

New care models

Emerging innovations
in governance and
organisational form

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Key messages

- Following publication of the *NHS five year forward view*, commissioners and providers at 23 vanguard sites are developing new, population-based models for local health services.
- Multispecialty community provider (MCP) and primary and acute care system (PACS) vanguards aim to bring together budgets and achieve closer integration of NHS services, in some cases also with social care.
- While the initial focus was on the new care models, commissioners in many of the vanguards are now considering how to contract for the new systems, including which streams of funding to bring together within a whole population budget and which services to commission within a single contract.
- There is considerable interest in bringing together the budgets for core primary care services with other services, but it seems unlikely that many GPs will contemplate giving up their core General Medical Services (GMS)/Personal Medical Services (PMS) contracts for new, unproven contractual arrangements in the immediate future.
- We spoke to a number of vanguards, many of whom would like to bring together the funding and contracting for local health and social care services, but only a small number of the vanguards we studied had made significant progress on this.
- While some of the vanguards are still using informal partnerships to take forward their plans, commissioners and providers in many areas are putting in place more formal governance arrangements – in some cases describing the new arrangements as integrated care organisations or accountable care organisations or systems.
- As they prepare to contract for the new models, many commissioners and providers are considering which entity or partnership should hold a whole population budget and the relationship it should have with other services in complex local systems.



- Few of the commissioners we spoke to were interested in engaging an ‘integrator’ organisation that would hold the population budget and co-ordinate the contributions of different providers but would not have managerial control of services or established relationships with providers.
- In the case of PACS, many commissioners are considering contracting with a local hospital trust, or a partnership between a hospital and other providers, to hold the population budget and manage the system. In the case of MCPs, commissioners are considering contracting with a ‘super-partnership’ or federation of GP practices. There is a trend towards broader partnerships of providers to oversee larger groups of services.
- In the case of MCPs, some commissioners are concerned that super-partnerships and federations may not be ready to take on responsibility for managing budgets covering a range of services going beyond core primary care on their own. This is leading to other options being considered for the lead provider role.
- Where they are planning to establish a partnership to lead the system, providers are considering what form this should take, including whether to establish a contractual joint venture or a corporate joint venture.
- At the most advanced vanguards, efforts are under way to explore how providers should work together within emerging partnerships (whatever organisational form they take), how to allocate funding and how to share risks and rewards.
- Commissioners and providers have usually worked in close partnerships during the initial phase, but in many cases, commissioners are now starting formal processes to procure the new services.
- Some consider it necessary to pursue a competitive procurement process to minimise the risk of legal challenge. However, few of the commissioners we spoke to saw benefits in using competitive processes for models that are built around established local services.
- There are particular concerns given the experience of the UnitingCare Partnership in Cambridgeshire and Peterborough, where commissioners went through a competitive tendering process, but where the successful bidder subsequently terminated the contract because of inadequate funding.



- As the UnitingCare example illustrates, commissioning and providing new care models involves major risks as well as significant opportunities. This underlines the importance of defining how these models are governed, the organisational form they take, how risks are shared, and how services are commissioned.
- Alongside work on governance and organisational form, the vanguards have demonstrated the importance of building collaborative relationships between the organisations and leaders involved in developing new care models and the time needed to demonstrate results. A focus on the relational as well as the technical elements of new care models is essential if they are to deliver on their early promise.



1 Introduction

The *NHS five year forward view*, published in October 2014, proposed two models for bringing together health services in local areas ([NHS England et al 2014](#)). Under the first model, the multispecialty community provider (MCP), groups of GP practices would come together to offer a broader range of services, including community and outpatient services. Over time, they might take responsibility for the health budget for their whole population. Under the second model, the primary and acute care system (PACS), a single entity would take responsibility for delivering the full range of primary, community, mental health and hospital services, to improve co-ordination and move care out of hospital.

In spring 2015, the national NHS bodies announced that they would provide support for commissioners and providers to develop these new care models. Fourteen local areas would receive support to develop MCPs and nine to develop PACS. The role of the national bodies would be to provide funding for the management of these projects, advise on technical issues and help overcome regulatory barriers. The ambition is for the 23 sites to develop models that can be rolled out at a faster pace across the NHS.

The two new care models seek to integrate services much more closely in a statutory framework designed in part to promote competition between organisations rather than collaboration within integrated systems of care. They are also being developed within a set of organisational arrangements that are more complex and fragmented than any in the history of the NHS, involving multiple commissioners and providers whose contracting relationships are regulated by the provisions of the Health and Social Care Act 2012. We have argued previously ([Ham and Murray 2015](#)) that legislative and policy changes are likely to be needed to remove barriers to the implementation of new care models – an argument reinforced by the evidence presented in this paper.

During the first 18 months of the support programme, most of the MCP and PACS vanguards have focused on building effective partnerships between organisations, developing their vision for how services need to change and testing new ways of



using resources and delivering care. They are also working on the governance and organisational changes needed to support the new systems. Providers are starting to put in place more formal governance systems and partnerships so that they can work together more effectively – in some cases aiming to create integrated care organisations or accountable care organisations.

Commissioners are considering how to contract for these new models of care and, in many cases, how to work with other commissioners in so doing. They are also reflecting on their role in the development of these new care models, including which activities they should continue to carry out and which might be better delivered by providers. As part of this, they are developing ways to measure the effectiveness of the new systems and incentives to encourage high performance; they are also considering using innovative and longer-term contracts.

Research and evaluation consistently emphasises the importance of organisational and system architecture in supporting high performance in health care and other sectors (Baker *et al* 2008). How the vanguards deal with these issues may turn out to be just as important as their current thinking on new care models – for example, in allowing groups of organisations to work together as effective learning systems.

This report takes stock of commissioners' and providers' emerging approaches to the contracting, governance and other organisational infrastructure of the PACS and MCP vanguards. It builds on the analysis and frameworks presented in an earlier report from The King's Fund, *Commissioning and contracting for integrated care* (Addicott 2014).

The report draws on published information and interviews with leaders of 12 of the vanguards. It focuses in particular on a small number including: Dudley, Sandwell and West Birmingham (Modality Partnership), Salford, Northumberland, and South Somerset (Symphony Project). The report gives a brief overview of the emerging models and a summary of the key themes arising from the interviews. The appendix provides short case studies on the five vanguards listed.

At this stage, it is only possible to provide an overview of commissioners' and providers' thinking on the architecture of their new systems. These arrangements are likely to evolve considerably in the medium term as organisations gain more experience of working together. It will take longer still to build a clear picture of how



effective different arrangements are in supporting strong, integrated local health systems. This paper should therefore be read as the first chapter in the still unfolding story of developing new care models – a story that will need to be updated and elaborated in the light of ongoing experience.



2 Emerging approaches in the MCP and PACS vanguards

There are similarities as well as differences in the approaches being taken by PACS and MCP vanguards. In most of the vanguards we spoke to, commissioners are planning to create a single budget to cover the health needs of their local population. New contracting arrangements are being developed to give providers responsibility for managing this budget and overseeing services, along with defined quality and outcome measures to be delivered. The intention is for commissioners to be able to hold providers to account for improving the overall health and wellbeing of their population within available resources. In turn, providers should have greater flexibility to decide how to use funds and reorganise services.

Providers are also using a similar set of approaches to design and deliver more integrated services. For example, all the vanguards we spoke to are consolidating primary care in larger groupings, often within neighbourhood clusters, so that they can deliver a broader range of services out of hospital and work more effectively with other parts of the system. They are all building closer partnerships between primary, community, mental health and social care services as a basis for changing how staff and resources are used. And they are all building partnerships between the primary and community system and local hospitals, as the following examples show.

- In Sandwell and West Birmingham, the Modality Partnership has brought together 15 GP practices within a single super-practice. It has established partnerships with other community services so that GPs can oversee an integrated set of primary and community services based in primary care centres.



- In Wakefield, federations of GP practices are working with community services to establish ‘connecting care hubs’ where groups of GP practices form a network with community nurses, therapists and social care staff to deliver joined-up community care (*see* box below).
- In Dudley, the clinical commissioning group (CCG) has started the procurement process to select a new single provider to hold a whole population budget and deliver the full range of primary and community services, thereby improving access, continuity of care and co-ordination.
- In Salford, commissioners have transferred a range of responsibilities to Salford Royal NHS Foundation Trust, which will play the lead role in overseeing an integrated care organisation that encompasses acute, community, mental health and social care services.
- In Northumberland, commissioners plan to create an accountable care organisation through which provider partners will work together to make best use of the health and care budget, reduce reliance on hospital care, and develop primary care and community services. Operational adult social care functions are already delegated to the foundation trust by the local authority.
- As part of the Symphony Programme, South Somerset’s PACS vanguard, Yeovil District Hospital NHS Foundation Trust, primary care in South Somerset and potentially other organisations are planning to work in partnership to oversee a single budget for the population. Aims are to shift resourcing and services into the community by developing enhanced primary care services and establishing integrated care hubs for people with long-term conditions.

While each vanguard is different, the changes to commissioning and the provider system are all designed to exploit opportunities for improvement in four broad areas, as follows.

- **Changing the type of intervention**
All of the vanguards are exploring opportunities to substitute between types of care to improve outcomes or reduce costs. For example, all are seeking to strengthen preventive services and introduce more proactive care for high-risk groups to avoid more disruptive and costly treatments. All are identifying people with higher levels of need to put in place more intensive support for them.



