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Grafton Group

Clinical contracting considerations

Grafton Group

The Grafton Group is a group of nine CCGs comprising Cumbria, North East Lincolnshire, Leeds South and East, Principia Rushcliffe, Nene, Bedfordshire, Tower Hamlets, Somerset and South Devon and Torbay, who have come together to share knowledge and ambition to be amongst the best CCGs nationally in delivering the commissioning agenda: ensuring excellent patient care for their populations.

The Grafton Group has identified contracting and choosing the appropriate contract mechanism as an area of interest, where further information and exploration of some of the key considerations would be helpful.

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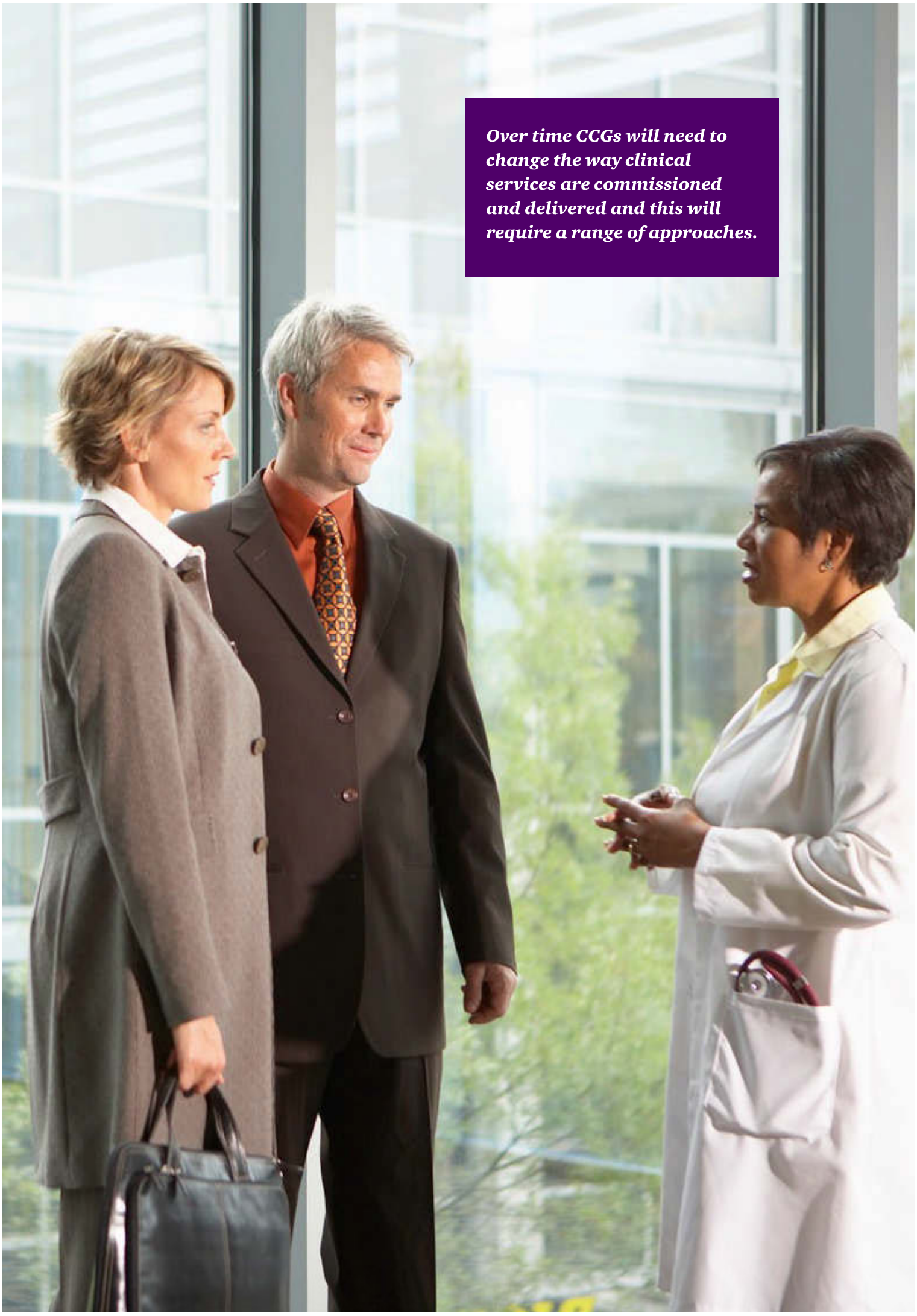
Introduction

