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Title: Developing a contracting model for integrated health and social care for older people

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Abstract

Current debates surrounding the NHS contract in England are suggesting that it is in need of change to support an integrated health and social care transformation agenda that meets the needs of an ageing chronically ill population. This paper describes a three phase project in England that sought to develop and validate a whole systems contracting model for integrated health and social care focusing on older people with long term conditions, and based on joint outcomes. A participative

mixed-method approach for the development of the contracting model was used; this consisted of 1) a literature review, 2) a design phase drawing on consensus method through stakeholder discussions and 3) an international validation phase. The final contracting model consists of four overarching and interrelated core elements: (i) outcomes; (ii) partnership, collaboration and leadership; (iii) financial: incentives and risk; and (iv) legal criteria. Each core element has a series of more detailed contracting criteria, followed by further specifications attached to each criteria. While the policy environment appears to be conducive to change and encourages the adoption of new ways of thinking, there are difficulties with the implementation of new innovative models that challenge the status quo, and this is discussed. The paper concludes with reflections on the way forward for local development and implementation.

Key words

Contract model, integrated care, joint outcomes.

Introduction

The desire to provide health and social care in a more integrated manner has long been a feature of government policy (eg. DHSS 1972), with different operational responses through the decades. The aims however have remained somewhat constant - to encourage increased implementation and improvement of integrated health and social care, promoting independence at home, and reducing unplanned hospital admission. In recent times, the Health and Social Care Act 2012 has provided yet another focus for the development of new approaches and innovations across England. Health and Wellbeing Boards have been established to enable better co-ordinated multi-agency working; the Better Care Fund, launched in 2013, has been set up to facilitate joint working through the pooling of budgets between Clinical Commissioning Groups (CCGs) and local authorities to improve efficiency and avoid duplication; and 25 Integration Pioneer sites have been created, aiming to share knowledge about how health and social care services can work together to provide better support at home.

In addition to this, NHS England published its 'Five Year Forward View' (NHS 2014) which selectively reflects some of the aspects of the 2012 Act, and as a consequence, 35 Vanguard sites have become viable, focusing on New Care Models - different forms of new integrated care provision through multi-speciality community providers, primary and acute care systems, urgent and emergency care networks, acute care collaborations and enhanced health in care homes. To support this, national bodies such as NHS Improvement have a specific remit to work with providers and local health systems to help them improve.

Ambitions, expectations and aspirations around this agenda are high. But the history of making integrated care work in the UK has been long and tortuous, with considerable and sometimes insurmountable fragmentation between services that have created difficulties with, for example, employing joint budgets and establishing workable cross-sector contracts (Hudson 2013).

Commentators agree that the current NHS contract is in need of change to support an integrated health system that meets the needs of an ageing chronically ill population (Addicott 2014). The predominance of activity-based payment in the acute sector (designed to tackle waiting lists), and block budgets in community services, offer little incentive to increase activity or efficiency in these settings and shift care from the hospital setting (Marshall et al 2014). McGough (2014) questions how budgets for developing integrated systems can be 'unlocked' from primary care, hospitals and local authorities. While the Better Care Fund may be a mechanism for this, currently organisations are at different points in their integrated care journey (Better Care Fund 2016/17), so a clear picture of how this will benefit the transformation agenda has yet to emerge.

Marshall et al (2014) argue that for frail older people the situation is even more complicated, especially when assessing the contractual relationship between payment, incentives and outcomes. For example, to address needs, different services will need different payment methods and different forms of incentivisation. While it may be appropriate to incentivise a process where it is clearly linked to an outcome, more complex outcomes with multiple determinants will need a different approach.

Prompted by observations such as these, the notion of joint outcomes is being debated, especially within the context of the re-emergence of the outcomes based commissioning approach (Kerslake 2006; Billings & de Weger 2015; www.cobic.co.uk; Taunt et al 2015). Views call for a single joint performance framework to ensure that NHS, social care and other services work together to improve outcomes for patients and service users (Humphries & Curry 2011; Kippen & Reid 2014).

Other commentators also point out that new approaches and innovation may be possible through NHS contractual forms using overarching contracts and models such as the prime contractor or alliance contract (Addicott 2014; McGough 2014; Billings & de Weger 2015; lh alliances 2016 http://lhalliances.org.uk/). McGough in particular notes that introducing integration successfully must include commissioning alignment, effective use of contracting terms, developing an appropriate service specification, and contract management.

With McGough's (2014) opinions in mind, the current contracting system could be criticised for not being sufficiently flexible and forward thinking to embed areas such as advanced assistive technology (AAT) and industry providers in a meaningful way. Currently, industry providers remain peripheral to the main delivery event in integrated care, and their central involvement in a contract specifying joint outcomes for example may overcome problems associated with device use, sustainable operability and user acceptability (Billings et al 2013).

Given these arguments, it is clear that current information on implementable integrated care contracting approaches that would work across services at the systems level, incentivise agencies to work to joint outcomes, enable the embedding of AAT and have a good fit with the transformation agenda are lacking. There are examples of areas that employing new contracting models (see lh alliances 2016; Addicott 2015; NHS RightCare 2016 www.rightcare.nhs.uk/ ; Taunt et al 2015), so within this context, investigating a way of reshaping local contracting processes to better support integrated care delivery would seem worthwhile. Such an approach would enable contracting to be more tailored to the aspirations of local commissioners and providers.

It is for this reason that a project was commissioned in Kent in 2014 by the former Kent and Medway Commissioning Support Unit (now South East CSU, to become North East London CSU from April 2017) to develop a new contracting model, conducted by the first author and initiated by the second author. Kent is a progressive county; it has both an Integration Pioneer site and two Vanguard sites. In addition two CCGs are establishing Integrated Accountable Care Organisations. The environment and motivation to develop and test such as model would seem therefore to be present.

Aim of the project

The purpose of this project was to develop and externally validate a contracting model blueprint for integrated health and social care for older people with long terms conditions that was:

- Focused on integrated care;
- Collaborative and based on achievable joint outcomes;
- System focused and;
- Based on evidence of good practice.