- **Changing who does what**
All of the vanguards are pursuing opportunities to change the roles of health and social care professionals in delivering aspects of people's care. For example, most are exploring how to make more effective use of GPs, nurses and other staff in community-based teams.
- **Changing where care is delivered**
All of the vanguards are seeking to move the delivery of significant numbers of services into more appropriate settings. In particular, all of the MCP and PACS projects aim to move services currently provided in hospitals to primary and community settings.
- **Improving co-ordination across related services**
All of the vanguards are seeking to improve how related primary, community, hospital and social care services work together. The aim is to ensure appropriate sequencing of interventions, to avoid duplication or delays, to manage patients' transitions between services, and to plan capacity across services.

In summary, we would describe the emerging models as a set of changes to payments and contracting and to the organisation of services to allow providers to exploit this new set of improvement opportunities. The defining feature of the MCP and PACS models is that they create more substantial opportunities for these types of innovation than could be pursued under the current, fragmented system. The work the vanguards are doing has been facilitated through support from NHS England and other arm's length bodies, as well as participation in learning networks with other sites that have adopted these models. They have also been learning from relevant experience in other countries that are further ahead in developing new care models.



Changing treatments, roles and locations in West Wakefield's MCP vanguard

In West Wakefield, a federation of six GP practices is working in partnership with other services to make better use of staff and resources, particularly by developing preventive services and delivering new services in the community.

The project team at this vanguard site has developed three hypotheses to guide thinking on how to transform services. The three hypotheses are: 50 per cent of the work done by GPs could be carried out more cost-effectively; 30 per cent of elderly people admitted to hospital acutely for a short stay of less than five days do not need to be admitted and could be cared for differently in an alternative setting; and 30 per cent of elderly patients occupying an acute hospital bed do not need to be there because their acute episode is over.

During the first 18 months, the vanguard created 'connecting care hubs', bringing together groups of GP practices with a team of community nurses, social care staff, therapists and voluntary organisations. These hubs deliver joined-up services for people most at risk of becoming ill, such as those with long-term conditions, complex health needs, or people who have been in hospital for an operation or emergency.

The vanguard has also brought pharmacists and physiotherapists into GP practices, allowing GPs to spend more time with people with more complex needs. It is developing pop-up primary care services offering health checks, wellbeing advice and assessments such as cardiovascular disease risk, diabetes screening, atrial fibrillation screening and cholesterol tests.

Finally, the vanguard is developing a care navigation service and training package, enabling existing staff to signpost patients to appropriate services including social prescribing pathways, preventive services, third sector services (such as walking groups), money and benefits advice, and activities to tackle social isolation.



3 Key choices when designing new systems

Vanguards are developing a range of new governance and organisational approaches to support their efforts to develop new models of integrated care. These approaches cover at least five areas (*see* Table 1).

- **Approaches to contracting for the new services**
Commissioners are deciding which budgets should be brought together and how they can be transferred to providers under a single contractual framework.
- **Partnerships and organisational forms among providers**
Vanguard sites are considering which providers should hold the budget for services and how they should be organised to deliver more integrated services. They are exploring a range of options, including sub-contractor relationships, joint ventures or mergers.
- **Governance, decision-making and management of providers' systems**
Providers are starting to consider the governance and decision-making arrangements needed to manage care and quality effectively – for example, how to ensure that each partner delivers their commitments, how to promote effective joint working, and how to motivate teams and individuals to work differently.
- **Roles of commissioners in the new system**
Commissioners are considering their future role in overseeing more integrated systems, including which activities they should continue to carry out and which to share with or transfer to providers.
- **Approaches to measuring and incentivising performance**
As part of the contracting process, commissioners and providers are agreeing objective measures to assess the quality and outcomes of care. They are also considering options for motivating and incentivising performance.



Table 1 Summary of approaches taken at six of the vanguard sites

	Salford	Northumberland	South Somerset
Scope of services in integrated system	Acute hospital, community health, mental health, social care within an integrated care organisation. Core primary care not included, but part of wider integrated system.	Acute hospital, community health, mental health, social care. Core primary care not included at present.	Acute hospital, community health, mental health, primary care. Core primary care not included at present. Social care may be included later.
Budgets and payments	No significant changes to current payments, including fee for service and block grants, although the intention is to move to a capitated model.	Plan to transfer a whole population budget to a host provider to manage within an alliance of partners.	Plan to transfer a whole population budget to a lead partnership.
Contracting process	Contract awarded following assessment of most capable provider.	CCG has published a prior information notice with intention of negotiating contract with a host provider foundation trust.	Currently evaluating procurement options.
Contract duration	Initial contract for 5 years, with scope to extend for a further 5 years.	10 years.	Likely to be 5 to 10 years with scope to extend.
Likely incentives	Salford Royal NHS Foundation Trust and partners likely to be able to invest savings from good performance.	Northumbria Healthcare NHS Foundation Trust and partners likely to be able to invest savings from good performance.	Possibility of some specific performance incentives or for providers to take some risk and reward.
Agreed or likely organisational structure	Salford Royal NHS Foundation Trust to provide acute, community and social services, and sub-contract for others. Currently working with commissioners and Salford Primary Care Together (GP provider body) to develop accountable care organisation model.	Northumbria Foundation Trust to hold budget on behalf of the accountable care organisation partnership, which will deliver acute, community and social services.	In South Somerset, Yeovil District Hospital NHS Foundation Trust, general practice and potentially other partners likely to establish joint venture company to hold budget and deliver or sub-contract services (subject to policy changes on VAT and other issues). Aim to move to county-wide structure over next 3 years.
Population size	230,000	322,000	135,000–500,000

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Table 1 Summary of approaches taken at six of the vanguard sites *continued*

	Dudley	Sandwell and West Birmingham	Wakefield
Scope of services in integrated system	Core and enhanced primary care services, community health, mental health, some outpatient services, some hospital-based urgent care services. Social care not included at present.	To be decided. May include most core acute, community and mental health services. Social care not likely to be included initially. GPs open to including core primary care if they are one of the lead providers.	To be decided. Envisaged to include non-core primary care, community health and some primary and secondary mental health services, some aspects of adult social and public health prevention services.
Budgets and payments	May transfer whole population budget to a single provider although other options are possible.	To be decided. May transfer large whole population budget to lead provider or providers.	Likely to transfer single whole population budget to a partnership.
Contracting process	Have started a competitive dialogue process.	To be decided. May be competitive dialogue or identification of only capable provider depending on scope of services and partnerships bidding.	To be decided. Likely to establish virtual managed care organisation through an alliance agreement in 2017–18, moving to an MCP contract in 2018. Commissioners are considering procurement options. They have not ruled out a restricted tender or competitive dialogue process.
Contract duration	Likely to be 15 years.	To be decided; possibly 10 to 15 years.	To be decided; possibly 10 years.
Likely incentives	Commissioners may make 10% of payments dependent on meeting targets. Unclear whether selected provider will seek to take profits.	To be decided. Super-practice would like to take risk and reward and take profits subject to cap and collar.	To be decided.
Agreed or likely organisational structure	A single company to hold budget and deliver services. It may need to sub-contract some services initially and sub-contract a small number of hospital services on a longer-term basis.	To be decided. GP super-partnership open to acting as lead provider or part of joint venture company with other providers.	To be decided. May be a joint venture of partners across the system, but it is too early to confirm this approach.
Population size	318,000	165,000	363,000



4 Contracting for the new systems

In many of the vanguards we spoke to, commissioners are preparing to enter more formal arrangements with their local providers to deliver new models of integrated care (indeed, a small number have already done so). They are considering which budgets to bring together, what changes are needed to supplement or replace existing contracts, and which contracting process to follow.

In its recent publications on the MCP and PACS models, NHS England describes three broad contracting approaches: a ‘virtual’ approach where commissioners do not pool budgets and bring services within a single contract, but where they establish ‘alliance arrangements’ with providers alongside existing contracts; a ‘partially integrated’ model where commissioners bring together budgets and re-procure a group of services (excluding core primary care) within a single contract; and a ‘fully integrated’ model, where commissioners bring together the budgets and re-procure a group of services (including core primary care) within a single contract (NHS England 2016b, 2016d). As discussed below, commissioners also need to make decisions on the scope of the new systems, for example whether to include public health, hospital services or social care.

‘Virtual’ partnership arrangements

At a few of the vanguard sites, commissioners are planning to rely on partnership arrangements between providers to support joint working. Under these ‘virtual’ arrangements commissioners and providers will agree a memorandum of understanding or contractual agreement that includes arrangements for shared governance, a shared vision, commitments to make better use of resources together, and agreements to integrate the delivery of services. These agreements would sit alongside rather than replace existing payment mechanisms, bilateral contracts and organisational structures. Commissioners might also vary existing contracts within the arrangement – for example, to align objectives and performance metrics, or commission additional services to support the new care models.



Interviewees at these vanguards saw this as a practical way of developing stronger partnership working without the need for complex changes to payments and contracts. However, the consensus was that these arrangements might offer a useful intermediate step (helping to build relationships across providers) but that commissioners would, at some point, need to make more fundamental changes to funding and contracts to ensure robust governance of budgets and services.

Pooling budgets and developing new contracts

In principle, many commissioners would like to pool the budgets and contract with a single provider or partnership to manage a range of services, including core primary care, enhanced primary care and community services. However, this depends on GPs being willing to join new partnerships or organisations (*see discussion on organisational forms below*). It also depends on whether General Medical Services (GMS) or Personal Medical Services (PMS) contracts are included within whole population budgets or aligned with these budgets.

In general, interviewees doubted whether GPs would be willing to give up their GMS or PMS contracts for new contracts covering a broader range of services. According to Dr Chris Jones, Programme Director for West Wakefield Health and Wellbeing, ‘There are some obvious attractions to bringing together funding for core primary care services, extended primary care and other community services in a single contract. But in practice there is going to be little appetite among GPs for giving up their GMS/PMS contracts for an unproven set of arrangements. So almost all of the MCPs are looking at an intermediate model, where GPs retain separate GMS/PMS contracts but are in parallel engaged closely in delivering a broader set of MCP services.’