The Health and Social Care Act 2012 changed the structure of the NHS in England introducing a new commissioning architecture, with the creation of the NHS Commissioning Board and Clinical Commissioning Groups ("CCGs"). The Act, subject to exceptions for specific services, transferred the responsibility for commissioning clinical services to CCGs.

Commissioning is a complex process involving a number of stages. At its simplest, it is the process of planning, agreeing and monitoring services; however, this simple definition conceals the complexity involved. A key task within commissioning is the actual procurement of clinical services. This involves the commissioner negotiating and agreeing a contract for the clinical services to be delivered with the provider. There are a range of different forms of contracts that can be used, ranging from a single provider contract to an alliance agreement involving a number of providers working collaboratively in the delivery of clinical services.

The Grafton Group has identified contracting and choosing the appropriate contract mechanism as an area of concern, and an area requiring further guidance. This paper seeks to identify the main contracting mechanisms for use when procuring clinical services and to provide a "road map" as to when the differing contracting mechanisms may be best applied. It also considers some of the procurement issues that CCGs will need to consider as part of this process.


Over time CCGs will need to change the way clinical services are commissioned and delivered and this will require a range of approaches.

Background

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Clinical Commissioning Groups

Following the introduction of the Health and Social Care Act in 2012, CCGs have clear responsibility for commissioning clinical services. They carry the financial accountability and risk and are clearly leaders in commissioning clinical services.

As commissioners, CCGs are responsible for contracting for a wide range of clinical services with a significant variation in the value and objectives of the various services to be delivered and the supporting contracts.

Initially, CCGs have inherited a range of existing clinical arrangements and are largely using traditional contracts. However, over time they will need to change the way clinical services are commissioned and delivered and this will require a range of approaches, including:

- changes to the behaviours of providers and commissioner;
- the introduction of more collaborative working between the various providers (public, private, third sector, local authority etc) and commissioners;
- changes to contracts and payment mechanisms;
- a move towards contracting for outcomes; and
- introducing new contracting approaches e.g. contracting for modalities, episodic, disease category and pathway or contracting for whole geographic populations.

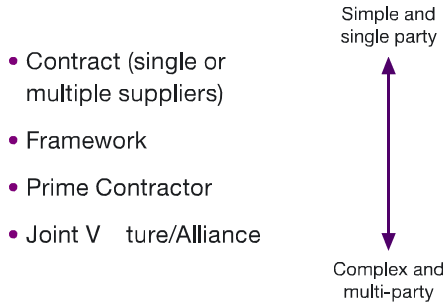
All these changes will ultimately require CCGs to agree new and different contracts with providers.

Clinical contracts

As of 2013/14, CCGs have inherited a range of clinical arrangements, and need to manage these effectively immediately in order to retain the confidence of the regulatory bodies. Initially the type of contracts is likely to be limited, however over time they will expand. As the range and complexity of contracts does so, CCGs will be required to become more sophisticated in how they manage these contracts and the associated financial risk.

However it should be remembered that contracting is merely the regulation and incentivisation of care delivery models. Thus fundamentally it should be borne in mind that contracting mechanisms are enablers of new delivery models which commissioners are seeking to promote.