The overall aim of the contracting model was to ensure high quality integrated care to support self-management and end of life care, in keeping with the English policy agenda. A further objective was to promote innovative care pathway transformation through embedding and accelerating the use of AAT.

Method

The project took place over a year, ending in January 2015. A three phase participative mixed-method approach for the development of the contracting model was used; this consisted of 1) a literature review, 2) a design phase using group discussion and 3) a validation phase. Methodological approaches to phases 2 and 3 are described and rationalised here, and a critical overview of the processes are presented in the discussion.

Phase 1

In phase one, an international literature review of contracting approaches, models and designs was conducted. This is reported in a previous publication; while eight models were identified, the publication specifically provides a critical account of four models currently under debate, namely Accountable Care Organisations, the Alliance model, the Lead Provider model and Outcomes-Based Commissioning and Contracting (Billings & de Weger 2015). The purpose of this review was to provide material to underpin phase two design group discussions with concepts, ideas and examples of good practice. An important feature of the review was to capitalise on learning from agencies and industries external to the NHS and transpose key messages into the developing model, enabling innovative 'blueprints' for effective contracting approaches to emerge.

Phase 2

In phase two, a Kent-wide design team of 25 representatives from CCGs, primary care, acute and community providers including mental health, a care home, social care, public health, the voluntary sector and the AAT industry, were convened to develop the model. The group was multi-disciplinary

and participants included GPs, nurses, commissioning support personnel, health and social care managers, legal and contracts personnel, and industry technologists.

The main methodological focus of the group was to draw upon consensus development method, as it helps to organise qualitative thinking and judgements particularly when creativity is required (Black 2006). Groups generally bring a wider range of experience and knowledge, with interaction stimulating the consideration of more opinions, particularly when participants are multi-disciplinary. They also challenge received wisdom and promote group agreement (Murphy et al 1998). Some structure was needed and to this end, a clear operative plan was developed with the group from the onset, consisting of a set agenda per session with milestones to be reached over a six month period. However 'blue skies' thinking was encouraged and, given the current perceived restrictions within contracts, group members considered what ideal components for a contracting model would look like. The value of including personnel from the 'sharp end' of contracting was evident in that they were able to ground thinking into practical realities of what was possible without restricting creativity. In line with consensus method, group members were provided with a synthesis of the literature review in a digestible manner for them to consider.

The design group met six times on a monthly basis for an afternoon and discussion groups were organised and facilitated by the main author. The initial session was concerned with extracting and agreeing on a set of overarching contracting elements and ensuing sessions elaborated on each one in turn, all the time discussing and getting consensus on their value and practical application. Thoughts and ideas were captured both on flip chart paper during the meetings to act as a visual stimulant for group members and to enable reflection on what had been agreed, and also electronically to record the rationale for consensual decisions. In between group meetings, discussions were converted to model design and circulated for review and comment by the first author. Each session reviewed progress and consensus reached from the previous session, before moving the model development on.

Phase 3

Phase three consisted of a validation phase. Given that the model had been a regional development and from an English perspective, conducting a consultation process as a means to provoke further discussion and ensure applicability across a broader sphere of contexts was seen as an important inclusion (Billings & Leichsenring 2005). The draft model has been assessed through consultation with five national and four international contracting, legal and long term care experts, and with organisations such as Monitor and NHS England in the UK, and the European Centre for Social Welfare Policy and Research in Austria. In addition it has been presented at webinars, conferences and discussed with numerous CCGs and professionals from other Commissioning Support Units across England. Overall, those experts and bodies consulted expressed favourable opinions, describing the model as innovative and ambitious. They were in agreement that the contracting model has face validity and potential in the field of integrated care and older people. All recognised however that there needed to be concrete testing before full confidence in the model could be gained, an aspect discussed later.

The Contracting Model

As a first step in the development of the model, the design group extracted values and principles that were sympathetic to what they wanted to achieve. These guiding principles acted as 'anchors' to thinking and influenced how the eventual contracting model was designed. This multi-disciplinary thinking proved to be important – as the literature review indicated, there is very little hard evidence for what works in contracting (Billings & de Weger 2015). Figure 1 portrays the outcome of these guiding principles; placing the person at the centre of the model was fundamental to thinking, with an inner core of four person-centred principles reflecting individual and community level ideals. This is surrounded by service-oriented principles that are geared towards innovation, partnership and joint working.

Figure 1 Overarching Principles
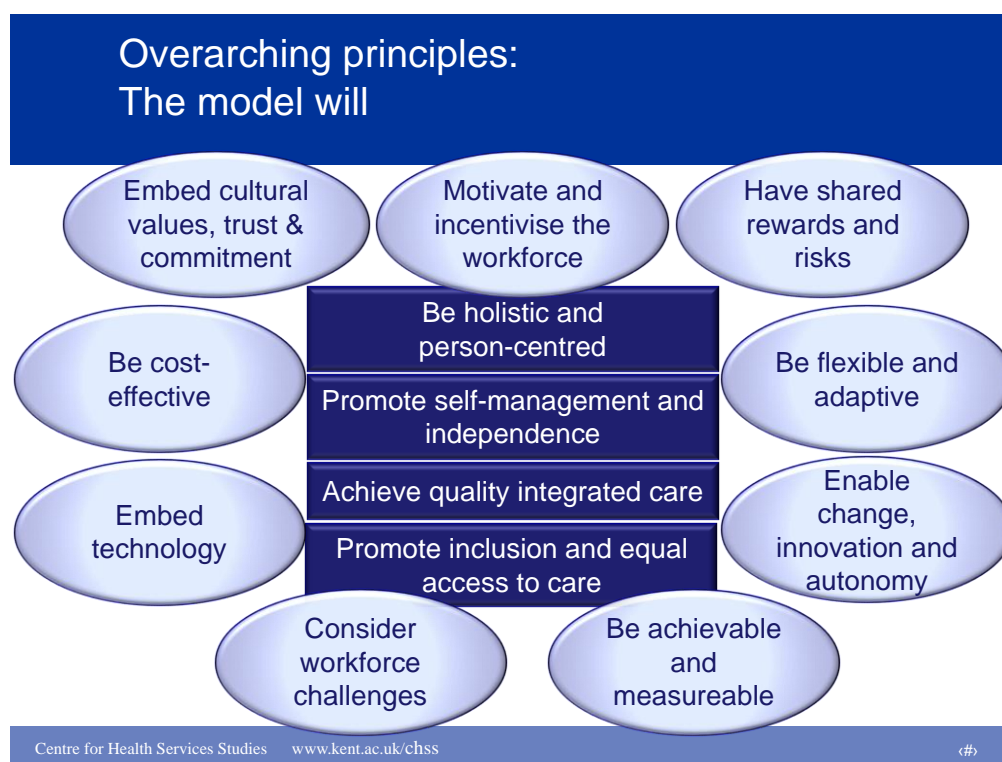
The principles reflected not only the literature review undertaken in preparation of the project, but also the overall aims of integrated care working (Leichsenring et al 2013; Oliver et al 2014; Goodwin et al 2014) and best practice aspirations in this area drawn from the professional literature (Billings 2005) and design group experiences. With reference to the literature review a number of ambitions within the different models were also influential, examples from four contracting models are given below:

- Accountable Care Organisations (ACOs) stress the importance of having a leadership committed to improving value and quality for their patients (Porter 2012), the skills and infrastructure necessary to manage the financial risk, and an information technology system capable of processing and sharing internal and external data with the ability to deliver key information to providers and patients (Miller 2011). ACOs are also strong on incentives to encourage health systems to look at all the factors that might negatively affect patients'

health status, including the social determinants of health. Incentives also promote healthy choices to their patient population, their employees, and the communities they serve, as those choices reinforce the preventive orientation of the health care delivered within an ACO (Corbett & Kappagoda 2013).

- The Alliance model focuses on the importance of trust, partnership, collaboration and commitment. There is a risk share across all parties and collective ownership of opportunities and responsibilities; alliances involve a closer and more interdependent relationship (Bruner & Spekman 1998; Zoller 1999; De Jong & Klein Woolthuis 2008). This model is seen as ideal for integrated care because it drives collaboration between all parties. Contracts are not separated from improvement and transformation initiatives, they are an integral part of them and promote innovation (lh alliances 2016; Mayer & Treece 2008).

- Principles underpinning the Lead Provider model also have a strong focus on integrated care, based around both the needs of patient groups and individual patients and with the aim of keeping patients as independent as possible at home and out of hospital (Corrigan & Laitner 2012; O'Flynn et al 2014; Addicott 2014).

- Outcomes based commissioning principles are concerned with contracting services at the individual service user level on the basis of measurable outcomes rather than tasks. This is purported to achieve service change and person-centred care for all service users taking into account service users' shifting needs. It must be driven by the service user's own expression and aspiration, and not something imposed upon them (Paley & Slasberg 2007). Taunt et al (2015) add to this by stating that outcomes-based commissioning seeks to solve the issue of how financial flows and the commissioning process can best support quality and efficiency across the system.

These underlying principles therefore influenced the development of the final contracting model, which consists of three layers of detail. There are four overarching and interrelated core elements:
(i) outcomes;
(ii) partnership, collaboration and leadership;
(iii) financial: incentives and risk; and
(iv) legal criteria.

Each core element then has a series of more detailed contracting criteria, followed by further detailed specifications that need to be taken into consideration when forming the contract (tables 1-4 listed after references). Some commentary regarding the rationale for the development of each of the core elements will now be given.

Outcomes Contracting Criteria

With reference to the underpinning principles, a key feature of the outcomes contracting criteria (table 1) was the development of person-centred joint outcomes, as this was seen to be pivotal to the contracting model.

A first step was for the stakeholder group to draw upon the current outcomes frameworks in England, as they are in common use across CCGs. These included the NHS Outcomes Framework 2013-14 (DoH 2012); the Public Health Outcomes Framework 2013-16; (DoH 2012) the Adult Social Care Outcomes Framework 2013-14 (DoH 2012); and End of Life NICE guidelines (NICE 2013). These

frameworks consist of a wide range of outcomes and indicators for establishing health and social care performance and wellbeing. Criticism has been levelled against these frameworks for being separate and not united, potentially threatening effective joint working at a local level, and reducing benefits for patients and service users (Humphries & Curry 2011). So aligning them in this research study to create a single outcomes framework for contracting seemed an appropriate endeavour. While there was initially some concern about the sensitivity of the outcomes to integrated care, some synergy with the principles was discovered. In addition to these, the work of Nick Hicks of COBIC (Capitated Outcome-Based Incentivised Commissioning available at www.cobic.co.uk) was drawn upon, particularly in relation to the development of the Oxfordshire Frail Elderly Outcomes Framework (2013). Overarching person-centred joint outcomes were agreed upon through this process, then coupled with the most relevant combined outcomes themes from the frameworks (see table 1 – source of combined themes is referenced).

The idea of how these would be used in practice is illustrated in figure 2: while all agencies (a suggested but not exhaustive list) would work towards the joint outcomes, there would also be individual deliverables that each organisation would work towards, that would be measurable and derived from the combined outcomes themes.