Many commissioners can see the attraction of bringing together budgets and integrating health and social care services. However, only a small number – for example, Salford and Northumberland – have made substantial progress so far. In both cases, there are strong relationships between health and social care commissioners, built through joint working over many years. In Northumberland, for example, health and social care commissioners have worked on neighbouring sites since the 1970s; they began to develop joint commissioning approaches in the 1990s, and brought together health and social care services in a care trust from the 2000s, before being transferred to Northumbria Healthcare NHS Foundation Trust in 2011.



Even in cases where there is a history of strong joint working, health or care commissioners may have particular concerns that limit how closely they can bring together budgets and integrate services. In Salford, for example, city councillors want to continue to maintain relatively close oversight of how social care funds are used. This means that, for the moment, health and social care commissioners will continue to manage the health and care budget rather than transferring that responsibility to providers.

In other areas, local authorities and CCGs need to build stronger relationships and develop a clearer sense of their shared objectives before they can consider pooling resources or closer integration of services. There are also additional complexities in bringing together the budgets for health and social care services. According to Claire Parker, Chief Officer for Quality at Sandwell and West Birmingham CCG, ‘We absolutely want social care to be a key part of the new care model. But it will be even harder to add in another large budget and set of services in the initial phase, without detailed information about their quality and costs.’

In most of the PACS vanguards we spoke to, CCGs are planning to contract with a single provider or partnership to deliver a range of acute hospital and community services. Most of the MCPs initially planned to stop ‘at the hospital door’. However, some commissioners are considering whether they should extend the scope of MCPs so that providers are responsible for a more unified system, including accident and emergency (A&E) and urgent care services. In this way, the differences between PACS and MCPs are narrowing.

Contracting and procurement processes

All of the commissioning organisations planning to contract for their new care models intend to move from annual contracting to much longer-term contracts of at least five years and, in many cases, 10 to 15 years. This is to allow sufficient time for providers to invest in and reconfigure services. These arrangements may allow investors to make losses in initial years but recoup them when the contract becomes more profitable in later years. It is also argued that longer contracts will make it easier for commissioners to hold providers to account for health and wellbeing outcomes.

Commissioners are deciding on the appropriate procurement process – competitive tendering, competitive dialogue, or awarding the contract to a preferred provider.



As NHS England explains in *The multispecialty community provider (MCP) emerging care model and contract framework*, commissioners will need to complete a number of steps including consulting, deciding the scope of the new system, developing the service specification and publishing a prior information notice. Beyond that, commissioners have some flexibility to determine an appropriate process providing that it respects various procurement principles such as equality, transparency and proportionality (NHS England 2016b, 2016d). Commissioners must also respect the Public Contracts Regulations 2015 and the Procurement, Patient Choice and Competition Regulations made under Section 75 of the Health and Social Care Act 2012.

Commissioners report that they intend to follow a transparent process and minimise the risk of challenge. However, most we spoke to are sceptical of the benefits of pursuing competitive procurements. In practice, only a small number of established local providers – often in partnership – are in a position to lead the new systems. All of the vanguards bring together incumbent providers, such as primary care and hospital services, who cannot easily be replaced. Meanwhile, a competitive process could undermine the trust and relationships between providers that the vanguards have sought to develop. As Jack Sharp, Director of Strategy at Salford Royal NHS Foundation Trust, put it, ‘I am not sure you can competitively commission a very broad alliance of providers to work together with shared aims.’

There will be other challenges in using competitive procurements to secure complex systems, where the objective is to exploit a range of new opportunities for innovation and improvement. For example, it may be difficult to make an accurate assessment of current quality and costs or what improvements in quality or costs might realistically be delivered in future. It may also be difficult to develop contracts that cover all eventualities or to ensure that the winning provider assumes the full costs of failure.

Competitive procurements in these circumstances often favour the most optimistic bidders, those making the least accurate calculations, or those planning to renegotiate terms after the contract has been awarded. The experience of the UnitingCare contract in Cambridgeshire and Peterborough is a case in point (*see* box on pp 21–23). In other sectors, these difficulties often lead purchasers to build long-term strategic relationships with their supply chains based on trust and mutual dependency as an alternative to competition.



A number of the commissioners of the MCPs including Dudley and West Wakefield, are likely to hold a competitive dialogue process, where they discuss different options with a small number of bidders before choosing a solution (*see* box below). Commissioners in Somerset initially considered a non-competitive process to confirm their PACS but have now reverted to a ‘light touch’ procurement process in order to comply with the regulatory framework. Commissioners in Salford undertook an assessment of the range of organisational forms to create an integrated care organisation and the potential prime providers, with the contract awarded following an assessment of the most capable provider.

Assurance processes

NHS England, NHS Improvement and the Care Quality Commission (CQC) are currently developing a single process to test both the case for change in relation to proposed new care models and the capability of the successful bidder to hold the contract. It is likely that they will assess the plans at three separate stages: an initial assessment before the procurement process of the CCG’s case for change and their reasons for choosing the new model; an assessment during the procurement process to ensure that the proposed provider is capable of delivering the care model and that the contract has been devised appropriately; and an assessment before ‘go live’ to ensure that providers are ready to commence the service ([Dudley Clinical Commissioning Group 2016](#)).

Plans to commission Dudley’s MCP

In July 2016, Dudley CCG started a procurement process for an MCP to manage the budget and all of its primary and community services. It aims to award the contract in April 2017 and to establish the new provider system by April 2018.

It intends to commission a provider to manage a whole population budget and provide primary care services, out-of-hours and urgent care services, community physical health services, community mental health and learning disability services, some outpatient services, intermediate care services and end-of-life services. It will also hold the budget for reimbursing hospitals for some emergency care, including admissions from falls and care homes.

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Plans to commission Dudley's MCP *continued*

The CCG intends to contract with a single legal entity, not a partnership or alliance, to manage the budget. It also expects the provider to oversee the budget and deliver a large number of services itself, although it may need to sub-contract for some initially. The organisation will have the flexibility to manage the budget and reorganise services as it sees fit to deliver agreed population outcomes.

Commissioners wish to contract with the MCP to hold the budget for and oversee core primary care services, as well as other primary and community services, and to build the new community system around primary care. The CCG envisages that GPs will join the MCP as members to deliver a range of primary and community services.

The chosen process is a competitive dialogue, whereby the CCG will engage with a range of bidders before negotiating with a preferred provider. It remains to be seen whether there is more than one provider that will be able to make a credible bid, particularly given the ambition to build services closely around core primary care services.

The current plan is to enter into a 15-year contract, possibly stipulating that 10 per cent of payments are dependent on meeting outcomes targets. It is not yet clear whether commissioners will choose a public or private provider or what scope might be allowed for profit-making. Since commissioners announced their plans, Dudley Group NHS Foundation Trust has argued that they risk undermining the viability of acute hospital services.

Termination of the UnitingCare Partnership contract

In 2013, Cambridgeshire and Peterborough CCG launched a competitive tendering process for a new provider to hold the budget and deliver all community health care for adults, as well as emergency care and mental health services for older people. It would commission the provider to deliver a set of outcomes for improving health and wellbeing and create financial incentives to improve services, including modelling services around patients' needs, moving care into the community, and improving how services work together.

Commissioners received 60 expressions of interest and identified 10 consortia that met their requirements at the pre-qualification questionnaire stage. They then shortlisted three bidders – the UnitingCare Partnership, Virgin Care and Care UK – for more detailed discussions

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Termination of the UnitingCare Partnership contract *continued*

in a competitive dialogue. UnitingCare was a limited liability partnership formed by Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust; they planned to work together to manage the budget and sub-contract back to themselves and other providers to deliver the services.

According to a recent report on the collapse of the contract by the National Audit Office (NAO) and a review by NHS England, the bidders had reported significant challenges in pricing their bids accurately ([National Audit Office 2016](#); [NHS England 2016c](#)). It was difficult to determine the number of patients, the services provided, and the costs of services. UnitingCare assumed that the block grant commissioners currently use for community services was an accurate reflection of costs, although this turned out not to be the case.

All of the other providers decided to bid to deliver services for the commissioners' maximum contract price of £752 million. However, the UnitingCare Partnership made a tactical decision to submit a lower bid (of £726 million) in order to win the tender, despite the difficulties in assessing costs and increasing demand for the services. Cambridgeshire and Peterborough NHS Foundation Trust's business case later revealed that it believed it would subsequently be able to negotiate an increase of more than 20 per cent to the contract price to reflect higher costs.

One month into the contract, UnitingCare requested £34 million in additional funding for the first year to reflect higher demand and more limited scope to make rapid savings. It also found that there were significant additional VAT liabilities because NHS sub-contractors were no longer able to recover VAT on services delivered to the partnership. (We understand that the government is considering changes on VAT policy to address this.) In December 2015, the UnitingCare Partnership terminated the contract when commissioners informed it that no further additional funding was available.

On termination, the CCG resumed direct commissioning of the services in the contract, at much higher cost than the contract value. It and UnitingCare's two parent companies shared debts from the first year and termination costs of at least £16 million. Commissioners needed to share these costs because UnitingCare was a limited liability partnership without substantial resources, and because they had not sought guarantees from the two parent foundation trusts to cover losses or pay penalties in the event of termination. (As the NAO points out, the foundation trusts may not have agreed to the contract if they had been

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Termination of the UnitingCare Partnership contract *continued*

required to provide such guarantees.) There would also have been other substantial wasted costs – not least the transaction costs, for commissioners and providers, of a complex tendering process.

