting have made in each case study are limited by the extent to which the vision of each model of contracting had been implemented by the case study and the length of time any service reconfigurations had been implemented. Given the early stage of the contractual arrangements in Case Studies A and C, and the relative lack of progress they made towards implementing their original vision during the research period, there are fewer findings which relate to the impact of the contractual arrangements on the achievement of better outcomes. However both Case Studies A and C reported that the discussions and planning for launch of the new contractual model had also had an impact on the delivery of services and ways of working, and these impacts will also be reported here.

Impacts - Case Study A

Service reconfiguration

Some initial progress had been made towards service reconfiguration even before the written contract was signed. Towards the end of the Year One transition period, the Case Study A Alliance put forward a summary of its achievements as part of the case for the extension of the Alliance agreement for a further nine years (as a project group tasked by the STP with the

delivery of specific business cases). Despite the lack of dedicated payment mechanisms and risk share arrangements, the Alliance made considerable progress in achieving its goals for Year One in relation to the remodelling of services.

The overall model of care had been agreed. Various work streams and service redesign groups had been established and it was reported progress had been made towards firstly, establishing Integrated Care Networks, which consisted of multidisciplinary team providing a single point of access, and secondly, towards the extension of care planning. However these initiatives appeared to be at the stage of planning and introduction, with questions still remaining regarding funding.

The main gains in service transformation were: the establishment of an integrated re-ablement and rehabilitation service, comprising services from Adult Social Care and the integrated acute/community NHS Trust, with co-located staff, which targeted reduction in systems duplication, non-elective hospital admissions and bed days; proactive weekly case management by multi-disciplinary team working from GP practices; the introduction of Personal Independence Co-ordinators; and the introduction of a shared care record.

Table 12: Case Study A - Service aims and reported progress for the first year of the contractual arrangement

Service aims (for Yr one)	**Reported progress (end of Yr one)**
Creation of a multidisciplinary community hub	Proactive weekly case management by multi-disciplinary team being rolled out
Development of individual plans for each service user	Shared Care Record introduced
Establishment of independence co-ordinators	In place
Establishment of a single point of access and information	No update given
Establishment of an integrated independent living team, providing integrated step-up and step-down reablement and rehabilitation	Integrated reablement and rehabilitation service established across the area with single eligibility assessment and review process. New multi-disciplinary discharge pathway introduced

Outcomes

While these arrangements were relatively new, early monitoring suggested there had been a 20% reduction in length of stay for people in hospital and the need for long term care packages had decreased significantly. Where the multidisciplinary teams in GP practices had been established this was thought to be leading to a 14% difference in non-elective admissions of

patients from those GP practices. Furthermore the integrated acute/community NHS Trust was reporting a reduction in the usage of emergency 'escalation' beds. However, at this early stage, there was no evidence of any savings which could be attributed to Alliance initiatives.

The CCG also noted that there was some evidence of unintended impacts of the service reconfiguration concerning opportunistic behaviour. The success of the Alliance in reducing length of stay had resulted in unintended incentives for the integrated acute/community NHS Trust. It was observed early in the year, that as length of stay in non-electives reduced, admissions were found to either remain level or increase, indicating that the incentives for the Trust around usage of capacity were skewed. This 'gaming' did not relate to the payment structures of the Alliance, but instead related to the incentives inherent in the PbR system for providers to maximise their activity and income.

Impacts - Case Study B

The aims of the Alliance in Case Study B were to minimise the need for inpatient rehabilitation and residential placement, through agreed threshold and eligibility criteria. Plans included the creation of a multi-agency support team to deliver more tailored packages of support, a reduction in placements and the creation of additional housing using social/commercial finance. This was anticipated to achieve approximately 25% savings from Year 2 of the contractual arrangement, which had been built into the financial plan.

Service reconfiguration

Interviewees felt the Alliance agreement had a clear impact on the configuration of services, service outcomes, service costs and collaborative working, and were in general extremely positive about the adoption of the alliance contractual model.

A number of services had been reconfigured to reduce the number of people using expensive inpatient beds, and to increase the use of accommodation and support services in the community. These included the creation of a multi-agency rehabilitation team and the development of accommodation based services to enable transition from residential care, such as packages tailored to the continuing complex needs of specific groups of people, and medicines management programmes.

Table 13: Case Study B - Service aims for the contractual arrangement

Service aims for the contractual arrangement	**Reported progress**
Review of each service user by multi-agency support team	Multi-agency rehabilitation team established to conduct reviews
Development of refreshed individual personalised support packages	Accommodation based services developed to enable transition from residential care, including packages tailored to the continuing complex needs of specific groups of people, and medicines management programmes
Agreement of Alliance rules for assessment of applications for personal budgets or funded care packages	Achieved
Agreement of Alliance thresholds for discharge from the service	Achieved
Minimisation of need for inpatient rehabilitation and residential placements (including reduction of residential placements by 50%)	Achieved, target for reduction in referrals to residential placements exceeded. Rehabilitation ward closed.

Outcomes

These service developments led to a decrease in people living in residential care, and had also successfully mitigated the increasing demand for services which had been seen in other localities, to an extent where third sector provision had also been reduced. The reduction in the demand for services had led to the closure of an inpatient rehabilitation ward belonging to the Mental Health NHS Trust, although this had not been an aim of the Alliance.

The Alliance had achieved its financial target of saving of approximately 25% of the original budget. Referrals to residential care had decreased significantly, in excess of the original target (by approximately two thirds, against a target of half), and the numbers discharged from residential care had increased (by approximately one third). The Alliance was confident that the rehabilitation ward was no longer required. Importantly, Alliance partners believed that outcomes for service users had improved.