Figure 2: Working towards joint outcomes.
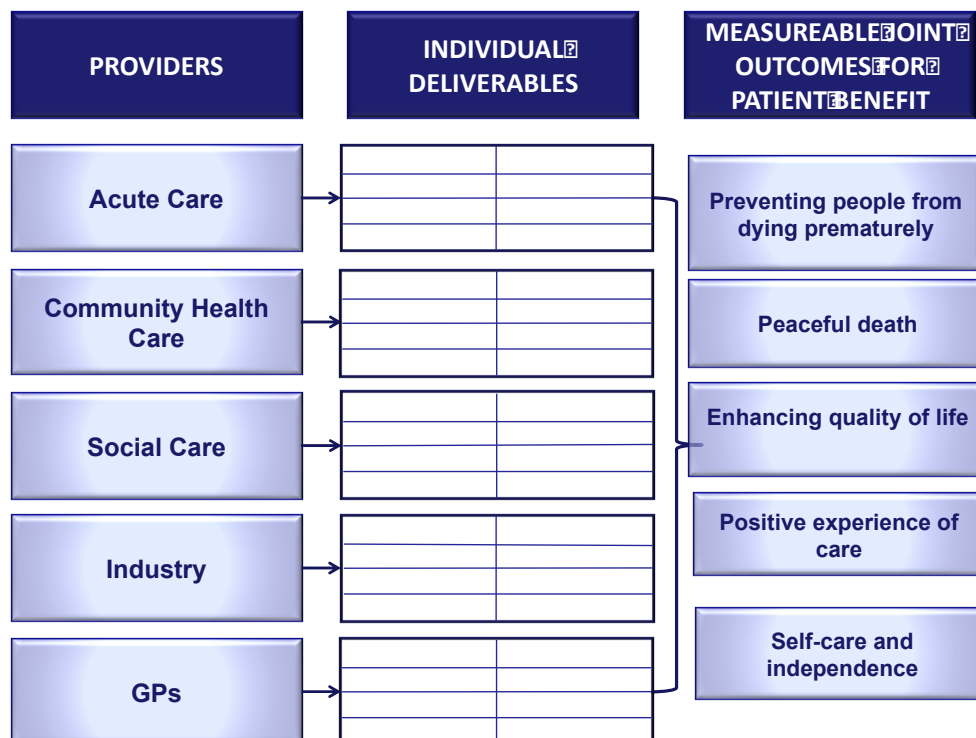
Partnership, Collaboration and Leadership Contracting Criteria

Contracting criteria here focused on key aspects felt to be central to the success of this core theme (table 2). Drawing from the literature associated particularly with the Alliance contracting model (eg De Jong & Klein Woolthuis 2008), the concept of 'sharing' features prominently with regard to

priority issues such as purpose and vision, benefits and risks, and information. Added to this, corporate culture is important as it affects many critical aspects of management and operations, such as how quality standards are internalised, decisions are made, and service users are treated (Kale et al 2000). Creating a sense of 'relational embeddedness' flows from this. Network structures and relational characteristics have become increasingly prevalent in the study of how firms find and exploit market and technological opportunities through knowledge sharing (Andersson et al 2005) and governance arrangements (Lin et al 2011). Nahapiet and Ghoshal (1998 p244) define relational embeddedness as the 'personal relationships people have developed with each other through a history of interactions'. Key facets of relational embeddedness include interpersonal trust and trustworthiness, overlapping identities, and feelings of closeness or interpersonal solidarity by emphasising the importance of openness, honesty and transparency between organisations.

In addition, having 'active' contracting criteria particularly in relation to partnership and communication processes was factored into the design, reflecting not only the guiding principles of motivation, change and innovation, but also to capture the drive needed for service transformation. Referring to the specifications to consider on this table, aspects such as recognising and using partner strengths, establishing formal governance, planning cycles, decision-making and problem-solving pathways as well as creating technological solutions are key ingredients (lh alliances 2016). Leadership is also key, particularly within integrated care and is closely linked to successful partnership and collaboration (Corrigan & Laitner 2012).

Financial: Incentives and Risk Contracting Criteria

As can be seen within these contracting criteria (table 3), the concepts of sharing and encouraging organisational harmony are also at the heart of this element. It emphasises the sharing of financial rewards, and intellectual and physical resources, but also risks and costs, again influenced by the Alliance model. Coupled with this, design features seek to create a positive innovating environment for incentivising and motivating sharing by working towards a common identity through 'branding' (reflected also in the partnership, collaboration and leadership element as 'having a collective understanding of roles and identity'), and harmonising local intellect and networks to support innovation throughout organisations. Emphasis upon local autonomy and freedom to develop innovation emanated keenly from design group discussions, where experiences were more seen as 'stifling' creativity when attempting to provide new ways of service delivery. So flexibility was seen as an important factor in contracts going forward.

The power of internal and external 'branding' and its potential influence in healthcare is a relatively new area (Gapp & Merrilees 2006), but is gathering momentum with the Vanguard status and recent introduced notion of ACOs where organisations are keen to carve out an identity. Gapp & Merrilees (2006) argue that harnessing the power of branding through a genuine commitment to a cross disciplinary approach, has the potential to take forward organisational change, quality care that is innovation driven, and transformation, where the workforce is considered as equal partners in creating an organisation of excellence. Such a notion seems worthy of inclusion within a contract.

Legal Contracting Criteria

The design group recognised that a cornerstone of a contract is the legal underpinning in order to create the conditions for change and ensure standards of governance and accountability are in place and adhered to (Nöldeke G & Schmidt KM 1995) (table 4). Contracts in integrated care that are between organisations create their own complexity, and in this case legal criteria will need to support a systems approach working towards joint outcomes.

For example, establishing a contract currency that is valid and acceptable across sectors will be important. Flexibility in how contracts are drawn up and operationalised is a predominant theme within the elements of the contract, and here it was acknowledged that flexible contracts that accounted for variability in duration and value with review dates rather than end dates, would better support joint working. Issues concerning the legal environment such as creating the stability for cross-sector working need to be in place, as do key factors associated with intellectual property such as where and when ownership and rewards can be shared, and when it is not appropriate. To support partnership working, there needs to be clear governance about how the relationships should work, with the provision of provider agreements concerning issues of money and responsibilities, and the entry and exit of partners (Mayer & Treece 2008).

Discussion

The project's aim was to develop a whole systems integrated care contract model that is more suited to the new policy agenda and meets local requirements. A model has been developed that has its operational basis within an integrated care system, is person-centred and grounded in available evidence and the most applicable principles of existing models, and embraces wide-ranging collaboration and partnership as a pathway to achieving joint outcomes. It has been exposed to many health and social care academics and professionals and gained acceptability in the course of its validation, and may have the potential to support the transformation. Predominant aspects such as partnership, collaboration, leadership and the focus on person-centred joint outcomes are appealing and have a good fit with qualities that are needed to succeed (Goodwin et al 2014). Given the contextual and operational complexities as expressed by McGough (2014), Marshall et al (2014) and others, in the absence of testing, the model could arguably be compared with the policy agenda as being equally ambitious. In this section, potential challenges for pragmatic adoption into the real world setting are discussed in three main areas – the evidence base, support given by policy, and the appetite for change. To start with however, a critical overview of the methodological processes involved in developing the contract model is provided.