The commissioners have faced strong criticism for aspects of the procurement process. This risks overlooking the strengths of aspects of their approach, which aimed to support innovation and patient-centred care. Neither the NAO report nor NHS England's review questions the potential benefits of bringing together budgets, focusing on outcomes, or restructuring contracts and relationships between providers to optimise resource use across traditional boundaries.

However, the experience of Cambridgeshire and Peterborough highlights the limitations of competition as a mechanism for identifying the best provider and how difficult it is to get the right balance between risk and reward. This is particularly the case for complex groups of services over a long contracting period, where current costs and the scope for improvement are extremely difficult to estimate, and where terminating the contract would impose significant costs. The UnitingCare example highlights the dangers that the most over-confident bidder – typically the one with the least accurate calculations – wins the tender, or that bidders put in unrealistic bids in the belief that they will be able to renegotiate terms once they have won the contract.

Where commissioners pursue competitive processes, it is clear that they need to ensure, as far as possible, that the winning bidder assumes risk as well as reward, including through establishing penalties for contract termination and requiring parent company guarantees. However, we doubt that simple changes (such as ensuring that partnerships offer parent company guarantees) will address all of the challenges highlighted above. In this case, of course, they would have simply ensured that more of the losses sat on the books of public sector providers rather than of public sector commissioners, rather than reducing any losses on the overall public balance sheet.

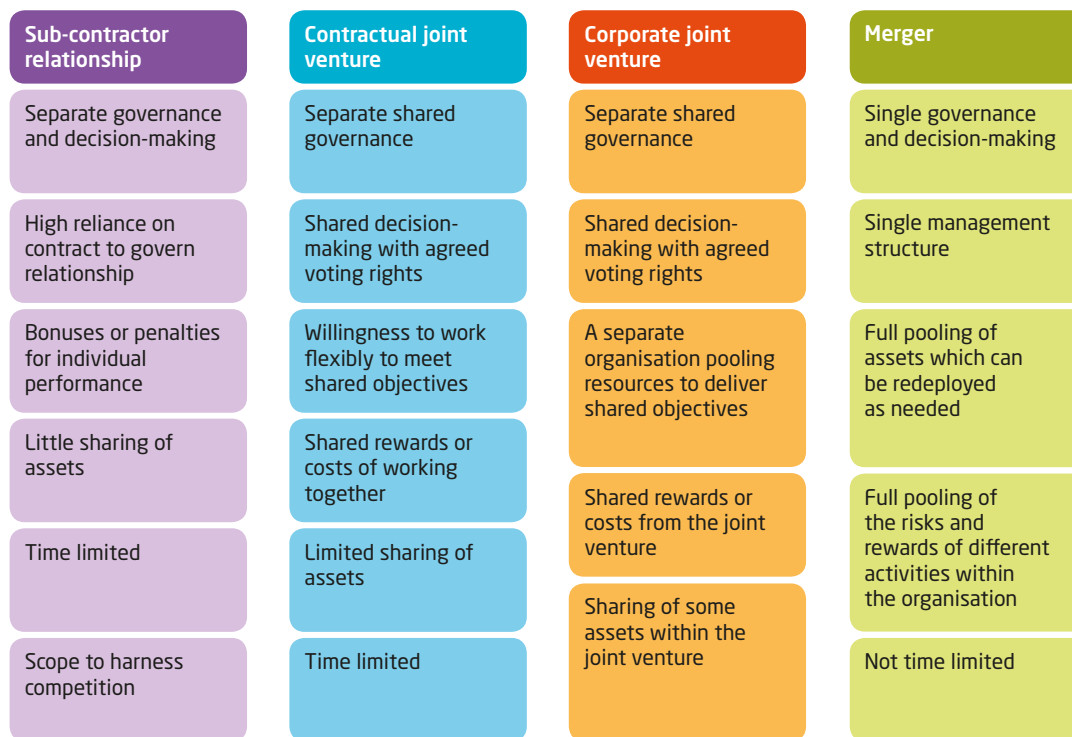


5 Partnerships and organisational forms in the new provider systems

Most vanguard sites we spoke to had initially used informal partnerships to manage their work, make decisions between organisations and implement changes to services. Interviewees argued that these informal arrangements had helped to establish common purpose and joint working.

Within the ‘virtual’ MCPs and PACS, commissioners and providers are planning to maintain, or build on, these partnership arrangements for the immediate future. However, as already discussed, most of the vanguards we spoke to are now developing arrangements to contract with a lead entity and bind providers together in a coherent system. As in other sectors, they might tie services together through sub-contracting relationships, contractual joint ventures, corporate joint ventures (including creating new limited companies or limited liability partnerships) or bringing groups of services together within a single organisation (*see* Figure 1 below).

Figure 1 Options for contractual or organisational forms



Source: The King's Fund

Each approach has advantages and disadvantages as a mechanism to support effective governance, partnership working and optimal use of resources in a complex system. According to the literature on various sectors, deeper forms of integration appear to offer numerous benefits, including: greater scope to build trust and common culture; reducing reliance on complex risk-share and gain-share arrangements and contractual terms; greater scope to easily reconfigure how staff and resources are used across boundaries; and greater resilience in the face of changing circumstances (Ghoshal and Moran 1996). However, they also require more substantial change. Many providers may be unwilling to contemplate the pooling of sovereignty and risk and reward that is entailed in closer forms of integration in the absence of the relationships and trust on which the sustainability of new organisational forms depends.



In practice, there is scope for overlap between these different models (depending, for example, on the detailed terms of contracts or joint venture agreements). Moreover, commissioners and providers are typically using a range of different contractual and structural arrangements to tie together their systems.

The 'lead' entity to hold the budget

At most of the vanguards studied, commissioners appear convinced of the benefits of transferring the budget and 'lead role' to a major incumbent provider or partnership of providers. Among the commissioners we talked to, there appears to be little appetite for handing the budget to an 'integrator' organisation that has specialist skills in co-ordinating groups of services but does not deliver any of the services or have established relationships with local providers. In relation to this, some observers were concerned that the vanguards might be underestimating the skills and capabilities needed to integrate and co-ordinate across complex groups of services.

In the PACS vanguards, many commissioners are thinking of contracting either with a local foundation trust or a partnership (between a foundation trust and other providers) to play the lead role. In Northumberland, the current plan is to ask Northumbria Healthcare NHS Foundation Trust to hold the budget, but to manage it in close partnership with primary care, mental health and other providers. In South Somerset, the original plan was to create a corporate joint venture between Yeovil District Hospital NHS Foundation Trust, primary care practices and potentially other partners to oversee the budget. However, commissioners and providers are considering other options, such as the foundation trust holding the budget, given concerns that channelling the budget through a limited company might create additional VAT liabilities. They will not make a final decision until the government has clarified policy on this.

As for the MCPs, the Forward View envisaged that larger groups of primary care providers could, in time, take responsibility for managing the health budget for their patients (NHS England *et al* 2014). However, as with some of the PACS vanguards, commissioners and providers in the MCP group are increasingly considering whether to establish broader partnerships to oversee the new systems effectively, particularly as they may need to cover a broader range of services (including



some hospital services). According to Naresh Rati, Executive Director at Modality Partnership, ‘If you control primary care, you can control a large proportion of spend in the system, since 90 per cent of touch points in the NHS are through GPs. So GPs need to be at the heart of an MCP to make it work. But we can’t do it alone. An MCP won’t be successful if we don’t bring community, mental health and hospital services along too.’

Following the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough, there is growing concern among commissioners about the risks of handing large, capitated budgets to small primary care organisations that do not have large balance sheets and might struggle to cope with even small losses. As Steven Foster, Director of System Transformation at Somerset CCG and Somerset County Council, put it, ‘The resilience of a GP-led start-up on its own could be insufficient given the demands made on the system resources.’

This may require GPs to partner with other organisations with greater financial resilience such as a foundation trust or private providers. In Sandwell and West Birmingham, Modality has entered a partnership with a private sector service company, Optum, which supports GPs and provider groups in delivering new care models, including through offering analytics, actuarial support, decision support for clinicians and support for contracting ([Optum 2016](#)). Some interviewees also saw strong benefits of partnerships with private providers such as Optum because they could offer capital investment to support transformation, particularly if the government is less able to provide this investment in future.

Organisational forms for the ‘lead’ entity

Where they are planning to establish a partnership to lead the new system, commissioners and providers will need to decide what form this should take – in particular, whether to establish a contractual joint venture or a corporate joint venture.

Under a contractual joint venture, the partners remain separate, but enter a set of contractual arrangements to work together, which define who will do what, how they will make decisions, and the risk and reward each partner will bear. These arrangements might take the form of an alliance contract, such as in Canterbury,



New Zealand, where providers agree contractually to work in close partnership on a particular set of issues and share the risks and rewards of doing so (Timmins and Ham 2013).

Under a corporate joint venture (sometimes described as a special purpose vehicle), the parties establish a new legal entity with its own board to oversee the company, staff, assets, and the ability to raise capital. The new legal entity could take the form of a limited liability partnership, limited company or community interest company. Unlike contractual joint ventures, the representatives of parent companies on the boards of corporate joint ventures have a duty to act in the best interests of the joint venture. This requires a greater pooling of authority. Also, unlike a contractual joint venture, the company itself – not the parent companies – holds the risk, although it has limited liability. The parent companies could, of course, give guarantees to cover liabilities in the event of insolvency.