> *'There's still an enormous saving, in terms of what they were having to pay before. So, you get a better quality of life, people being supported in the community, the main link being with the GP, rather than secondary care, and there may be some clinical intervention too, and they're in a better setting, being supported differently. On one*

level it's one of those rare win/win situations' (Third sector organisation, Case Study B)

While interviewees suggested that the impact of the Alliance agreement was generally very positive, a small number of negative or unclear impacts were noted. The performance of the Alliance against the outcome measures was queried: firstly, it was not clear that the Alliance had made an impact on rehabilitation, as this takes time to occur and is difficult to measure, and secondly there had been less success in relation to some of the outcome targets concerning employment. In relation to the financial benefits of the Alliance agreement, it was noted by providers that the commissioner had benefitted from the savings made by the Alliance rather than the service providers. However, this arrangement was in line with the agreement made in the Alliance agreement, so could not be regarded as a failure of the agreement itself.

Impacts - Case Study C

Service reconfiguration and outcomes

Early work addressed establishment of the wider lead provider contractual arrangement involving the signatories to the Memorandum of Understanding, with the establishment of working groups, and progress towards the establishment of multiagency teams. It was reported that close working relationships were being established between the signatories to the Joint Venture agreement (GP Federation and Community NHS Trust), particularly through workshops which focused on service redesign.

At the end of the first year of the contractual arrangement the impact of the contractual arrangements in Case Study C had been limited, and was acknowledged by participants not to have realised its potential. The scope of the contract in terms of its value, services and participants had not been developed as envisaged, and the payment mechanisms and arrangements regarding the sharing of financial risks necessary to incentivise cross organisational service transformation had not been put in place. It was clear the vision underlying the service model of the contractual arrangement was no longer supported, and had been largely overtaken by events in the local area and nationally.

The focus on the development of five pathways (cardiology, frail elderly, diabetes in the first year of Transition Period and respiratory and end of life in the second year of Transition Period) which fell within the work of the parties to the Joint Venture agreement was no longer supported by the commissioner. The focus of these pathways on the separation of physical and

mental health services, and on health services to the exclusion of social care, was felt to be against the direction of national policy focus on the integration of health and social care on a population. However, parties to the Joint Venture agreement felt strongly that their work around the development of the five pathways had been successful in part, despite a lack of support from the CCG and acute providers, and that they had also used their partnership to develop other work, such as co-designing a walk in centre. In particular from the pathways work a diabetes hub had been developed to repatriate diabetes patients to the community and primary care from acute services. The impact of these initiatives was not recognised by the CCG who acknowledged that some pathway redesign had taken place, but that it had not resulted in any savings.

The ambition of a wider sharing of risks across the 'transformation partners' had been abandoned in the light of the changing geography of inter-organisational relationships and planning due to the STP and the worsening financial position.

Furthermore, the position of the new leadership of the CCG was that the use of the contractual model in their local health economy was simply not a feasible option, given the lack of robust relationships between the proposed contractual partners. It was suggested that in this case, it had been expected erroneously that the service development would follow the contract, and that the imposition of the contractual model where there was a lack of pre-existing partnership work on which to build, had stifled relationship building and innovation due to an overemphasis on bureaucratic governance structures.

The provider view regarding the lack of impact of the new contractual model was broadly similar, in that they too acknowledged that the impact of the contractual model had been limited.

Other impacts

Interviewees highlighted other impacts that the contractual arrangements had which did not relate directly to the formal objectives. These concern the improvement of inter-organisational relationships, improved informal joint working and the generation of knowledge and experience regarding the new contractual model. Where third sector organisations had been involved in the contractual arrangements, these organisations also cited benefits within their own organisations relating to improved networking and the generation of business

opportunities. In one case study (C), the commissioner felt the contractual model had impacted negatively on inter-organisational relationships.

Case Study A

In Case Study A there was broad consensus that parties' involvement in preparations for the Alliance, particularly through an organisational development programme, had a substantial impact on relationships between the leaders of each provider organisation, who did not have a close relationship despite previous joint working between some of the organisations, to the extent they were now happy to make a commitment to work together. It was noted that the impetus of relationship development, and the progression towards reaching agreement about the contractual arrangements, had been slowed by subsequent staff turnover.

Despite the lack of agreement regarding payment and risk share models, the CCG (who was the only party interviewed for the second stage of data collection in this case study) felt that the improved relationships between the Alliance parties had resulted in improved informal risk management, due to increased understanding of the financial position, the risks belonging to each individual organisation and possible ways they could act to manage those as a group. Another interviewee suggested that more incidental collaborative work was occurring at service delivery level between social care and health services, as a result of the service reconfiguration work which was occurring.

The third sector organisation felt that their seat at the table as an equal partner during negotiations had brought them increased influence and raised the profile of their services amongst other local providers, resulting in an increased uptake of the services they offered.

Case Study B

The Case Study B Alliance had resulted in more productive working relationships both at a service and organisational level. At a service level, working within the multi-disciplinary, multi-agency teams created through the Alliance, had created trusting working relationships which allowed professionals to challenge each other regarding placement decisions for individual service users.