The study was initiated by one individual 'champion' working across the health and social care sectors, who convened the group for the study. As with all groups involving busy representatives working in a variety of health and social care agencies, maintaining the momentum of involvement over a six month period was challenging. Membership also changed with deputising and new posts. This did affect progress with conceptualising and agreeing content and tended to prolong discussions as people 'caught up'. Each session for example was dependent upon learning from the

previous one, and on the one hand it became difficult to maintain fluidity of thinking, but on the other we gained new critical group members who challenged content and rationale as the structure became more defined. In order to ensure input from members unable to attend (in particular the NHS contracts members to ensure that the criteria were grounded), we sought feedback and opinions in between where possible. Some scepticism was evident in the process; members were unsure for example whether the contracting criteria could be transferable to the NHS and social care context, particularly the relational aspects of partnership and trust connected to risk and reward sharing. This concern is largely supported by the wider literature, which infers that partnerships in industry frequently 'revert to type' due to pressures of competition, and ultimately break down (Augustine & Cooper 2009).

Although the last two groups of the six month study consisted of eight members, it was of interest that representation from the IT industry and the Commissioning Support Unit was maintained throughout. Their contributions towards the 'branding' and marketing criteria (Financial: Incentives and Risk) and intellectual property (Legal) were noticeable, and it could be argued that this provided the end product with a more outward-facing appeal.

The importance of the consensus method quickly became evident, in that there would never be total agreement on a defined content and associated wording, but reaching a 'happy' agreement became the goal. There were many heated debates about what should be included and converted to contract criteria. This was particularly the case for the outcomes contracting criteria; faced with a multitude of different outcomes frameworks and measurements, what would be the best way of selecting and grouping these in a contract to foster meaningful joint working? Are they actually appropriate for a contract of this nature? For this and other contracting criteria, themes and 'long lists' were created from the discussions and the first author analysed and created structure in between meetings for discussion and agreement at the next.

Given the reduction of group membership to develop the model and the potential for bias in emphasis of certain content, the validation process took on a heightened degree of importance. As mentioned in the methods section, the resultant model was exposed to some clear experts in the field and a number of organisations that are currently reviewing their contracting processes. However, the reactions were the same. The contracting model certainly seemed to connect to the audiences as a 'good idea' but the lack of a clear implementation plan alongside uptake and testing discoloured the positive view.

This leads on to a broader discussion of the potential challenges for pragmatic adoption. Firstly, the spotlight is upon evidence – do new contracting models bring about the desired change? Despite the widespread desire to promote integrated working through new contracting approaches, their evidence-base in achieving successful outcomes does not appear to be convincing nor strong (Billings & de Weger 2015). Areas that have already adopted models such as the Alliance and prime contractor have encountered problems. Addicott (2015) for example examined experiences of commissioning and contracting for integrated care in the English NHS, through case studies of five health economies that are implementing novel contracting models. Findings indicated that the cases have largely relied on the vision of individual teams or leaders, alongside external legal, procurement and actuarial support.

In addition, an examination of outcomes-based commissioning in the NHS has demonstrated that it is promising as a means to help transform healthcare, but evidence to support it remains limited and it is proving harder to implement than foreseen (Taunt et al 2015). Indeed, while the Oxfordshire Frail Elderly Outcomes were drawn upon in our model, in reality there was conflict between the CCG and its main acute and mental health providers as they strove to implement their plans and move away from activity-based contracts (McLellan 2013). Taunt et al and Addicott conclude that careful learning and significant support is needed to help it live up to its potential, and that operating novel contractual approaches will require determination, alongside advanced skills in procurement, contract management and commissioning. Marshall et al (2014) add to this by stating that there is currently limited evidence and guidance to support financial incentivisation of outcomes, in part due to the fact that outcomes are difficult to measure and attribute. It is generally acknowledged that outcomes are distant in time from the care activity and influenced by many variables, making clear links to specific provider actions problematic.

Secondly, some commentary on the supporting policy is provided. On the face of it the policy structures within Health and Social Care Act 2012 would appear to be in place, although historically, political integrated care imperatives do not seem to have brought about the anticipated widespread change. The Act's 'instruments', such as the Better Care Fund has decidedly mixed reviews. For example, a prevailing belief as articulated by McGough (2014), is that the effective pooling of funds across organisations is vital in delivering integrated care at any scale. He adds that there is the potential local flexibility for the parties to agree to move to different and innovative financial models which depart from activity based payment structures and more towards alternatives. However its sceptics are not convinced that essentially relabelling a pot of money will create a sudden organisational collaboration to reshape the care system, and may even result in their own organisations losing services and money (Smith 2014). Fundamentally, it is not yet apparent that the policy structures can fully succeed in skewing resources away from the acute sector towards home-based community care, nor that there is sufficient incentivisation to channel resources and effort towards targeting the highest risk populations.

Thirdly, the discussion considers the appetite for change. Such doubts surrounding evidence and policy have the potential to foster a climate of uncertainty surrounding new contracting models, demanding the question as to whether the drive to support them is still evident among commissioners, providers and politicians alike. This appetite is perhaps being dulled even more by investigations, such as the Cambridgeshire and Peterborough CCG partnership contract (NAO 2016). This CCG commissioned an innovative integrated contract with a budget of about £0.8 billion to provide its older people's and adult community services from UnitingCare Partnership - a limited liability partnership formed from two local NHS foundation trusts. The five-year contract started in April 2015 but was terminated after only eight months because it ran into financial difficulties. The investigation highlighted gaps in specialist procurement advice, an insufficient sum to help redesign the service, and contractual terms that exposed the CCG to significant unintended risks and potential costs. Despite the fact that the NAO reported significant and widespread stakeholder support for the innovation and ambition surrounding the contractual model, the desire for cultural change clearly is not enough to be converted to a successful outcome. With such a lot at stake, fears about replicating these mistakes may deter others from embarking on such complex partnership contracts and hinder progression with innovation.

Conclusions: Implications and reflections.