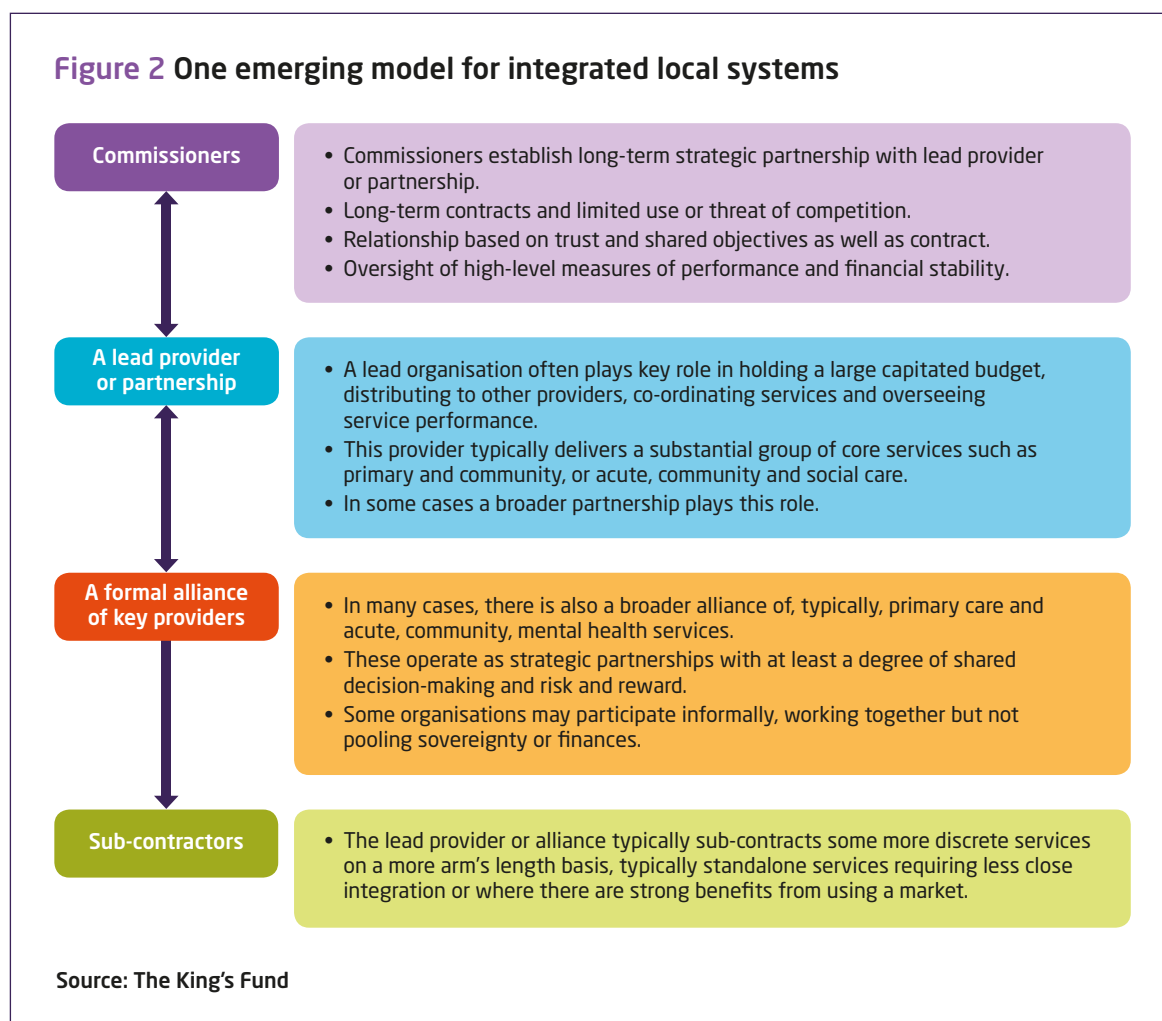
Robert Breedon, partner at Gowling WLG, says that it is possible to structure contractual joint ventures as well as corporate joint ventures in ways that pool more or less risk and reward between the partners and that achieve the desired level of delegated authority from the partners. Generally, however, the partners in a contractual joint venture typically retain greater authority and it is easier to return to the previous contracting arrangements. Conversely, there is typically a more significant transfer of sovereignty to a corporate joint venture, with less recourse back to parents, and it is harder for members to walk away.

From a commissioner's perspective, there may therefore be advantages in contracting with corporate joint ventures that establish a single entity, with pooled sovereignty, to oversee a budget and related services, providing its parent companies are able to guarantee its performance under the contract. On the other hand, commissioners might be concerned that partners would be unable to reach decisions or fall out and withdraw from a contractual joint venture. Conversely, groups of providers may prefer to establish contractual joint ventures precisely because they may require less radical changes to current arrangements and be easier to exit if needed. A final consideration (not covered in detail in this paper) is whether particular corporate forms increase VAT liabilities or change other tax liabilities.



Bringing other providers together

Only a small number of the vanguards have reached decisions on how to bring together the full range of providers in an integrated system. The most advanced are using a range of mechanisms to bring services together, as in other complex chains. It may be possible to point to broad similarities across some of the larger vanguards – for example, a strong lead provider, a degree of structural integration, alliance relationships between particular groups of providers, and sub-contracting relationships with others (see Figure 2 and box below).





Partnerships and organisational structures in Salford's integrated system

In Salford, commissioners and providers have established a new set of contracting arrangements and merged services to create an integrated care organisation that brings together hospital, community, mental health and social care services. The aim is to support prevention and person-centred care, as well as to shift care into the community and use staff and resources more effectively.

Under the new arrangements, Salford CCG and Salford City Council collectively oversee the budgets for core health services and adult social care services. However, they have established contracts with Salford Royal NHS Foundation Trust to deliver or contract for both sets of services as an integrated system.

Salford Royal acts as the 'prime provider' responsible for delivering all of Salford's core hospital services, community health services and adult social care services. This follows the transfer of community health services to Salford Royal in 2011 and the transfer by the city council of 450 adult social care staff to Salford Royal in 2016.

In addition, Salford Royal acts as the 'prime contractor' responsible for commissioning local non-specialist adult mental health services from Greater Manchester West Mental Health NHS Foundation Trust and procuring a range of residential, domiciliary and social care support services. The aim is to ensure that all these services work together as an integrated system.

Salford Royal and Greater Manchester West will work in a close alliance rather than an arm's length contracting relationship. The two foundation trusts have agreed to work collaboratively to secure improvements, to share risk and reward, and to ensure the financial viability of services. Commissioners have made clear that they wish to treat the services provided by both trusts as an integrated system, and it is not expected that Salford Royal will re-commission mental health services separately.

Salford Royal will maintain arm's length relationships with sub-contractors for other services such as residential care, domiciliary care and social care support services. For example, the commissioning and operating principles for the new system specifically allow the trust to pursue procurement processes, with the possibility that it chooses new providers for these services.

In October 2016, GPs established Salford Primary Care Together, bringing all of Salford's 46 separate practices into a single grouping. This will provide the basis for GPs to engage with the integrated care organisation.



Approaches to restructuring primary care

Commissioners and providers face specific challenges in restructuring primary care so that it can ‘speak with one voice’ in the leadership of the new systems and deliver a broader range of services. Across the MCPs and PACS, commissioners and providers are pursuing a range of strategies, including:

- running practices within a single organisation (eg, Symphony Healthcare Services in South Somerset), bringing together GPs in some practices as salaried employees to deliver core GMS or PMS along with additional primary and community services
- establishing super-partnerships (eg, Whitstable Medical Practice), where GPs join as partners – retaining their own GMS and PMS contracts – to deliver core primary care services along with additional primary and community services
- establishing limited liability partnerships (eg, PartnersHealth, in South Nottinghamshire), community interest companies (eg, Tower Hamlets GP Care Group) or private limited companies to deliver additional primary and community services
- creating federations that allow GPs to ‘speak with one voice’ in the new systems.

GPs are pursuing different approaches depending on local conditions. In some areas, a growing proportion are seeing advantages in becoming salaried employees within a foundation trust or super-practice, where the organisation will provide back-office services and manage recruitment. In others, there is less interest in giving up the autonomy of independent practice or ownership of estate.

In many of the vanguards we spoke to, commissioners and providers are developing alternative approaches that allow GPs to engage in different ways, depending on whether they are willing to give up their core GMS or PMS contract, what type of new primary care groupings they are willing to join, and what types of activities they are willing to take on. This is likely to lead to quite complex contracting arrangements in the new systems. It might mean that some GPs will be overseeing the overall budget, some will be managing a whole population budget for a range of core and additional primary and community services, and some will be working as sub-contractors either in a joint venture company or independently to offer additional services (*see box below*).



South Somerset's approach to engaging primary care in its integrated system

In Somerset, a range of strategies have been pursued to bring together primary care providers in larger groupings. The vanguard is also developing a menu of options for GPs to engage in the new integrated system.

In April 2016, Yeovil District Hospital NHS Foundation Trust established a subsidiary, Symphony Healthcare Services, to deliver core and additional primary care services. Independent GPs can become salaried employees with access to shared services, based in the hospital, including human resources, finance, IT and estates.

Three GP practices have joined the company to date. One of these practices also holds a contract for a walk-in centre. Interviewees suggested that other practices in South Somerset might join the company. There is also interest from practices in neighbouring areas. One of the main attractions was being able to work in a larger organisation that would manage staff shortages and recruitment.

Alongside this, all of the GP practices in Somerset have joined a limited company, Somerset Primary Healthcare, which acts as an umbrella organisation so that GPs can work with other parts of the health system to improve services.

Commissioners and providers within the South Somerset vanguard have been developing an approach whereby Yeovil District Hospital NHS Foundation Trust, primary care and potentially other partners would establish a limited liability partnership to manage a capitated budget and oversee the provider system. They foresee primary care providers wanting to engage with the partnership in one of three ways: joining the partnership as full risk-bearing partners; participating in the governance of the partnership but not bearing risk; or delivering services as sub-contractors.