In the future, the main types of contracts that CCGs are likely to consider applying include:



In recent years the Department of Health (DH) has required commissioners to use the standard form NHS contracts. With effect from April 2013 there is a new standard form contract covering: acute hospital, mental health, community and ambulance services (http:// .commissioningboard.nhs.uk/2013/02/04/standard-contract/).

Whilst the use of standard contracts has many benefits, this has given rise to some restrictions, as it is often hard to vary these to suit local needs, encourage changes in behaviour or changes to care pathways and models of care. A key area of challenge has been in relation to risk sharing and payment mechanisms.

As the range and complexity of contracts expands, CCGs will be required to become more sophisticated in how they manage these contracts and the associated financial risk.

Commissioners are therefore looking to try and address this and prime contractor, joint venture and alliance contracts are seen as some of vehicles to overcome such constraints (as they encourage more seamless integration of care delivery which can lead to beneficial patient outcomes and experiences).

The new contract identifies the following payment mechanisms:

- block payments;
- nationally agreed tariff payments;
- locally agreed tariff payments; and
- risk share mechanism.

An area of further evolution may be the development of new pricing mechanisms for different areas of patient need. This is still an emerging area, but could be along the lines of: (1) emergency and urgent care; (2) planned and elective; (3) LTCs; (4) rare and complex; and (5) specialist.

The idea being that any such changes would be to support patient care rather than purely price regulation. In turn they would assist commissioners in future contract discussions with providers and introduce more flexibility to recognising differences in the delivery of clinical services and the sharing of financial risk.

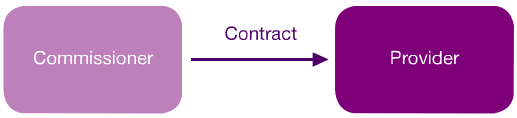
In going forward, the typical contracts which CCGs are likely to operate can be summarised as follows *(Appendix 1 contains further details relating to situations in which each contracting model may be appropriate).*

Individual Provider Contract (single or multiple)

This is the simplest form of agreement that a commissioner can hold. It is an agreement between a commissioner and provider for the delivery of a service or services. The terms of the agreement between the two parties are included in the contract itself – e.g. payment mechanism, volumes per an activity plan, and risk transfer.

A commissioner will typically hold a number of contracts with a wide range of suppliers. Contracts are based on the NHS standard form contract. The challenge for commissioners however, is to manage a care pathway using multiple separate contracts.

Figure 1. Contract (single)



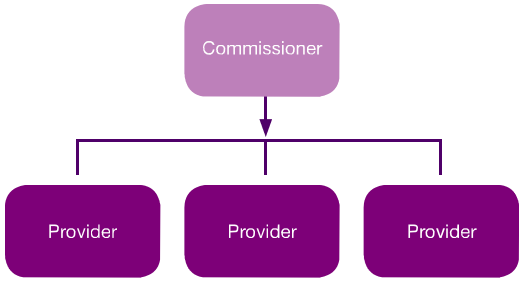
Framework

A framework agreement is a general term which refers to an agreement between a commissioner and a number of providers, which defines the conditions within which the services will be provided but does not specify the volume of these services e.g. Any Qualified Provider (AQP). The Framework establishes the terms and conditions from which individual contracts with providers can be created for the supply of specific services over a given period. The Framework acts as an overarching agreement from which individual contracts are created.

A Framework does not normally contain any obligation on commissioners to purchase services. It provides a mechanism for commissioners to purchase services from providers at the time that the services are required without the need to enter into an individual procurement each time. Depending on the terms of the Framework, it can also provide the commissioner assurance over the availability of a service and prices.

Frameworks are typically used when commissioners know that particular services will be required over a given period, but are unclear as to the exact volume and timing of the requirement.

Figure 2. Framework



Prime Contracting

A prime contracting mechanism is essentially a contracting model which enables commissioners to transfer the responsibility and risk for the delivery of a particular range of services to a single provider.