There is no doubt that implementation of a new type of contract model will be difficult. Despite this and on a more optimistic note, McGough (2014) explains that new approaches and innovation are possible through overarching contracts. He adds that there is not a one size fits all model for integration and different schemes such as in Torbay have adopted approaches which suited their specific circumstances. The integrated contracting model should be developed and refined to fit the parties' requirements and not the other way around. McGough and Addicott (2015) seem to be suggesting that individual 'bespoke' contracting methods such as has been developed in our study may have more success and applicability. This view is supported by the NHS Clinical Commissioners, who see CCGs becoming more strategic, with the emergence of a range of contracting models that grow from local initiatives rather than a centrally driven template approach (NHS Clinical Commissioners 2016).

But while debates around contracting methods take place, there is still the local imperative to move forward with transformation and improved care for those most in need. Some innovators are beginning to establish services such as 'primary care homes' (see the National Association of Primary Care at www.napc.co.uk/primary-care-homes), which navigate around local contract and organisational structures by creating a 'coalition of the willing' to do the right thing for patients. To make this happen they have established 'provider boards' with Memorandums of Understanding to govern how they work together (Steve Kell www.larwoodsurgery.co.uk). Our model in Kent is being tested by bringing together adult social care, enablement services, intermediate care and paramedic practitioners, to 'dummy run' the new contract alongside current contracts which will help identify any problems and challenges with application and adjust accordingly.

The local context would seem to be therefore an important starting place for contracts. Such organic developments may promote more meaningful ways of creating local incentives and joint outcomes to bring about the wholesale changes that seem to have eluded health and social care agencies for so long.

Declaration of Conflicting Interests

The Authors declare that there is no conflict of interest

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References

Addicott, R. (2014) "Commissioning and contracting for integrated care." London: The King's Fund, available at: http://www.kingsfund.org.uk/sites/files/kf/kings-fund-commissioning-contracting-integrated-care-nov14.pdf (accessed January 13th 2015).

Addicott, R. (2015) "Challenges of commissioning and contracting for integrated care in the National Health Service (NHS) in England." *Australian Journal of Primary Health* Vol. 22 No. 1, pp. 50-54.

Andersson, U., Blankenburg, H. & Johanson, M. (2005) "Opportunities, relational embeddedness and network structure." Chapter 1 in Ghauri, P., Hadjikhani, A. & Johanson, J. (eds) *Management Opportunity Development in Business Networks*, pp 27- 48. London: Palgrave Macmillan UK.

Augustine, M.S. & Cooper, C.D. (2009) "Getting the most from strategic partnering: A tale of two alliances." *Organisational Dynamics* Vol. 38 No. 1, pp. 37-51.

Better Care Fund, Policy Framework 2016/17: SCLGCP/ SCP/ Integrated Care Policy / 11120 available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf (accessed 5th April 2016)

Billings, J. & Leichsenring, K. (eds) (2005) *Integrating Health and Social Care Services for Older Persons.* Evidence from Nine European Countries. Public Policy and Social Welfare Vol. 31. Aldershot (UK): Ashgate.

Billings, J. (2005) "What do we mean by integrated care? A European interpretation." *Journal of Integrated Care* Vol. 13 No. 5, pp 13-20.

Billings, J., Carretero, S., Kagialaris, G., Mastroyiannakis, T. & Meriläinen-Porras, S. (2013) "The role of information technology in LTC for older people." Chapter 12 in Leichsenring, K., Billings, J. & Nies, H. *Long Term Care in Europe – Improving Policy and Practice* pp. 252-277. Basingstoke: Palgrave Macmillan.

Billings, J. & de Weger, E. (2015) "Contracting for integrated health and social care: a critical review of four models." *Journal of Integrated Care* Vol. 23 No. 3, pp. 153-173.

Black, N. (2006) "Consensus development method." Chapter 12 in Pope, C. & Mays, N. (eds) *Qualitative Research in Health Care* 3rd edition pp. 132-141. Oxford: Blackwell Publishing.

Bruner, R. & Spekman, R. (1998) "The Dark Side of Alliances: Lessons from Volvo-Renault." *European Management Journal*. Vol. 16 No. 2, pp. 136-150.

Corbett, J. & Kappagoda, M. (2013) "Doing Good and Doing Well: Corporate Social Responsibility in Post Obanacare America." *Journal of Law, Medicine & Ethics*. Vol. 41, pp. 17-21.

Corrigan, P. & Laitner, S. (2012) "The Accountable Lead Provider. Developing a powerful disruptive innovator to create integrated programmes of care." NHS RightCare Casebook series, available at: www.rightcare.nhs.uk/downloads/Rightcare_Casebook_accountable_

lead_provider_Aug2012.pdf (accessed 1 November 2016.

Corrigan, P. (2013) "Could GPs act as the accountable lead provider to rationalise contracting?" available at: www.insidecommissioning.co.uk/ (accessed January 9th 2014).

De Jong G., & Klein Woolthuis R.J.A. (2008) "Contract research and high tech alliances: Vistas for future studies." *Scandinavian Journal of Management*. Vol. 24, pp. 284-289.

Department of Health (DoH) (2012) Adult Social Care Outcomes Framework 2013-14, available at: http://www.hscic.gov.uk/article/3695/Adult-Social-Care-Outcomes-Framework-ASCOF (accessed 14th April 2016).

Department of Health (2012) NHS Outcomes Framework (2013/2014), available at: www.gov.uk/government/publications/nhsoutcomes-framework-2013-to-2014 (accessed 14 April 2016).

Department of Health (DoH) (2012) Public Health Outcomes Framework 2013-16, available at: https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency (accessed 14th April 2016).

Department of Health and Social Security (DHSS) (1972) "National Health Service reorganisation White Paper". The Stationary Office: London.

Gapp, R. & Merrilees, B. (2006) "Important factors to consider when using internal branding as a management strategy: a healthcare case study." *Journal of Brand Management* Vol 14 Nos.1/2, pp162-176. doi: 10.1057/palgrave.bm.2550058.

Goodwin, N., Dixon, A., Anderson, G. & Wodchis, W. (2014) *Providing integrated care for older people with complex needs. Lessons from seven international case studies.* London: the King's Fund.

Hudson, B. (2013) "Competition and Collaboration in the New NHS." Centre for Health and the Public Interest, available at: http://chpi.org.uk/wp-content/uploads/2012/06/report_28_June_2013.gif (accessed 6th April 2016).