The closer relationships between organisational representatives involved at a governance level was thought to have facilitated the flexibility management of resources between the Alliance providers in order to meet the overall goals of the Alliance. The collective nature of the Alliance allowed them to achieve solutions that would not be possible in a single organisation:

'And what it rams home, it's people that make things happen and the world of commissioning that sits on strict adherence to contracts is never going to affect the change, or the level of change, or whether it's out of hospital care that the NHS has been talking about for the last ten years and hasn't achieved. You won't do it, unless you really invest in strong relationships across the whole provider chain.' (CCG, Case Study B)

Additionally, it was felt that the small scale Alliance had served as a successful pilot, demonstrating the value of the Alliance from a commissioner and provider point of view, illustrating the benefit of focusing capacity on 'best for service' and 'best for service user' objectives rather than acting in organisational interests.

The third sector involvement was reported to have brought innovation and a focus on solutions to the partnership working. The third sector organisations themselves viewed the Alliance agreement as an opportunity to increase their income through offering bespoke solutions to the statutory sector:

'I think, in terms of our more commercial interest in developing business, I think we continue to be very interested in how we develop services in collaboration with other partners. So one of the things that's been a really important part of our business development, has been to be able to offer solutions to commissioners and other partners, which are designed around the needs of a particular set of people... so that's been very much part of our, kind of, wish to develop that as a part of what we, as an organisation, increasingly can offer' (Third sector organisation, Case Study B)

Case Study C

The parties in the Joint Venture agreement felt their relationship had been strengthened by their contractual relationship. However the continuation of negotiations between the signatories to the MoU was thought by the new CCG leadership to be antagonising participants and detracting from the development of strong relationships due to an emphasis on mandatory participation in governance structures.

Summary

This chapter outlined the contribution which the new models of contracting made in each case study area during the research period.

The findings suggest that these new models of contracting brought benefits relating to service reconfiguration, improved outcomes, costs savings and improved inter-organisational relationships and integrated working.

A particular issue arising in relation to the impact of the contractual arrangements concerns the role of the written contract itself. A recurrent theme in this report has been the role of the contract in relation to improving relationships between contractual partners. Interestingly, Case Study A progressed much of the service reconfiguration agenda and experienced improved relationships without agreeing payment systems and risk sharing arrangements to achieve unity of purpose by sharing financial risk between providers. The role of the contract will be discussed further in Chapter 13 - Discussion and conclusions.

In particular, the Alliance agreement in Case Study B achieved all of its objectives and was universally considered as a success. There are numerous factors which may be attributed to this success. The most recurrent factors throughout this report relate to the issue of scale and scope of contractual arrangements (in Case Study B the contractual arrangement related to a smaller service area, lower value service contracts and a shorter duration) and previous history of working relationships. Interestingly, whilst it might be hypothesized that the smaller scale of the endeavour in Case Study B had contributed to its success, the participants' intention was to build on their experiences and learning to put in place a further Alliance agreement on a larger scale. Both these issues will be returned to in the Discussion chapter of this report.

The consideration of the 'other impacts' of the new contractual arrangements highlights the role of the third sector in the case studies. In the two case studies which involved third sector organisations (A and B – the two Alliance agreements), despite their relative small size and lack of participation in risk share arrangements, these organisations have been identified as positively impacting the process of negotiation and service reconfiguration. This chapter also indicates that third sector organisations considered their participation in these contractual arrangements as carrying benefits for their own organisations. The role of the third sector will be discussed further in the Discussion chapter of this report.

Chapter 13 – Discussion and conclusions

This study concerned the use of new models of contracting in the English NHS which seek to share financial risk between a group of providers, and which, it is thought, may have the potential to improve the integration of services and thereby allow the better use of resources. In this study we aimed to explore why NHS commissioners are choosing new models of contracting, the characteristics of the new models and how they are used in practice, and the impact they are having.

The research questions were:

1) Why commissioners choose particular models of contracting, and what they think such models can achieve

2) In detail, the characteristics of these new contractual documents, in particular how outcomes are specified and how financial risk is shared between the parties

3) How the contracts are used in practice, in particular whether the contractual documentation is adhered to, and if not, in which ways it is not

4) The strengths and weaknesses of the different contractual models, both in respect of encouraging co-operation between providers and achieving better outcomes

5) How the NHS Standard Contract is used in conjunction with the new models of contracting and whether any problems arise in attempting to do so

6) How the new contractual models contribute to reconfiguration of services in local health economies

The design of the study consisted of three case studies to investigate how new models of contracting are being used in the NHS. We studied two Alliance agreements. Organisations in the third case study aspired to put in place a lead provider contractual model, but in the interim two parties had signed a Joint Venture agreement. Our main methods of data collection consisted of interviews with the management leads for the contractual arrangements in commissioner and provider organisations, and an analysis of the contracts and associated documents. Additionally we examined other local planning documents, and observed a small number of meetings at which the contractual arrangements were being discussed. There were two stages of data collection, October 2016 – June 2017 and April 2018 – July 2018.

This chapter discusses the research findings, and is structured as follows:

- A summary of the findings
- A discussion of the cross cutting themes emerging from the analysis of the findings
- A consideration of the wider institutional context in which the contractual models are utilised
- A summary of the limitations of the research
- Implications for policy
- Implications for practice

Summary of the findings

Commissioners perceived new models of contracting such as Alliance contracting and lead provider contracting to be vehicles which could incentivise providers to act together to address system-wide issues. There was a widely expressed belief that the contractual models had transformative potential and could achieve service reconfiguration leading to significant savings. The contractual arrangements under investigation focused on the provision of services to a particular population or a particular service, and involved statutory and third sector partners drawn from health and social care, but differed greatly in scale (the value of the service contracts to which they related) and scope (the population affected). They were seen as a pilot or 'proof of concept' for future similar contractual mechanism relating to larger service contracts, or alternatively, for different forms of integration (such as the creation of different organisational forms), involving similar partners and/or similar underlying payment mechanisms.