Under this model, the commissioner holds a single contract with the prime contractor, who then sub-contracts elements of the service from further third party providers thus providing the full range of services commissioned under the agreement.

The prime contractor takes full responsibility for service delivery and provides a single point of contact to the commissioner. The commissioner monitors the performance of the prime contractor and pays the prime contractor. The prime contractor is responsible for managing the performance of its subcontractors and co-ordinating the delivery of an integrated service from a number of providers.

Whilst the model provides a single point of contact for commissioners, it provides less ability for commissioners to influence the behaviour of individual subcontractors, and relies on the strength of the prime contractor in managing the service. Although this puts appropriate emphasis on contracting for outcomes (the “what”) it still requires some scrutiny of how the prime contractor engages and manages their supply chain (the “how”).

The prime contractor model is sufficiently flexible to accommodate a range of payment mechanisms (block price, price per procedure, capitation based and/or outcomes focussed payments).

Figure 3. Prime contracting

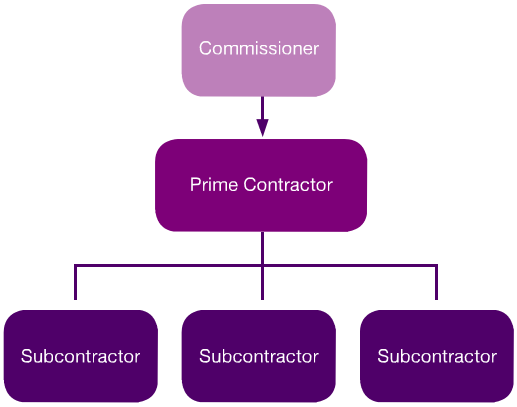
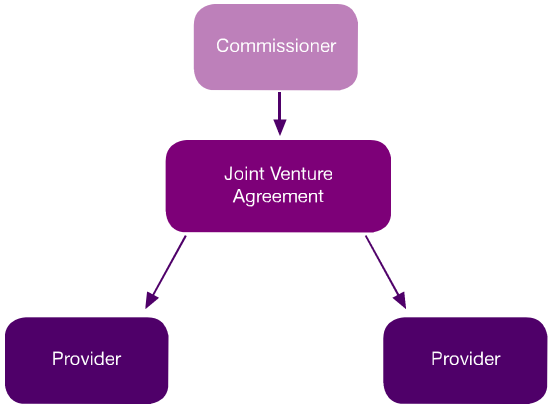


Figure 4. Joint venture



Joint Venture/Alliance

The term 'joint venture' is often used to describe an arrangement where a number of parties form a new legal entity for the purpose of providing a particular service. The new entity (usually a limited company or LLP) will enter into contracts in its own right. The parties who established the joint venture vehicle will very often provide support services to the vehicle in order to enable it to fulfil its obligations. This model allows the joint venture vehicle to bid for and provide services to other third parties so that the founding parties can share in the success of the business as it expands.

An alternative to this corporate joint venture is a contractual joint venture.

Contractual Joint Venture

A contractual joint venture is a contractual agreement between two or more parties to come together for the delivery of a particular project or service. It can be one, two, or more providers (provider JV), or one or more providers plus one or more commissioners (commissioner JV).

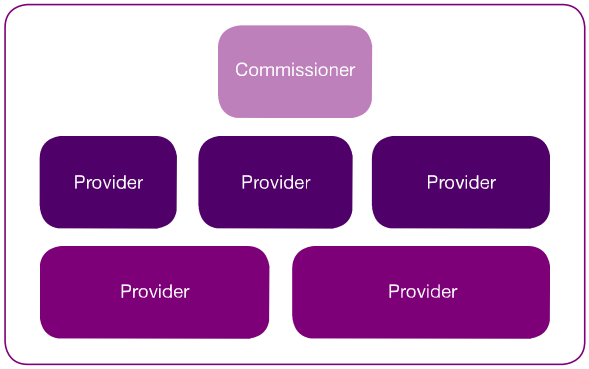
The joint venture agreement will specify the nature, responsibilities and terms and conditions of the relationship between the parties. Whilst the parties agree under the joint venture agreement to work together on the project, they retain their own separate organisational identity.