Humphries, R. & Curry, N. (2011) "Integrating health and social care. What next?" London: The King's Fund, available at: http://www.kingsfund.org.uk/publications/integrating-health-and-social-care (accessed 14th November 2015).

Kale, P., Singh, H. & Perlmutte, H. (2000) "Learning and protection of proprietary assets in alliances." *Strategic Management Journal* Vol. 21, pp. 217–237.

Kerslake, A. (2006) "The purchasing process: an approach to outcome based commissioning and contracting." Chapter 9. *The Commissioning eBook*, available at: http://www.thinklocalactpersonal.org.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap9AKerslake.pdf (accessed 10th November 2015).

Kippen H & Reid RS (2014) "from providers to partners: what will it take?" Coalition of Care and Support Providers in Scotland: Edinburgh. Available at http://www.ccpscotland.org/wp-content/uploads/2014/12/FromProviderstoPartners.pdf (accessed 12th November 2016)

Leichsenring, K., Billings, J. & Nies, H. (2013) *Long Term Care in Europe – Improving Policy and Practice.* Basingstoke: Palgrave Macmillan.

lh alliances, available at: http://lhalliances.org.uk/ (accessed 2th November 2016).

Lin, H.M., Huang, H.C., Lin, C.P. & Hsu, W.C. (2011) "How to manage strategic alliances in OEM-based industrial clusters: Network embeddedness and formal governance mechanisms." *Industrial Marketing Management* Vol. 41, pp. 449-459.

Marshall, L., Charlesworth, A. & Hurst, J. (2014) "The NHS Payment System: evolving policy and emerging evidence." The Nuffield Trust, available at: www.nuffieldtrust.org.uk/publications/nhs-payment-system-policy (accessed 5th January 2015)

Mayer, K.J. & Treece, D.J. (2008) "Unpacking strategic alliances: The structure and purpose of alliance versus supplier relationships." *Journal of Economic Behaviour and Organisation*, Vol. 66, pp. 106-127.

McGough, R. (2014) "Contracting for integrated approaches to NHS healthcare services" available at: http://www.capsticks.com/assets/Uploads/COMM10.pdf (accessed 3rd March 2016).

McLellan, A. (2013) "Oxfordshire battle will determine the impact of CCGs." *Health Service Journal*, available at: http://www.lgcplus.com/opinion/health/more-on-health-and-social-care/oxfordshire-battle-will-determine-the-impact-of-ccgs/5066216.article (accessed 30th October 2014).

Miller, H.D. (2011) *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care*. Pittsburgh PA, Center for Healthcare Quality and Payment Reform.

Murphy, M.K., Black, N. & Lamping, D.L. (1998) "Consensus development methods and their use in clinical guideline development." *Health Technology Assessment* Vol. 2 No. 3, pp. 1-88.

Nahapiet, J. & Ghoshal, S. (1998) "Social capital, intellectual capital and the organizational advantage." *Academy of Management Review* Vol. 38 No. 2, pp. 242–266.

National Audit Office (NAO) (2016) "Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough. Department of Health, available at: https://www.nao.org.uk/wp-content/uploads/2016/07/The-collapse-of-the-UnitingCare-Partnership-contract-in-Cambridgeshire-and-Peterborough.pdf (accessed 20th October 2016)

NHS Clinical Commissioners (2016) "The future of commissioning" October 2016, available at www.nhscc.org (accessed 21st October 2016).

NHS (2014) "Five Year Forward View", available at: www.england.nhs.uk/wp-

content/uploads/2014/10/5yfv-web.pdf (accessed 11th November 2016)

National Institute for Health and Care Excellence (NICE) (2013) End of Life NICE Guidelines https://www.nice.org.uk/guidance/qs13 (accessed November 12th 2016).

NHS RightCare (2016), available at: www.rightcare.nhs.uk/ (accessed 14th April 2016).

Nöldeke, G. & Schmidt, K.M. (1995) "Option contracts and renegotiation: A solution to the hold-up problem." *Rand Journal of Economics* Vol. 26 No. 2, pp. 163–79.

O'Flynn, J., Dickinson, H., O'Sullivan, S., Gallet, W., Currie, K., Pettit, M., Pagan, A. & Robinson T. (2014) *The Prime Provider Model. An opportunity for better public service delivery?* Social Policy Working Paper no. 18. University of Melbourne and Brotherhood of St. Laurence Published Report.

Oliver, D., Foot, C. & Humphries, R. (2014) "Making our Health and Care systems fit for an ageing population." London: The King's Fund.

Oxfordshire Frail Elderly Outcomes Framework (2013), available at: http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2013/03/Outcome-Based-Commissioning-Phase-1-report.pdf (accessed 6th September 2016).

Paley, C. & Slasberg, C. (2007) "Implementing outcome-based commissioning." *Journal of Care Services Management* Vol. 1 No. 4, pp. 353-361.

Porter, M.E. (2012) "Value-Based Health Care Delivery." Presentation, Harvard Business School, 7 March, available at: www.hbs.edu./healthcare/Documents/2012%2003%2007%20SUT%20HCI%20presentation.pdf (accessed December 13th 2013).

Taunt, R., Allcock, C. & Lockwood, A. (2015) "Need to Nurture: outcomes-based commissioning in the NHS". The Health Foundation, available at http://www.health.org.uk/publication/need-nurture-outcomes-based-commissioning-nhs (acessed 21st October 2016)

Smith, D. (2014) "Reality check: how the Better Care Fund will work on the ground." *Health Service Journal* available at: http://www.hsj.co.uk/sectors/commissioning/-reality-check-how-the-better-care-fund-will-work-on-the-ground/5071513.fullarticle (accessed 7th April 2016).

Zoller, S.A. (1999) "Are You Satisfied with Your Technology Alliances?" *Research Technology Management* Vol. 42 No. 2, pp. 10-12.