Alliance and lead provider contracting differ significantly in the nature of the contractual arrangements they entail. An NHS Alliance agreement overlays (but does not replace) existing service contracts (NHS Standard Contracts and PMS/GMS/APMS contracts). The Alliance agreement sets out shared objectives and principles, and a set of shared governance rules allowing providers to come together to take decisions. Alliances are based on a collaborative and collegiate model, incorporating shared decision making, open book accounting and undertakings that that parties will work together to resolve issues without recourse to outside bodies. The service contracts to which the Alliance agreement relates may also be subject to payment systems and risk sharing mechanisms which create a collective ownership of risks . In lead provider contracting the NHS commissioners procure under a single contract (an NHS

Standard Contract) a set of services. The organisation holding the contract may arrange for a series of NHS Standard subcontracts to be in place with other providers to achieve this. Both the lead provider contract, and the sub contracts, may be subject to a variety of payment mechanisms to incentivise unity of purpose. The experience of our case studies suggests that these new multi-party contractual arrangements may entail the adoption of NHS Standard Contracts (or NHS Standard subcontracts) by providers who previously did not hold them (i.e who may have previously held a service contract with the LA), incurring changes to contractual terms as a result, which may cause potentially significant operational issues for those providers and their staff.

The development of the contractual arrangements was a time consuming, resource intensive process, requiring significant dedicated resources consisting of external support (i.e. management consultants and legal advice) and the dedication of internal staff time. Heavy investment in the process of negotiation resulted in frustration across all parties where agreement was not reached. Costs were borne across all contractual parties. As is standard practice in contractual arrangements, legal support was not shared across contractual parties, but this investment was acknowledged to be particularly difficult for smaller organisations. In one case study, both the commissioner and a provider commissioned management consultants to produce independent financial models. Where negotiations were significantly extensive (A and C) enthusiasm for the originally envisaged models waned without reaching full realisation due to changes in the local and national context and changes in commissioning personnel.

Commissioners aspired to use a range of payment mechanisms within the contractual models, including the adoption of linking payments to outcome based measures, multilateral risk share arrangements and capitation. In practice these payment mechanisms proved difficult to agree and implement due lack of provider acceptance of the proposed underlying financial models and lack of robust activity data. This resulted in the abandonment of the majority of payment mechanisms to share risks among providers in two case studies. Where payment mechanisms which shared risk among providers were agreed, the proportion of the service contracts at risk was modest. This reflected the wish of contractual partners to trial the use of this payment method, and a lack of provider appetite for financial risk. Payments were made on the achievement of outcomes in only one case study (B). These payments totalled 1% of the annual service contracts' value and were allocated from funds which were already subject to performance prior to the introduction of these specific outcome measures. A further means of

sharing risk was to agree how financial gains and losses would be shared between providers. A single contractual arrangement (B) specified arrangements regarding the sharing of such risks. However the written contract failed to specify how the financial losses resulting from activity changes due to service reconfiguration should be shared amongst providers, beyond the general principles of the Alliance agreement that none of the partners would incur 'unreasonable' profits or losses.

As far as actual behaviour is concerned, our findings suggest that both commissioner and provider adherence to contractual undertakings was context dependent, reflecting the influence of factors such as the financial position of the parties, the wider institutional context, and the existence of trusting relationships between individuals. Within the case studies there was an example of post-hoc adjustment to a contractual agreement which served to decrease the financial risk to which a provider was exposed. On the other hand, elsewhere, providers adhered to general undertakings to share financial losses. The Alliance agreement foregrounds general undertakings regarding the behaviour of Alliance members in the light of their commitments, such as those to uncompromising trust, honesty, collaboration, innovation and mutual support, and to a collective ownership of risks and rewards. These general undertakings were not consistently adhered to. For example, while agreeing to act on a 'best for service' basis, in both Alliance case studies interviewees in NHS providers indicated that in the future they would act in the best interests of their own organisation rather than of the Alliance. These intentions were formed by NHS providers' understanding of the wider regulatory framework which continued to hold them accountable for organisational financial performance. Furthermore, whilst all Alliance partners agreed in the written contract to collectively share risks, in practice it was acknowledged that only the large statutory organisations were feasibly able to bear the magnitude of risks involved.

Commissioners viewed the contractual models as a vehicle to achieve unity of purpose amongst providers. However the capacity of the contractual models in our case studies to achieve this in practice was limited. Where there were pre-existing rifts, primarily between NHS commissioners and NHS providers (i.e NHS Trusts and NHS Foundation Trusts), these were not remedied by the development of the contractual model. Despite the multi-party nature of these contractual arrangements, also involving partners from local authorities, primary care, and the third sector, negotiations tended to be dominated by the largely binary relationship between the NHS Commissioner and the NHS provider(s) who was the main recipient of their

funding and which tended to be the organisation at greatest risk of financial losses as a result of the proposed service reconfiguration. This dynamic was exacerbated by the inability of smaller contractual partners to commit to sharing financial risks. The exception to this observation is the reported good relationship between all contractual parties in Case Study B. In this case, trusting and productive working relationships existed both organisationally and individually prior to the negotiation and establishment of the Alliance. Further influential factors may be the smaller scale and scope of the contractual arrangement, and the adoption of a co-production approach to develop the contractual arrangement. Where conflict existed in the other case studies, the managers interviewed in these NHS providers were often conflicted between a desire to work collectively with other providers, and distrust of NHS commissioner intent, and the plausibility of financial models produced by NHS commissioners. It appeared the negotiation of the contractual models did little to improve these relationships, indeed in both cases, the full contractual model was not realised.