A contractual joint venture typically relates to the delivery of a single project.

Alliance

An alliance contract is a particular form of contractual joint venture. It is typically a commissioner led contracting mechanism which aims to incentivise collaboration between a number of providers, who cooperate to deliver a particular service or an interrela t of services. The model can be illustrated as follows:

Figure 5. Alliance contracting



In this model, a commissioner holds a single contract with a number of providers, who share a common performance framework with collective measures. While each party maintains their own internal controls, there exists collective accountability for services delivered, with providers judged on performance as a whole rather than as individual components. Risk and reward is therefore shared between parties within the alliance, incentivising cooperation to drive successful delivery of services (e.g. a care pathway).

While alliance contracting has not been tested in the UK health services, forms of alliance contracting have been used in New Zealand as a response to the need to develop new care delivery models and to integrate services.

Strategic and Procurement considerations

Strategic considerations

The current contracting model which CCGs have inherited is typically a series of arrangements with individual providers. It is usual that each contract has been developed in isolation with limited interaction between providers and commissioners in different sectors for example health and social care. The contracts typically envisage a payment for activity.

If CCGs are going to be able to respond to the commissioning challenge presented by a growing, aging population, increasing cost of health care and ever tightening budgets, this status quo will need to change. CCGs will need to drive change, and to do this they will need to ensure there is:

- behaviour change;
- service integration;
- cost saving;
- pathway reconfiguration; and
- improvement in patient outcomes and experiences.

There will be resultant changes to contracts. CCGs will need to use their contracting discussions to support these service changes. In turn the contracting model should support the service delivery model which the CCGs want.

Before entering into any contracting discussions with providers, commissioners need to have clearly identified and defined their strategic aims and objectives and be clear about what they are seeking to achieve from these discussions and why.

Commissioners will need to have a clear understanding of the proposed service changes and the characteristics of the services (is it simple or complex, any constraints – people/equipment/ premises etc). They will also need to have considered:

- the market appetite for changes;
- investment requirements;
- budgetary and value for money issue; and
- payment mechanisms e.g. tariff.

Commissioners will need to have considered the current contracting arrangements, regulatory issues and identified any constraints. This will involve assessing and understanding:

- **Existing contractual arrangements**
- **Anti-competitive issues:**
  - Procurement complies with competition law and procurement regulations
  - Service bundling takes account of the potential impact on competition with the benefits from a potentially more integrated service
- **Patient choice:**
  - Where services are bundled be clear of any impact on patient choice (of provider or service)
- **Payment mechanisms are permissible:**
  - Monitor's license conditions need to be met unless an exemption from Monitor can be obtained
  - If operating outside of tariff monitoring service quality will be a key consideration, they need to be particularly careful about monitoring quality

In addition, commissioners will need to have considered what the desired contract characteristics are. For example:

- promotes provider collaboration where there are patient benefits that exceed the cost from reduced competition;
- promotes innovation;
- eliminates duplication and over supply;
- facilitates sustainable cost reduction;
- robust, simple performance management; and
- clear clinical accountability.

Having assessed the current situation and having a clear understanding of the desired outcomes, commissioners need to:

- assess whether a new procurement is required; and
- consider the preferred contractual model.