Commissioners and providers would also need to decide the scope for profit-making within the new arrangements and what risk the partnership will bear. One option would be to transfer a whole population budget to the partnership, allowing it to retain a share of any savings from productivity improvements. The organisations within the partnership would need to decide how to share these savings depending on the level of risk each bears. It remains to be seen whether primary care will be able to take on significant risk in the partnership or whether it will rely on Yeovil District Hospital NHS Foundation Trust and/or other organisations to do this.

Finally, leaders in South Somerset are devising strategies to allow GPs to return to their previous arrangements if needed. GPs would be able to return to holding their separate GMS or PMS contracts if they desire to do so if Symphony Healthcare Services is sold or liquidated, or if the contract to deliver integrated services is transferred to a new supplier.



Many commissioners and providers took the view that these contractual and organisational relationships would evolve over a number of years. Current approaches were largely being driven by what providers were willing to contemplate at this stage; in future, they might be willing to consider closer integration as relationships developed or if they encountered difficulties working in looser partnerships.

We heard concerns about the complexity of some potential arrangements, particularly where providers are unwilling to consider closer integration. At some of the vanguard sites, providers would like to establish alliances to share the overall responsibility for managing the budget for the integrated system and sub-contract back to partners to deliver particular services. It is not yet clear whether these arrangements offer sufficient clarity of roles and accountability.



6 Governance and management of the new provider systems

Some of the vanguards are beginning to consider the governance and decision-making arrangements they will need to oversee and manage the new provider systems, including how to share risk and reward and manage performance. These discussions are at an early stage and, in most cases, depend on decisions on organisational form that have not yet been made.

Decision-making in the new care models

For ‘virtual’ models (for example, those not underpinned by contractual agreements or new organisational forms), organisations are putting in place stronger informal partnership arrangements, based on a memorandum of understanding or other agreement, to support decision-making and joint working. The governance structures and constitutions of participating organisations continue to have primacy over the new arrangements in these cases (*see* box on Mid-Nottinghamshire below).

Within models that depend on a more formal partnership to hold the budget and lead the system, commissioners and providers are considering how the partnership can operate as a unified entity and make effective decisions. Commissioners and providers will need to agree what rights each member has to influence decisions on particular issues. In Northumberland, leaders are considering numerous options: whether providers should have an equivalent voice; whether their voting rights should reflect their budgets or the populations they serve; or whether some organisations should have greater influence based on their ability to deliver key system objectives, such as shifting care into the community.



Where the lead provider is part of a contractual or corporate joint venture, the participants will need to agree voting rights, including the weight of each participant's votes and whether to make decisions on a majority or unanimous basis. Under contractual joint ventures, they will need to agree which issues the group decides collectively and which are reserved for individual participants. Under corporate joint ventures, they will need to determine which issues are referred back to shareholders. As far as we are aware, the vanguards have not considered these issues in great detail yet, since few have made firm decisions on the preferred organisational form.

Allocating funds and managing risk and reward

Partners will also need to decide how to allocate funds and manage risk and reward in an integrated system. At present, some are simply planning to divide the budget into smaller capitated budgets for providers in such a way that broadly reflects current spending, intending to modify this over time. They also envisage some specific mechanisms to compensate individual providers in the group for taking on significant additional activity. Some interviewees are concerned that the vanguards might recreate complicated payment systems (such as pay for performance or marginal rates) within the new arrangements.

In Northumberland, commissioners emphasised that providers in the partnership needed to work together to ensure their collective financial sustainability. According to Julie Ross, Chief Operating Officer at Northumberland CCG, 'As a health economy, we cannot afford for any of our providers to topple over. So it wouldn't be acceptable for the partnership to allocate funds in ways that destabilise a particular provider's cost base.' Other commissioners were also considering checks and balances to ensure that a prime provider or partnership could not take actions that would compromise another provider's financial position.

Interviewees agreed that, within the partnership models, providers would need to agree mutually acceptable mechanisms for sharing rewards from cost savings in ways that motivated staff while allocating funds as effectively as possible. For example, they might agree that the services responsible for achieving savings should capture at least a proportion of the benefits for reinvestment in their services. Similar agreements need to be made for sharing risks.



Addressing poor performance

Interviewees were considering what powers a lead provider or partnership would need to be able to intervene to address poor performance. One interviewee asked, ‘What will we do if we transfer an additional £15 million to a particular provider to take activity out of hospital, but they fail to do so?’ One option is for the lead provider or partnership to apply penalties; another is to replace the management team of a poorly performing service or to take the service in-house.

Lead provider models, and those which bring a substantial number of services together within a single organisation, make it easier to manage many of these challenges around effective decision-making or allocation of resources across services, because there would be a single non-executive and executive leadership responsible for making such decisions. There would be no need for complex arrangements for sharing benefits and costs if services were to sit within a single organisation with a single balance sheet.

Governance of Mid-Nottinghamshire’s virtual PACS

In Mid-Nottinghamshire, commissioners and providers are building on partnership arrangements to support closer joint working in the use of funds and service delivery, rather than making substantial changes to organisational arrangements at this stage.

Commissioners and providers have entered an alliance agreement that sets out governance arrangements for the partnership and its objectives. The contract also includes a commitment by all parties to move towards an outcomes-based capitated budget covering the vast majority of services for the population.

They have established an alliance board, with an independent chair and chief executive-level members, to oversee the use of health and social care funds and identify opportunities to integrate services. Full members can vote on decisions and share the risks and rewards from joint activities. Associate members, including primary care providers, Circle Partnership, and the voluntary sector, can participate in board discussions. In addition, executive directors sit on an operational board to oversee work on payment systems, care models and public engagement.

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Governance of Mid-Nottinghamshire's virtual PACS *continued*

Commissioners and providers have agreed a scheme of delegation setting out which decisions should be made by the board and which should be referred back to their members' governing bodies. The CCGs still carry out the population health needs assessments and make procurement decisions. They work in collaboration with providers on how best to use resources and configure services.

The members have committed that, providing proposals are tabled in advance, they will put forward representatives who can make decisions on issues delegated to the alliance board in board meetings. Commissioners have also established a citizens' board whose role is to provide public oversight and advise the alliance board on proposals for integrating services.

Commissioners have established a new contract with members of the alliance detailing which services they should work together to deliver in an integrated fashion. They have also aligned the performance metrics in contracts with those of individual providers so that they are all working towards the same targets.

Commissioners and providers agreed that these arrangements were the best way of supporting service improvement in the short term. Commissioners envisage more substantial changes to budgets and contracting arrangements in the longer term as the group builds experience of working together.

Governance and decision-making in Salford's integrated care organisation

Salford is one of only a small number of vanguards to have developed detailed accountability and governance arrangements for its new integrated systems. These include new commissioner and provider boards, new arrangements for commissioners to hold the provider system to account, a scheme of delegation for decisions, and a risk-sharing agreement between commissioners and Salford Royal NHS Foundation Trust.

In July 2016, Salford City Council and Salford CCG established a new 'integrated adult health and care commissioning joint committee', comprising six councillors and six GPs from the CCG's governing body. Oversight of both the combined budget and commissioning plan for adult health and social care services and of strategic planning for the use of the pooled budget for health and social care services for adults has been delegated to the committee. It will agree significant changes to specifications and how services are delivered.

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Governance and decision-making in Salford's integrated care organisation *continued*

Alongside this committee, the two commissioners will sit with Salford Royal NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust and GPs on an advisory board on the use of health and social care resources. It will discuss strategies for integrating adult health and social care services and for designing and improving services.

Under the new arrangements, the two commissioners, through the joint committee, will hold Salford Royal to account for the performance of its provider system. Salford Royal will be responsible for co-ordination and for sub-contracting with and overseeing the performance of mental health, residential and domiciliary services. Commissioners will participate in Salford Royal's contract monitoring meetings with sub-contractors and agree some operational decisions in the first year.

Salford CCG will cover any deficits in that first year, aiming to recoup any losses in the second year. If there are deficits for more than three years, commissioners will review options for the system. The commissioners and Salford Royal are committed to working together to manage risks and ensure sustainability of the system.



7 Roles of commissioners in more integrated systems

As commissioners contract (or prepare to contract) for the new systems, many are introducing a clearer separation between commissioners and providers. For example, commissioners are establishing separate boards to focus on budgeting, contracting and system oversight, while providers are continuing to work together on operational issues. At the same time, commissioners are considering what role they should play in overseeing more integrated local systems and which activities previously carried out by CCGs or commissioning support units should transfer to providers.

Many interviewees considered that commissioners should play a more strategic role in planning and overseeing the new systems. For most, this included assessing the health needs of the population, setting appropriate objectives for the provider system, overseeing performance, and holding the provider system to account for its overall use of resources. Commissioners would also continue to maintain high-level responsibility for overseeing payments, contracting and system architecture.

In some of the vanguards, commissioners intended to continue to oversee some decisions on resource allocation within the provider system. However, in most of those we spoke to, commissioners were planning, at least in the longer term, to transfer whole population budgets to providers, who would then be responsible for allocating them across services in order to improve outcomes.

Some commissioners are considering whether to retain oversight of particular operational decisions within the provider system – for example, whether to be able to veto decisions that might undermine the cost base and viability of a provider, or decisions by a lead provider to stop sub-contracting particular services and bring them in-house.