In terms of provider to provider relationships, providers generally reported that inter-provider relationships had improved. This was not necessarily due to the written contract, but to improved knowledge, familiarity and trust gained from working together during the contractual negotiations. The Alliance model in particular relies in part on the equality of contractual parties. While there were clear problems with the model in some respects, specifically the difference in commissioner/provider roles and the difference between risk sharing and non-risk sharing parties, it was also the case that the inclusion of multiple providers as equal partners was valued. This was particularly the case in relation to the inclusion of the third sector in the two Alliance agreements, who were reported to be an innovative force, providing an independent critical voice capable of challenging established dynamics between the larger partners.

Findings in relation to the contribution and impact of the contractual models are limited by the extent to which the vision of each new models of contracting had been realised in the case studies. Only one case study (B) had progressed the contractual arrangements sufficiently to influence the reconfiguration of services and other impacts, such as the achievement of financial savings. This Alliance achieved its service reconfiguration aims and savings targets. However, this success should be considered cautiously. Firstly, some aspects of performance are difficult to measure, and secondly, it is difficult to attribute impacts to the contractual model itself. The view of the Alliance members was that the Alliance structure was central to the

successful achievement of aims. Payment mechanisms appeared to have a limited influence on the behaviour of contractual partners: the use of outcome based payments were negligible across all case studies, and furthermore, one case study (A) had progressed some of its service reconfiguration agenda without agreeing any underlying payment mechanisms.

Discussion of key themes

Analysis of the findings in the light of contractual theory led to the identification of key themes related to how the models were used in practice in the NHS. These themes are:

- Scale and scope of contractual arrangements
- Transaction costs
- The involvement of the third sector
- The role of the contract in the formation of relational norms
- The Alliance governance model in the NHS context

Each of these themes is discussed below in relation to relevant theory and empirical evidence.

Scale and scope of contractual arrangements

Issues concerning the 'scale and scope' of the proposed contractual arrangements were recurrent, and can be divided into two associated sub-themes concerning the adoption of a 'piloting' approach, and the 'carving up' of populations and services.

The proposed contractual arrangements in the three case studies differed greatly in their scale (value of associated service contracts) and scope (breadth of services and population covered, and duration of contractual arrangement), factors which appeared to influence the agreement of arrangements regarding the allocation of financial risks. The successful agreement of the financial model and the way financial risk was to be shared in Case Study B, was facilitated partly by the pre-existing trusting relationships between the parties, but also related to the size and scope of the proposed arrangement. All case studies faced similar issues: commissioners were proposing the significant remodelling of services and changes to financial and activity flows, and providers had concerns regarding the veracity of the financial model and the activity data it was based on. Arguably in Case Study B, the relatively small scale, scope and duration of the proposed arrangement eased negotiations and facilitated agreement. Doubts about the

veracity of the activity data on which the financial model was predicated were assuaged by the small cohort of service users to which the Alliance related, and the subsequent ability of the Alliance providers to monitor activity against the plan on a regular, almost real time, basis. The Mental Health NHS Trust felt the financial risk was significant, but contained within a distinct area. The relative 'smallness' of the Case Study B Alliance agreement was thought to confer governance advantages too, specifically that it was easier to be innovative and drive through decisions, operating somewhat 'under the radar'.

Despite the advantages of adopting a relatively small remit for these type of contractual arrangements, there were drivers to put in place models with a larger remit, most clearly the opportunity to achieve more substantial savings. This manifested as a 'piloting' approach in which the models are intended as a 'test' to develop later initiatives with greater scale and scope. Indeed, while Case Study B reaped many benefits from the relative smallness of its endeavour, the intent was to 'scale up' to an Alliance agreement to deliver a 'system wide' solution based, building on the proven success of the approach and with the benefit of the associated learning and experience of partnership working. This intent was echoed in the other case studies, where commissioners referred to using learning and experience of the contractual models to enter into more ambitious agreements regarding the sharing of financial risks.

However, scaling up in this manner is unlikely to be unproblematic. The experience of Case Studies A and C illustrates that an increased magnitude of financial risk may dissipate risk appetite due to the unreliability of underlying data, and the more significant implications of miscalculations. It is also not necessarily the case that the sharing of financial risk can be 'piloted'. While participants in Case Study B argued that the success of the Alliance agreement constituted 'proof of concept', it is possible that larger arrangements bring different challenges. The behaviour of participants may change in the face of more significant financial risk. For example, the financial risk attached to payments made on the achievement of outcomes in Case Study B was so small that arguably this aspect of the arrangements had not been trialled at all. The benefits of prior successful partnership working, such as trusting relationships between individuals, may also be lost due to changing personnel.

The second subtheme relevant to 'scale and scope' relates to the boundaries of the contractual arrangements. A common approach taken when new contractual models such as Alliance contracting are used in the NHS, is to focus on a specific service or group within the population

and this approach had been taken in the case studies. However, there are challenges associated with this approach. Firstly, there were practical difficulties with 'carving up' services, service users and budgets to specify what fell within the remit of the Alliance. These include that disease based boundaries can fail to take into account co-morbidities, and that approaches which segment the population can lead to a two tier systems (Addicott, 2014). Secondly, there were issues of a conceptual nature associated with the perceived contradiction between placing additional boundaries around services amid the wider move towards integration. Indeed two case studies (A and C) were moving away from the notion of a project approach to take a wider perspective at the end of the research period.