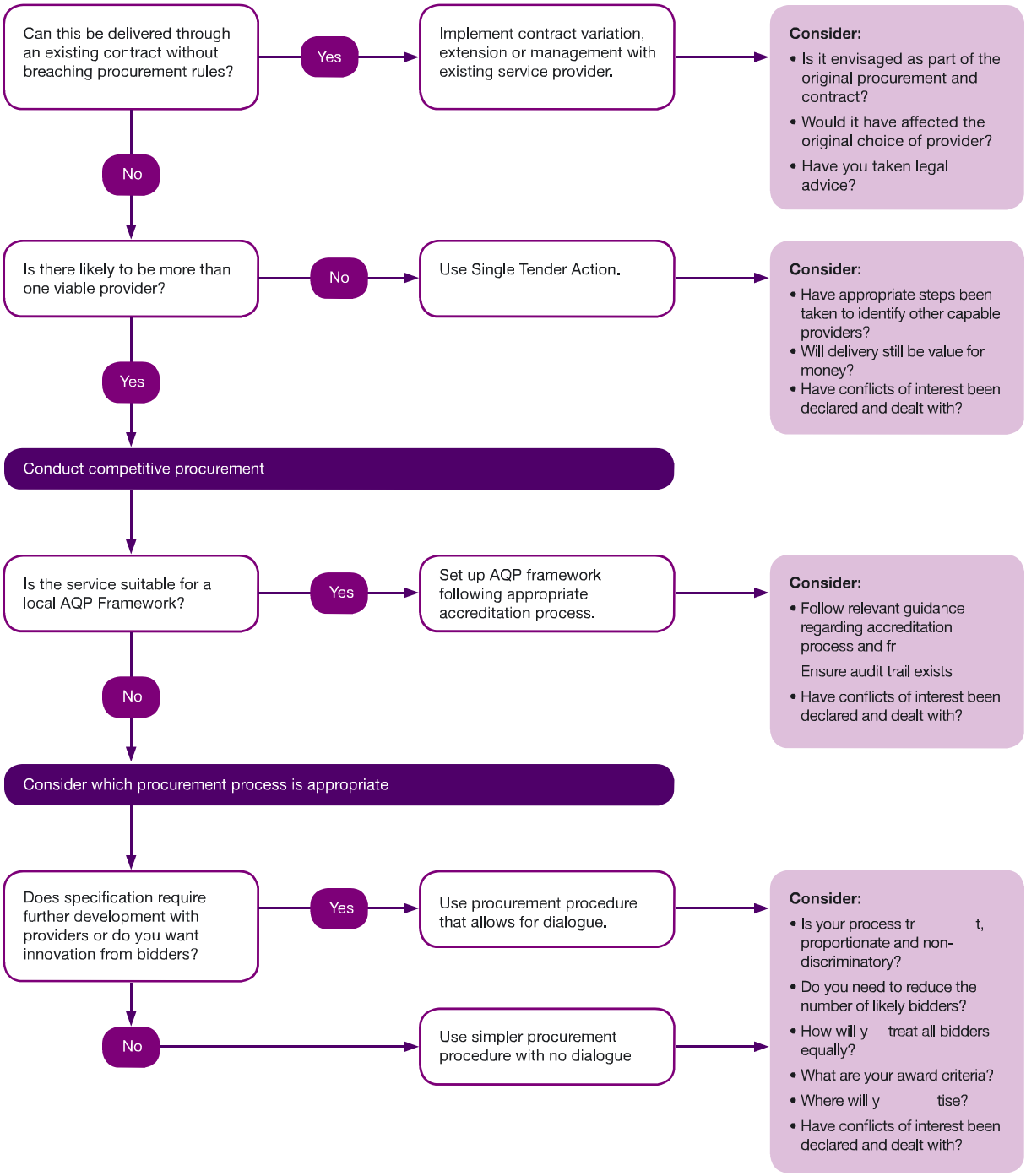
If CCGs are going to be able to respond to the commissioning challenge presented by a growing, aging population, increasing cost of health care and ever tightening budgets, the status quo will need to change.

Procurement considerations – when to undertake a new procurement

Having identified the key considerations for the service change/new service requirements, and before considering the final form of contract required, the CCG will need to consider whether it needs to enter into a new contract or procurement, or whether it can achieve the necessary change through a variation to the existing contractual arrangements.