Most commissioners we spoke to envisaged transferring a number of operational activities currently delivered within CCGs or by commissioning support units to the provider system, particularly those related to contracting and overseeing individual services, as well as aligning and co-ordinating services. In Somerset, for example, commissioners envisage creating a ‘managed services organisation’ that will sit within the PACS and act as the ‘engine room’ of the accountable care organisation. It will provide data analytics, carry out some clinical case management, oversee the performance of individual services, act as a system integrator, and ensure that services and care models are being delivered as planned.

Commissioners are also considering structural changes to reflect their new roles. In a number of areas, such as Northumberland (*see* box on page 41), CCGs and local authorities are considering closer integration of their commissioning teams so that they can oversee an integrated health and social care provider system more effectively. In many cases, commissioners will be left with small teams – in part because they will transfer some staff into the provider system. Commissioners in Fylde and Erewash, for example, are considering whether to merge with neighbouring commissioners to operate more effectively. In other vanguards, such as at Sandwell and West Birmingham, commissioners are considering whether they should separate into smaller groups, each overseeing the integrated system for a local area.



Strategic commissioning in Northumberland

In Northumberland, health and social care commissioners are planning to develop a more strategic approach to commissioning. Under the new governance arrangements, the health and wellbeing board will continue to oversee public health and social care commissioning and the wider system. Meanwhile, the CCG board will continue to oversee and make final decisions on health funding and will monitor system performance.

A new joint commissioning unit will support both these boards and oversee the accountable care organisation, which is likely to be a partnership between Northumbria Healthcare NHS Foundation Trust (the acute, community and adult social care provider), Northumberland, Tyne and Wear NHS Foundation Trust (a mental health provider) and general practice. The unit is expected to maximise opportunities for joint planning across public health, health and social care, and to make best use of much smaller commissioning teams.

Under the proposals, commissioners will focus on a narrow range of more strategic issues. These include: setting the high-level outcomes it expects the accountable care organisation to achieve; allocating funding to the accountable care organisation and to a small number of separate services; monitoring outcomes and performance, and intervening where there are significant concerns about performance; overseeing public engagement; and, in some cases, making final decisions on major service change.

Meanwhile, commissioners envisage transferring almost all of the annual £400 million budget for core services to the accountable care organisation, which will be a partnership of its acute, mental health, community services and primary care providers. Northumbria Healthcare is likely to formally hold the contract for managing the health budget. However, the intention is for the other providers to work in partnership to manage the budget and manage risks.

Finally, the CCG intends to transfer staff to the provider system to carry out a range of more tactical activities, including developing the contracts and overseeing the performance of individual services.



8 Setting objectives, and measuring and incentivising performance

Across the vanguards, commissioners and providers are establishing common objectives and new ways to measure performance. All are attempting to overcome the disincentives in current payment mechanisms for services to work together towards shared goals. Some commissioners are also considering new financial rewards (or penalties) to motivate performance.

Across the vanguards, commissioners and providers see the need to develop clearer statements of their shared objectives for the new integrated systems. Some interviewees pointed out that this was, in itself, a significant step forward from current arrangements, whereby groups of services focus on different and sometimes contradictory objectives. In Northumberland, for example, an immediate objective for the provider system is to ensure financial stability; reducing reliance on hospital services and moving care into the community is a medium-term objective, while the longer-term objective is to demonstrate improvements in a range of population health outcomes.

Measuring system outcomes

Commissioners are working with providers and the public to establish a set of measures of their systems' performance in delivering these objectives, focusing on overall measures of value and service users' priorities. Commissioners are generally developing between 15 and 20 overall outcome measures covering population health, patient involvement and experience, clinical effectiveness, access, fairness and equity (*see* box on page 46 for Mid-Nottinghamshire's approach). NHS England has also published a set of 'core metrics' for monitoring the impact of the PACS and MCPs ([NHS England 2016a](#)).



There were differences of view on whether these high-level outcome frameworks could be relied on to provide an accurate picture of system performance. As well as outcome measures, commissioners were developing a set of secondary process measures such as number of patients being treated in community settings or delayed transfers of care. According to Steven Foster, Director of System Transformation at Somerset CCG and Somerset County Council, ‘These indicators should at least give us some assurance that the oil tanker is starting to turn before the outcome measures become more visible.’

New financial incentives

As well as setting new objectives, all the vanguards recognise the need – at least in the longer term – to make substantial changes to payment systems to align providers’ financial incentives to work together to deliver agreed outcomes. As Julie Ross, Chief Operating Officer at Northumberland CCG, explained, ‘We have a set of payment mechanisms that pitch providers against each other. The hospital is paid for activity. Primary care and community services receive block contracts, so they cannot expect additional funding if they treat more people. No part of the system benefits financially if it keeps more people out of hospital. Our system is based on an out-of-hospital model – the money needs to flow accordingly.’

Commissioners are considering two related issues in redesigning payments and incentives. First, they typically want to transfer a set of risks from commissioners to providers. Most importantly, they want providers to bear responsibility for operational risks that they have control over, such as whether they reduce hospital admissions or avoid delayed discharges. They may enter arrangements that allow providers to reinvest savings in services or to take a share of savings in profits.

Second, they need to decide the strength and nature of the incentives for providers to manage those risks more effectively. For example, they can transfer upside risk only, so that providers share the benefits from improving how they run services and reducing costs. Or they can transfer upside and downside risk, so that providers either share the benefits from making improvements or share any additional costs.

In some vanguards, the immediate plan is to align incentives under the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN). This is to encourage providers in the new system to develop closer



partnerships and start working towards common outcomes, while leaving existing fee-for-service and block grant payments intact. For example, commissioners in Mid-Nottinghamshire have established new CQUIN targets, encouraging providers to work more closely to deliver diabetes prevention and reduce A&E attendance and hospital admissions. This means that providers need to work together to secure around 1.8 per cent of their annual income. However, misaligned payment systems remain in place.

Under these types of arrangements, there is little change to where risk sits in the system. Commissioners still bear operational risks that might better sit with providers – for example, the costs of avoidable hospital admissions. As in some payment schemes in the US health care system, providers receive an upside payment if they make improvements such as reducing admissions, but they do not receive a downside penalty if they allow admissions to rise.

Commissioners in most of the vanguards we spoke to want to go further in the longer term. In particular, as already noted, most commissioners wish to transfer a whole population budget to providers for a broad group of services. This would sweep away current, misaligned payment systems rather than merely seeking to mitigate their impact. It would ensure that providers assume a much broader range of operational risks and potentially other risks that currently sit with commissioners. It would also generally mean that providers assume upside and downside risk, sharing the benefits if they do well and sharing the consequences if they do badly.

One emerging approach within the PACS may be for commissioners to hand a large population-level budget over to a lead public sector provider or partnership of public sector and not-for-profit providers to manage as effectively as possible.

Under these arrangements, many commissioners increasingly see little benefit in withholding a small proportion of the budget for payment if particular targets are not met. According to Jeremy Martin, Director of South Somerset's Symphony Project, 'We originally thought that commissioners should retain a chunk of the funding to use as an incentive. We are now increasingly thinking that "the pot should be the pot". Commissioners could hand the full budget over to providers. Their incentive to improve is to be able to invest the savings.'



Similarly, commissioners in Northumbria see the outcomes framework as a basis for conversations with providers on overall performance rather than a basis for making incentive payments.

An alternative approach being considered in some of the MCP vanguards is for commissioners to hand a whole population budget over to a lead independent provider, such as a partnership involving primary care. As noted above, this means that the partnership would assume a broader range of operational risks and would typically take on upside and downside risks. However, the incentives are likely to be much stronger than for public providers, since the provider will seek to take profits and will bear losses directly. (The Modality Partnership in Sandwell and West Birmingham would like to pursue this type of model, partnering with a private company, Optum, to support it in doing so.)

Commissioners recognised that it would be much more technically difficult to design an effective scheme for these circumstances. For example, commissioners and providers would need to have much more accurate information on current quality and costs. Commissioners would need to monitor performance more carefully to ensure that the provider did not reduce costs by reducing access or quality. It would be particularly important to ensure that the provider bears the full risks of failure.

Commissioners and providers would also need to agree the appropriate balance of risk and reward, probably in the absence of a competitive process. In Sandwell and West Birmingham, Modality recognised that it would need to agree a cap and collar arrangement where it might extract profits from improving services up to a certain threshold, and reinvest profits beyond that threshold in services, and where it would also share losses beyond a certain threshold with commissioners. The challenge will be in deciding where those thresholds should be set.

Interviewees also recognised that there might be challenges in bringing together public and private sector providers within a single alliance to manage a capitated budget, where one group would reinvest profits in services and the other would wish to extract profits for shareholders.

Whatever the balance of different types of incentives set at the system level, interviewees recognised that, in time, they would also need to develop strategies



to translate the high-level system objectives into aligned objectives for individual providers, services, teams and individuals. For example, they might break down the high-level outcome measures for the integrated system into measures that reflect the contributions of individual service lines. A small number of the vanguards were also considering how best to motivate individuals and teams within the new systems.

Mid-Nottinghamshire's outcomes framework

In Mid-Nottinghamshire, commissioners have developed a single outcomes framework to measure improvements in the wellbeing of the population and in system performance. The framework aims to enable providers to work together to deliver a set of common goals and use resources more effectively. It should encourage innovation in how providers deliver services, since it focuses effort on improving outcomes rather than inputs or processes.

Commissioners developed the framework in a working group bringing together representatives of the local authority, local doctors, and Healthwatch. They also carried out engagement activities involving 400 people across Mid-Nottinghamshire. They have focused on developing a set of outcome measures that reflect what is important to service users and how services can help them meet their personal goals.

The framework includes four domains: measures of population health such as premature mortality; overall quality of life (including independence and management of conditions); quality of care (including patients' experience of care); and the effectiveness of care, including immediate and longer-term recovery.