Transaction costs

These models emphasise the *ex-ante* elements of the contractual process, namely the agreement of the arrangements to share risk between the principal and agent(s) and between groups of agents. As suggested by the evidence regarding the use of these models in other sectors (e.g. Rowlinson et al., 2006, Chen et al., 2012) and the NHS (Addicott, 2014, Collins, 2019, Taunt et al., 2015, Sturgess et al., 2011), and contractual theory in this regard (Coase, 1937, Williamson, 1985), the models in the case studies incurred significant *ex-ante* transaction costs. The commissioners in all case studies used external law firms and management consultancies, and all providers required independent legal support. Furthermore the models relied on significant involvement of all contractual parties in the negotiation of the arrangements. Where these models have been used successfully in other sectors, proponents argue that the savings attainable through working together mitigate these substantial costs (Langfield-Smith, 2008). It has also been suggested, from a transaction cost theory perspective, that the improved learning between partners in a structure such as an alliance will serve to reduce the hazards that may normally be associated with an incomplete or inadequate contract (Love et al., 2002).

It is more difficult to make this argument in relation to two of our case studies where the payment mechanisms underpinning the transfer of risk were not agreed, and moreover, there was no evidence of cost savings caused by making the contracts. Furthermore, given the lack of contract and lack of payment mechanisms, and flexibility interpreting the contract, the added value of the written contract itself is subject to debate. This appears particularly so when considered in the light of the *ex-ante* transaction costs. In this respect, our findings are in agreement with the existing literature relating to the use of such new contractual models in the NHS, which suggest that the development of complex contractual and payment arrangements

can distract attention from other methods of achieving integration, including the need to concentrate on building strong relationships (Addicott, 2014, Collins, 2019).

The involvement of the third sector

Third sector involvement in the contractual arrangements was greatly valued, however the findings suggest that the implications of the involvement of a third sector organisation should be investigated and understood by all parties to the contractual arrangement prior to the start of the contractual process.

The term 'third sector' encapsulates a variety of organisational types and legal forms, including limited companies, charities, co-operatives and community interest companies, and some make profits (Allen et al., 2011). Indeed, the third sector organisations involved in our case studies differed in type and form, and as a result encountered different challenges. Smaller third sector organisations may need support to participate fully in the new contractual model, for example financial support to attend meetings or obtain legal advice. Depending on their organisational type and legal form, third sector organisations may not be able to contribute to contractual arrangements in the same way as statutory organisations. None of the third sector organisations in our case studies shared financial risks.

Despite these difficulties, where third sector providers were involved in the new contractual arrangements, they made a significant positive contribution. They were particularly valued for their innovation. This is in line with empirical evidence which suggests that third sector providers are able to innovate by filling gaps in service provision (Bartlett et al., 2011). They were also valued as an independent voice in binary debates between NHS commissioners and providers, and in this respect the Alliance model, which gave them an equal seat at the table, was particularly beneficial.

The role of the contract in the formation of relational norms

As described in Chapter 2, all contractual models to varying degrees rely on the evolution of relational norms to permit the enactment of the contract, and it is likely the contractual models which are the subject of this report will rely heavily on relational norms (Macneil, 1978, Hughes et al., 2011a, Hughes et al., 2013). A pertinent issue in this regard is the impact of these new contractual models on the development of relational norms, specifically on the establishment, maintenance and growth of relational norms.

Our findings in relation to this issue are firstly, that these contractual forms, and particularly the Alliance contractual arrangement, have the capacity to support the growth of relational norms between contractual parties. Both Case Studies A and B (and the provider signatories to the Joint Venture Agreement in Case Study C) reported that trust, flexibility and solidarity between the contractual parties had to varying degrees become greater due to the process of negotiating and writing the contractual arrangements. To some extent therefore, our findings agree with the suggestion of Deakin (1997), Daintith (1986) and Lorenz (1999) that the written contract is not associated with a lack of trust between parties. However, unsurprisingly, there were clear limits of the capacity of the negotiation process and the written contract to form relational norms, as illustrated by the lack of change in norms in the face of the structural inequalities between NHS commissioners and NHS providers.

Secondly, whilst it has been suggested that there may be a complementary relationship whereby well specified contracts can promote co-operative, long-term, trusting relationships and relational contracting may help generate refinement to the formal contract (Poppo and Zenger, 2002), our research does not support this hypothesis. The findings in this respect are that the contractual complexity did not increase as relational norms increased: for example, improving relationships between contractual parties did not enable them to improve the specification of how risks were to be allocated. In fact, the existence of relational norms, and the concurrent ability of contractual partners to deal with future unknown contingencies flexibly, lessens the need for contractual completeness.

A further question raised by contractual theory relates to the impact of the formalisation of commitments to relational norms as express terms in the Alliance model. In Case Studies A and B this formalisation did necessarily translate to behaviour. Instead, we found that behaviour to each other was also affected by the wider context in which individuals and organisations were situated. This suggests that the use of formal agreements may not be an effective way to encourage the adoption of norms of behaviour, and it is more likely that relational norms will be formed where circumstances and relationships support them. This is supported by existing empirical evidence from the NHS (Addicott, 2014) and the New Zealand health system (Lovelock et al., 2014, Lovelock et al., 2017) which also suggests that the contract does not itself lead to close relationships, and attention must be paid to the contextual realities of the

settings in which contractual arrangements are to be put in place. This indicates the limits of the written contract as a means to formalise relationships, and suggests instead that it remains necessary for parties to act flexibly outside the terms of the contract if circumstances demand it.

The Alliance model in the NHS

The Alliance model has been adopted by the NHS from other sectors. However, in doing so the model has been adapted to accommodate the requirements of the delivery of public services, and the specific requirements of the NHS institutional context. This section discusses the most significant implications of the fit between the Alliance model and the NHS.