The following chart summarises the key decision making process which CCGs will need to follow in making this assessment.

Fig.6 Procurement considerations



Selecting the contracting model

Selecting the contracting model

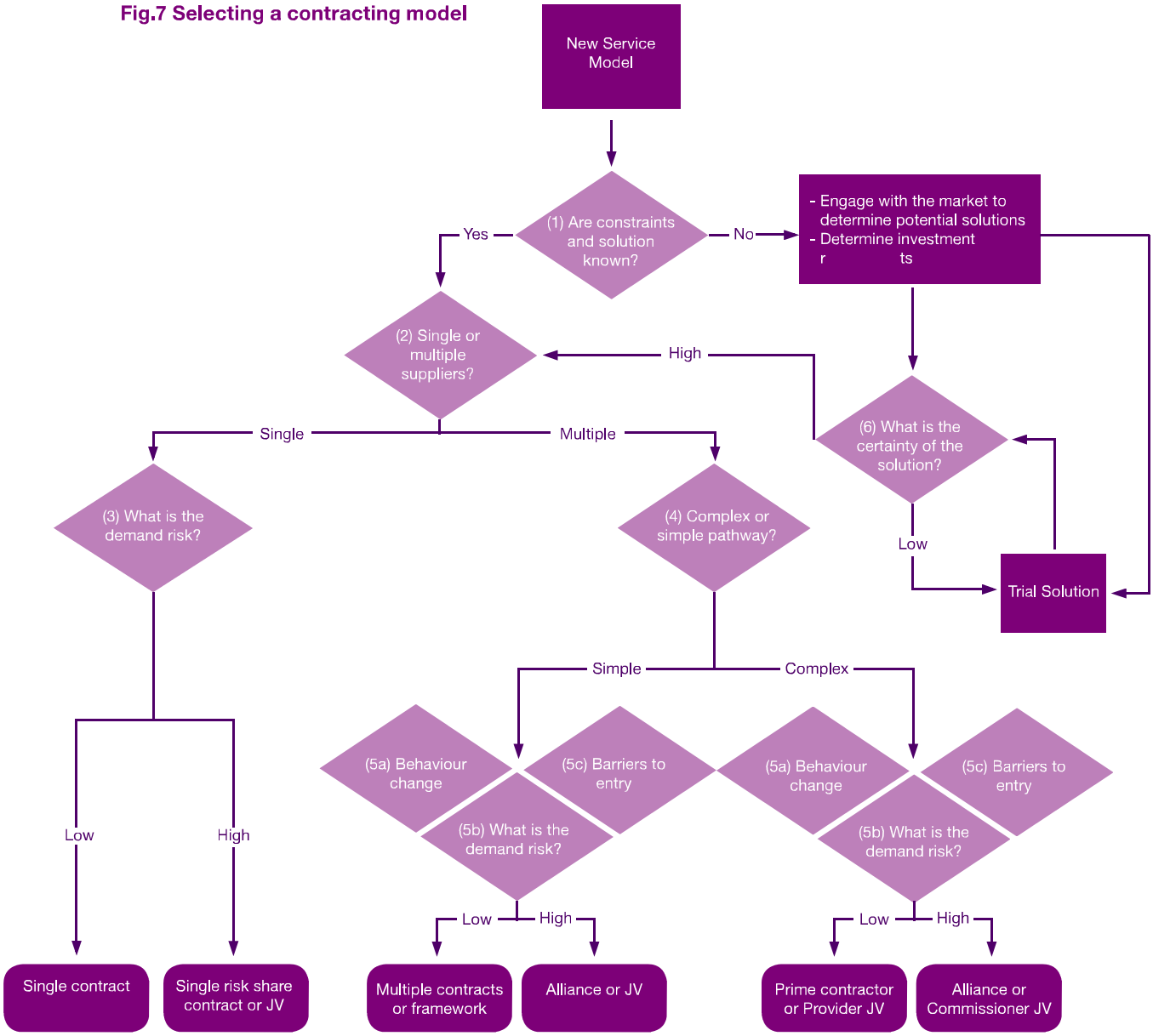
The decision on contracting approach follows responses to a series of questions. CCGs will need to:

- have a sound idea of what service and outcomes they want;
- understand the market and potential suppliers; and
- understand any constraints for service delivery (e.g. investment, barriers to entry, economies of skill and scale).