Table 1: Outcomes Contracting Criteria

Outcomes Contracting Criteria	
Joint Outcomes	**Specifications to consider (outcome themes)**
Preventing people from dying prematurely	Reducing premature mortality from the major causes of death (NHS1; PH4) Improving recovery from injuries, trauma, stroke, fragility fractures (NHS3) People are protected as far as possible from avoidable harm, disease and injuries (ASC4A) People are supported to plan ahead and have the freedom to manage risks the way that they wish (ASC4A)
Enhancing quality of life	Enhancing quality of life for people with LTC (NHS2; PH4) Slowing the rate of progression of frailty and vulnerability (OxFEO) People are protected as far as possible from avoidable harm, disease and injuries (ASC4A) Enhancing quality of life for carers so that carers can balance their caring roles and maintain their desired quality of life (NHS2; ASC1)
Positive experience of care	Improving people's experience of seamless care in all settings (NHS4) People are discharged from hospital to their place of choice with relevant support in place (OxFEO) People who use social care and their carers are satisfied with their experiences of care and support services (ASC3) Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm (ASC4)
Maximum self-care and independence	Ensuring people feel supported to manage their condition (NHS2) People manage their own support as much as they wish, to be in control of what, how and when support is delivered to match their needs (ASC1) People know what choices are available to them locally and what they are entitled to, and who to contact when they need help (ASC3) When people develop care needs the support they receive takes place in the most appropriate setting and enables them to regain their independence (ASC2) Patients and their carers are informed, supported and have access to advice about their care, and are engaged in the planning of care, treatment and care plans (OxFEO) Helping older people to recover their independence after illness or injury
Peaceful death	Improving the experience of care for people at the end of their lives (NHS4)

Key: NHS = NHS Outcomes Framework 2013-14; PH=Public Health Outcomes Framework 2013-16; ASC=Adult Social Care Outcomes Framework 2013-14; EoLNICE=End of Life NICE guidelines 2013; OdFEO=Oxfordshire Frail Elderly Outcomes. Numbered references marked in () relate directly to the outcomes framework documents and their domain numbers.

Table 2: Partnership, Collaboration and Leadership Contracting Criteria

Partnership, Collaboration and Leadership Contracting Criteria	
Contracting Criteria	**Specifications to consider**
Shared purpose and vision	Establish common goals and objectives of what needs to be achieved Ensure a shared value-base and culture throughout the partnership, reflected through policies, procedures and guidance Ensure equality and diversity Expand strategic competencies Commitment to high quality outcomes and cost efficiencies
Shared benefits and risks	Pool assets, share knowledge and resources, understand risks Shared ownership of development and design within partnership Collective ownership of opportunities and responsibilities
Relational embeddedness	Contract must specify how partners should interact: Trust, openness, commitment, loyalty, honesty, transparency, co-operation, interdependency
Active partnership	Having a collective understanding of roles and identity Structural embeddedness based on ownership ties to support the employment of formal governance arrangements Establish formal governance, legal and accountability arrangements Have a plan for integrated commissioning service delivery and redesign aligned to goals Have a well-designed planning cycle and local framework where commissioning and delivery plans are reviewed Establish a mechanism for managers, staff and service users to contribute towards the planning cycle Acknowledge and utilise core strengths of partners Ensure innovation and expedite access to technologies Establish networks to share learning and promote best practice Foster a dynamic environment that responds to change Shared and clear decision-making and problem solving, with strong commitment to resolving issues without litigation Capitalise on cultural differences Have clarity and equality on levels of collaboration and partnership within a potential alliance of partners Evidence-based developments
Active communication	Clear lines of communication Target communication effectively

	Consistency of messages throughout the organisations **Have a common language**

Information sharing	**Universal access to relevant data between partners** **Establish robust electronic data capture mechanisms** **Establish governance procedures, and consistent pathways and processes for data sharing and interrogation**

Clear leadership	**Establish a leader with an advisory board that is not affiliated to one organisation** **Create clear leadership structure to take forward the shared purpose and vision** **Establish a leadership forum for leaders within the partnership**

Table 3:: Finance: Incentives and Risk Contracting Criteria

Finance: Incentives and Risk Contracting Criteria	
Contracting Criteria	**Specifications to consider**
Sharing of financial rewards	According to joint outcomes and key performance indicators Robust ways of measuring improvements and providing evidence
Sharing of risk and costs	Risk associated with complex untested situations Building safeguards and transparency Recourse to negotiation if high risk of losing money
Sharing of intellectual and physical resources	Sharing of knowledge and learning Sharing of intellectual property ownership as a principle Workforce and skills transfer Data-sharing and communication Developing effective systems to collect and interpret data
Branding as an integrated service	Harnessing shared values of partnerships especially trust Positive impact on reputation Publicity and dissemination of good practice
Local autonomy for developing services	Freedom to innovate and change service delivery Flexibility in how services are delivered and funded Agreed level of oversight
Pioneering innovation	Having an innovation process to support the workforce Access to academic support through local universities and the Academic Health Science Network Linking to local innovation platforms, eg Kent Innovation Pioneer Hub Having the right level of flexibility to encourage local innovation, and evidence to inform what works and doesn't work

Table 4: Legal Contracting Criteria

Legal Contracting Criteria	
Contracting Criteria	**Specifications to consider**
Flexible contracts	Aligning contract duration, value of contracts and access to contracts to the requirements of joint outcomes and policy changes Making provision for review rather than having end dates Alignment with relevant third party agencies
Contract currency	Making and incentivising contract currency conducive to joint outcomes Designing contract currency without inhibiting productivity
Legal environment	Creating conditions and stability to allow people to work unhindered across organisations (eg consideration of company law, NHS and LA statute, competition law, Official Journal of the EU and how they are interpreted) Creating conditions to promote investment
Policy and guidance framework	Ensuring they are working at a local level to support joint outcomes Managing conflict
Intellectual property	Clear declaration of where and when ownership and rewards can be shared Clarity around where and when sharing is not desired
Liability in partnerships	Having a balance of risk How partnerships are defined (eg industry not having any clinical responsibility) Clarity of responsibility regarding service termination Governance issues in relation to clinical issues, data sharing, safe-guarding Complaints management
Partnership governance	How relationships within the corporate partnership should work Having provider agreements (regarding for example money, responsibility) Having clarity of ownership around assets Having clarity around entering and exiting partnerships
Plain language	Having accessible contracts understood by all