Firstly, whilst in industry the Alliance model upholds the principle of equality of all Alliance partners, including the principle of shared and unanimous decision making, the statutory framework in respect of NHS commissioner duties significantly impacts the types of decisions which can be taken collaboratively, and the responsibilities which providers can assume. Areas where decision making or action cannot be delegated or shared include duties regarding commissioning, public consultation and relating to budgetary constraints. The NHS Template Alliance agreement outlines those areas in which it is necessary for decision making to rest solely with the CCG. Additionally, the NHS Template Alliance Agreement deviates from the principle of unanimous decision making, allowing the possibility that in some matters majority rule will be sufficient. The reasons for this deviation are not made explicit, but may relate to the desire to avoid delays to necessary decision making (e.g. to ensure the delivery of services) in the case of stale mate between Alliance members. These divergences in governance structures reflect the fact that NHS commissioners have wider statutory responsibilities which cannot be given up, and that, more broadly, the state has a responsibility to all citizens in certain areas, for example to ensure equality of access.

A second area of difference regards risk sharing. The Alliance model is predicated on the notion that all Alliance members equally share risks. Although in practice this may not be the case in any context, with purchasers shouldering less risk (Caldwell and Howard, 2014), in the NHS Alliance agreement the commissioner, although an Alliance member, is not a formal risk sharer. Furthermore, due to the limited diversity of provision in the NHS supply side, in practice despite the multi-lateral nature of these new contractual arrangements, financial risks were borne exclusively by the statutory providers.

These differences are necessary to accommodate the Alliance model within the NHS context as recognised in the literature concerning the use of these models in the public sector (Finn, 2011, Finn, 2012, Davies, 2008). However these divergences lead to questions regarding the impact and effectiveness of the model. For example, it is unclear whether, and in what ways, the (necessary) changes to Alliance governance impact on the empowerment and engagement of members, and commitment to negotiations. This issue was also a concern to some interviewees who reflected on the differences between the Alliance model in the NHS and elsewhere. The Alliance agreement in Case Study B differed from the Template Alliance agreement (it was put in place prior to the production of the Template) in including unanimous decision making, and interviewees felt strongly that the commitment to unanimous decisions was a particularly powerful tool to counter the dominance of acute providers. Knowledge of the difference between the NHS Alliance agreement and the model in other industries also caused some dissatisfaction. It appeared that expectations had been raised by the general principles of Alliances of equality, co-production and openness, which could not be fully satisfied.

These factors together point to a fundamental dissonance between the Alliance model and public sector services. The Alliance model has evolved to deal effectively with problems relating to purchaser/supplier and supplier/supplier relationships in the market, however the transposition of this model to the NHS does not address the additional concerns relating to the provision of public services (such as equity) which necessitate a leadership function to achieve place based planning and local coordination. Furthermore, while Alliance models are designed to collectively share risks, this emphasis does not address the much wider agenda of integrating services (and maybe organisations) which is of concern in relation to health services.

The wider institutional context

The restrictions of the wider institutional context in which they were situated constituted a potential drag on the development of these contractual arrangements, and the general drive towards greater organisational co-operation in the delivery of health and care services. Providers were being asked to take a system wide perspective, while still being held accountable for individual organisational performance. This problem is relevant to many of the models of integration being developed in the NHS currently, as illustrated by our research concerning recent developments in the commissioning system (Moran et al., 2018).

While, since the publication of the *Five Year Forward View* strategic plan (NHSE, 2014), the principle of cooperation has been elevated to become the preferred mechanism governing the supply of health care services, this is situated in the context of a residual legislative framework which favours competition. As illustrated in our case studies, this impacts inter-organisation co-operation in a number of potential ways including the following competitive procurement processes and guarding against conflicts of interest when sharing information.

The emerging institutional context

Recent developments occurring after the research concluded, including the proposals of The NHS Long Term Plan (LTP) (NHS England, 2019) (published after this research was concluded), and the subsequent proposed legislative changes (NHS England and NHS Improvement, 2019) suggest changes in the policy and regulatory landscape which may reduce some of the complexities and perverse incentives associated with inter-organisational collaboration.

These are considered briefly below in the light of the ongoing use of new models of contracting.

The process of encouraging organisational collaboration already in place at the time of the research through STPs is being further extended through the introduction of Integrated Care Systems (ICSs) which are being granted increased autonomy, providing greater freedom over how they manage resources collectively. ICSs, covering the whole country by 2021, are a vehicle for liaising with Local Authorities at place level, and will be granted increased autonomy from national NHS bodies with greater freedom over how they manage resources collectively through 'earned financial autonomy'. The LTP indicates that local forms of contract such as an Alliance contract will be a key way of securing local co-operation in ICSs. As described in Chapter 6, the fit between 'system' wide co-ordination and smaller-scale ('place' based) contractual arrangements is not necessarily cohesive. Therefore, if these modes of contracting are to play a key role within ICSs, issues of scale and scope relating to the different modes of co-ordination will need to be addressed.

A clearer benefit of the proposals of the LTP is the establishment of system control totals (the aggregate required income and expenditure position for trusts and CCGs within the system), which allow the agreement of financially neutral changes to individual organisations' control totals. It is anticipated that provider organisations will move away from individual control

totals, with the aim to remove individual organisational financial control totals from 2020/2021. These changes will address the perverse incentives experienced by NHS providers in our case studies when considering participating in service reconfiguration which would result in a loss of income. Providers will be further incentivised adopt a system wide perspective through the linkage of a proportion of payments from Provider Sustainability Fund to the achievement of system control totals. However, despite STP/ICS membership extending to Local Authorities and other local providers, including the independent and third sector these changes do not address the important role non-NHS providers play in these arrangements, and the lack of incentives to encourage sharing of risks beyond the NHS.