The starting point is an understanding of the service to be provided. For example do CCGs and providers know and understand the service and any associated constraints, if not does the CCG need to work with the providers to develop a service solution.

The following algorithm illustrates a process which CCGs could follow to help inform them on the potential contracting mechanism they should use when procuring services.

Fig.7 Selecting a contracting model



As can be seen from the algorithm, the starting point is a clear understanding of the proposed service requirement (and combination of provider skills needed to deliver the required outcomes); is this known, or is work required with providers to develop and test the solution? The table below summarises some of the key considerations required at each decision point. The list is not exhaustive and the considerations will vary depending on the service being commissioned, local market conditions and commissioner intentions.

Please note: The algorithm deliberately excludes considerations regarding payment mechanism and tariff issues, as these will be factors irrespective of the contracting mechanism chosen. The algorithm does not include a specific decision point on regulatory and competition issues. These are included as considerations at a number of the decision points with the key issue for commissioners being, having a clear understanding of the issues and risk of challenge.

Decision	Considerations
1 Are constraints and solutions known?	Do Commissioners have clear vision of the clinical solution? Is the solution understood by providers? Will the solution require significant investment from commissioner or providers? Do the skills/resources exist locally to deliver the service?
2 Single or multiple suppliers?	Is there more than one potential provider locally? Does the demand support more than one provider? Does solution require significant investment/specialist resources and assets (people/ equipment/facilities)? Does solution require specialist skills and do these exist locally? What is the regulatory/competition risk?
3 What is the demand risk?	Is the demand constant? Is the demand predictable? Is the demand manageable?
4 Complex or simple pathway?	Is the pathway simple or complex? What are the clinical risks? Can the services in the pathway be easily "bounded"? Are there multiple hand-offs between services in the pathway?
5 (a) Behaviour change (b) Barriers to entry (c) What is the demand risk?	Are providers resisting behaviour change? Does the solution require changes to align providers, services and processes? Will the solution require providers to interact with each other/other services/across health and social care sectors? Does the solution require staff to work across organisations? Does the service require significant investment/specialist assets (staff/buildings/equipment)? Is the demand constant? Is the demand predictable? Is the demand manageable?
6 What is the certainty of the solution?	Is the clinical solution known and fully understood by commissioners and providers? Are there unidentified risks associated with the clinical solution?

The algorithm should be used as a guide on the potential contractual mechanism to be used in a given situation. Depending on circumstances, an alternative mechanism could still be appropriate.

Appendix 1

The following table provides a summary of typical situations when particular contractual mechanisms may be appropriate.

Contract Form	Key Characteristics of Situation
A Single Contract	Known market with steady demand Lower volumes (potentially) Barriers to entry/investment requirements (staff/assets/infrastructure) Defined and clear payment mechanisms
B Single risk share contract or Joint venture	Unpredictable demand/volatile market Lower volumes (potentially) Barriers to entry/investment requirements (staff/assets/infrastructure) Regulate suppliers
C Multiple contracts or Framework	Known market with steady demand Significant volumes (potentially) Limited barriers to entry/investment requirements (staff/assets/infrastructure) Defined and clear payment mechanisms
D Prime Contracting or Provider JV	Generally appropriate for larger clients Economies of scale and knowledge /reach critical mass In a JV, everything is agreed at the start Potential to build up long-term relationships

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