The requirement for all providers within an ICS to contribute to ICS goals and performance, will be backed up by potential new licence conditions supporting NHS providers to take responsibility, with system partners, for wider objectives in relation to use of NHS resources and population health.

Procurement processes ran the risk of creating transactional relationships between providers and commissioners, and disincentivising inter-organisational working. In our case studies, commissioners were able to navigate the procurement legislation, resulting in the selection of the local providers they had identified as most suitable at the start of the process. The LTP proposes significant changes in this regard, specifically the proposal to repeal the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and allow NHS commissioners to decide the circumstances in which they should use procurement, subject to a best value test to secure the best outcomes for patients and the taxpayer. Whilst the nature of the best value test is yet to be clarified, it appears that these proposed changes, may address potential blocks to ongoing inter-organisational collaboration.

Limitations of the study

The findings reported here are from a longitudinal study which adopted a qualitative case study research design. The study has certain limitations which should be noted.

Firstly, it should be noted that the study was not designed to assess the prevalence of these new models of contracting in the English NHS, nor to evaluate the actual effects of such contractual models on system costs. It would only be possible to gauge the extent to which these type of

contractual models are being adopted locally through the use of an extensive national survey. The assessment of the impact of the contractual models is complex not least due to difficulties of drawing definitive conclusions about causal effects, and accounting for the influence of local context.

This leads to the second limitation of the study, which relates to the unique nature of each case study. During our study we followed the development of new contractual arrangements over a period of almost two years, between 2016 and 2018. A case study design enabled exploration of the context of the development of these new contractual models. The case study sites each represented a unique demographic and service configuration context, thus any trends uncovered here may not extend to the NHS as a whole. The unique setting of each case study site also made the straightforward cross- case study comparisons problematic.

Thirdly, the contractual arrangements in two case studies were under discussion during the research period, and once signed were still subject to ongoing negotiation and development during the first year of the written contract in order to agree payment mechanisms. Given this position, the findings are limited regarding how the contractual arrangements are used in practice, in particular the contribution they can make to achieving better outcomes and contributing the reconfiguration of services. A longer research project would be required to find out how these contracts bed down over time. Furthermore, the lead provider arrangement which was anticipated to be put in place in Case Study C did not occur. Therefore aspects of our findings and analysis apply only to Alliance agreements.

Implications for policy and practice

Based on our study, we can draw a number of implications for policy and commissioning practice.

Policy

Our research suggests that new models of contracting can play a significant role in facilitating the reconfiguration of services at a local level, and are particularly valuable in terms of their capacity to establish trusting relationships and shared vision. However, such contractual arrangements cannot influence system design and regulation at higher levels of the system, and the overall aim of agreeing the allocation of financial risk amongst providers is impeded by the

overall payment systems to which providers are subject, and the individual accountabilities of providers for their own financial performance. These elements need to be addressed before the potential of such contractual models can be realised. Furthermore, the scope of the contracts is limited mainly to financial issues and do not deal with integration of services.

The legislation framework in relation to procurement does not support inter-organisational co-operation. The findings suggest that the move to alter the procurement requirements may ease this situation, although the nature of the proposed best value regime is not yet clear.

Practice

Our findings indicate that third sector organisations can provide valuable input to multi-lateral contractual arrangements, however the participation of these organisations may be hindered by the substantial *ex-ante* transaction costs. Furthermore, smaller third sector organisations may not be able to participate in risk share arrangements. At a local level, there is a need for commissioners to investigate and understand the implications of third sector involvement in new contractual arrangements at an early stage, in particular to clarify risk share ability and to provide support to facilitate participation.

In addition to the above, the findings suggest all parties to such contractual arrangements should clarify their position regarding participation in risk share arrangements at an early stage of the negotiation process.

Issues of scale and scope of contractual arrangements may influence the negotiation process. This research suggests that contractual arrangements of more modest scale and scope may have advantages, including increased provider willingness to accept financial risks, increased provider willingness to enter contractual arrangements in the face of uncertainty regarding activity data, and increased ability to make independent decisions without reference to individual organisations' decision making processes.

Local commissioners should consider the local context before deciding to use models of contract such as Alliance contracting which aim to achieve unity of purpose across groups of providers. Our findings indicate that contracts cannot help where organisational interests are substantially misaligned, and all organisations must be ready and willing to work together.

Before entering into multi-lateral contractual arrangements of this nature, all contractual parties need to consider that the establishment of these arrangements are likely to incur high costs, and be a difficult and resource intensive process, even where local organisations are supportive.

Specifically, in relation to the use of Alliance agreements, potential Alliance members should understand limitations of Alliance approach within NHS context. Statutory responsibilities and commissioner/provider role differentiation will not change, and consequently the notion of 'equality' must be applied differently from the way the model is used in other sectors.

Finally, in relation to the Alliance model, the governance model was valued by Alliance members in the case studies, but it was also acknowledged that the model has a tendency to 'natural inertia' due to the drive to reach consensus. Therefore the model requires enthusiastic leadership.

Conclusion

Our research shows that whilst new models of contracting can play a significant role in facilitating the reconfiguration of services at a local level, such contractual arrangements cannot influence system design and regulation at higher levels of the system, and also do not themselves address the complex problems that organisations face when they attempt to work collectively. They should however be viewed as mechanisms which can help strengthen attempts to work collaboratively.

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