The framework includes indicators to allow commissioners to monitor system performance, in particular: to monitor shifts in activity from hospital to the community; to identify areas where activity is decreasing, and allow commissioners to challenge providers if they are restricting access to care; and to measure financial sustainability. It also includes indicators to allow commissioners to monitor how providers are transforming care, such as the proportion of patients with up-to-date care plans or levels of social prescribing as an alternative to medical care. The aim is to avoid setting measures that will overly constrain how providers deliver care.

Commissioners are now aligning contracts with the framework. They are working with providers to agree a baseline of performance and trajectories for improvement, so that they can establish financial incentives linked to the outcome measures.



9 Conclusion

The evidence presented in this paper shows that the new care models programme has generated innovations in how health and social care services are commissioned, provided and delivered. A common thread is the development of more integrated models of care, led by hospitals in some cases and GPs in others. There is a growing focus on integrated care organisations and accountable care organisations and systems, both within the programme and in other areas, as commissioners and providers seek to transform care to better meet the needs of an ageing population.

Developments in England mirror experience in other countries, where integrated care is also receiving greater attention. Previous work by The King's Fund has described examples from the United States, Canada, Europe, Australia and New Zealand ([Timmins and Ham 2013](#); [Curry and Ham 2010](#)), as well as relevant experience in other parts of the UK ([Ham et al 2013](#)). This work illustrates the many different forms that integrated care can take, ranging from organisations that fund and provide the full range of care to alliances and networks of providers that deliver care under contracts with insurers or commissioners.

This body of previous work also shows the benefits for patients and populations when fragmented systems of care are brought together in integrated care and accountable care organisations. It demonstrates that successful models are those based on trusting relationships and collaborative organisational cultures, often developed over time, which enable clinical teams as well as organisational leaders to work together effectively. These models are underpinned by various organisational forms and governance structures; there is little evidence to suggest that one particular form is superior to others.

Parallels can be found between the experience of managed care in the United States in the 1990s and current developments in England. Research by Robinson has tracked how managed care led to many different forms of integrated care organisations emerging, based on two main variants: ownership of the full range of care delivery in some cases; network arrangements using contracts in others. He and co-authors have described these main variants as vertical integration and virtual integration



respectively, recognising the many different manifestations of each (Robinson 1999; Robinson and Casalino 1996).

Robinson's research draws attention to the strengths and weaknesses of vertical and virtual integration both in theory and in practice. He also notes the role of hybrids, as when vertically integrated systems like Kaiser Permanente contract with independent providers for the provision of some services, or where network models combine elements of ownership and contractual relationships. Based on our work on integrated care and accountable care organisations and systems, and to echo an earlier point, we would add that the performance of different types of organisation is strongly influenced by softer factors such as relationships, cultures and leadership, as well as by the form they take ([Shortell et al 2015](#)).

An important implication is that the effort going into developing new organisational forms in England needs to be matched by work on these softer factors. This is happening in many of the PACS and MCPs through work to build closer links between primary care and secondary care and between health and social care. It is also evident in work to support organisational leaders to come together to provide system leadership of new care models that cut across organisational and service boundaries. The challenge now is how to build clinical collaboration and system leadership in a statutory context which, as we argued at the beginning of this paper, was not designed with these purposes in mind.

As this challenge begins to be addressed, we would reiterate the need to establish robust forms of governance – clinical and organisational – within the new care models to ensure effective stewardship of public resources, and to cater for occasions when relationships may go wrong. On a more positive note, in some of the quite complex partnerships that are emerging, well-designed governance structures may make it easier to nurture the relationships on which collaboration over the longer term depends. Put simply, a focus on the relational as well as the technical elements of new care models is essential if they are to deliver on their early promise.

The partnerships that are developing within these models also need time to mature and move beyond the focus on organisational accountability and competition, which have been the guiding principles of recent NHS reforms. With the NHS facing unprecedented financial and operational pressures, there is a clear and present danger that work to transform care of the kind under way in the new care models



will take second place at best to efforts to eliminate deficits and meet performance targets. National leaders need to hold their nerve in this context and recognise that innovations in care on the scale described here will likely take three to five years to become established and demonstrate measurable improvements in care.

Much the same applies to the sustainability and transformation plans (STPs) being developed in 44 areas of England, which will only succeed if partner organisations are willing to work in collaboration in planning how services and budgets should be used, and are given time to do so. Work on new care models needs to be aligned with work on STPs as the focus on collaboration and systems gathers momentum. This is beginning to happen in some areas, with STPs being used to extend the scope of new care models where their ambitions support the transformations in care outlined in emerging plans (Oxford 2016). More concerted efforts are now needed to embed new care models within STPs.

Our account of work under way in terms of the emerging organisational forms and governance structures at the vanguard sites we spoke to demonstrates the progress made to date and the extent of unfinished business. It shows, in the time-honoured phrase, that building new care models is a marathon not a sprint, and illustrates some of the choices available to commissioners and providers. These choices have implications for commissioners and providers alike in terms of payment systems, how services are contracted, and the outcomes used to hold providers to account. This work will often be challenging for smaller commissioners, underlining arguments we have advanced elsewhere for strategic commissioning that brings together scarce expertise and involves local authorities as well as NHS commissioners where appropriate (Ham and Alderwick 2015).

There are implications too for rules on procurement and how these are being used in an environment that feels quite different from, and much more challenging than, the context in which they were created. At most of the vanguard sites we studied, commissioners are taking a pragmatic approach in recognition that incumbent providers are usually best placed to lead the development of integrated care and accountable care organisations. Despite this, there is a risk that they will be challenged by other providers for not going through competitive tendering processes. National regulators have sought to clarify how procurement rules should be applied in practice, but there remains uncertainty about what is and is not permissible in the current context.



At the outset of this paper, we argued that it should be read as the first chapter in the evolving story of how new care models are developing – a story that will be revisited in future work. For now, it is clear that what may have appeared a relatively simple task of putting in place new care models is resulting in substantial changes to both the anatomy and physiology of health and, in some cases, social care. Unlike in previous ‘reorganisations’, these changes are being driven from the bottom up rather than the top down. The process of discovery that is unfolding feels much more dynamic and empowering than nationally mandated reforms of the kind that accompanied the Health and Social Care Act 2012, for example.

However, it is also likely that the service and organisational innovations under way will reveal obstacles that only national bodies and, in some cases perhaps, parliament, can remove. This underlines arguments in our previous work ([Ham and Murray 2015](#)) for close alignment between the statutory and policy context and the changes the Forward View is seeking to bring about. Although, at the time of writing, there appears little appetite for changes to legislation affecting the NHS, some changes may be both inevitable and desirable to enable leaders at a local level to build on the foundations they have laid.



Appendix: Innovations at the vanguards studied

Developing an integrated care organisation in Salford

In September 2014, Salford City Council, Salford CCG, Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust established an alliance to work in partnership to deliver health and social care for older people. This included establishing an alliance board of commissioners and providers to oversee a pooled budget of £112 million and oversee changes in how care was delivered.

Over the past two years, commissioners and providers have expanded on these arrangements to bring together the funding and service delivery for all health and care for adults within an integrated care organisation. The aim is to develop a focus on population health and to extend integrated services from older people to wider sections of the population. Since March 2015, the Salford alliance has been pursuing these plans as one of the NHS primary and acute care system (PACS) vanguards.

In July 2016, local leaders disbanded the alliance board and established a new joint commissioning board, comprising city councillors and GPs from the CCG's governing body, to oversee a larger pooled budget of £236 million for all adult health and care services (excluding specialised services). While this group oversees the budget and services, the CCG administers the pooled budget, with a joint commissioning team comprising CCG and council staff. Commissioners and providers sit on an advisory board to discuss use of resources and changes to services.

Under the new arrangements, the city council and CCG contract direct with Salford Royal to deliver a range of adult health and care services. In mid-2016, the council transferred its 450 social care staff to Salford Royal to undertake assessments and contract for the provision of adult social care support. This means that Salford Royal will deliver a large proportion of the services, including acute care, community health care and some social care services in-house.



Salford Royal is the accountable body for all the services in the integrated care organisation, whether delivering services itself or sub-contracting them. It holds the contract with Greater Manchester West to deliver mental health services. It will carry out the adult social care assessment function and deliver a large proportion of intermediate care services, while sub-contracting with independent providers for most domiciliary and residential care services.

Salford Royal has created a new division, Salford Division of Health and Social Care, to oversee the services provided by the integrated care organisation. It is also continuing to oversee changes to integrate services, such as establishing new neighbourhood-based health and social care teams.

The funding for the Salford integrated care organisation is held in a pooled budget jointly administered by the CCG and council. Overspends and underspends will be managed within the pool and efficiencies realised will be used to offset the expected provider growth and demand pressures. Any net underspend will be re-invested in services. Governance meetings are in place and attended by CCG, council and provider management, ensuring performance and financial risks are promptly identified, with action plans developed collaboratively, as required.

Eighteen legal documents underpin the new arrangements, including a Section 75 agreement delegating functions from the city council to Salford Royal; a new service contract with Salford Royal; sub-contracts; agreements on pensions; commissioning and operational principles; a scheme of delegation for decision-making; and a risk-share agreement.

An immediate priority for the integrated care organisation is to engage primary care more fully in its work. GPs are already part of new multidisciplinary community groups and are engaged in the leadership of the new system, although not part of the integrated care organisation itself. In October, GPs brought Salford's 46 separate practices into a new grouping, Salford Primary Care Together. This should provide a basis for GPs to engage with the integrated care organisation and to jointly integrate care and services. It is likely that commissioners and providers will want to revisit the governance arrangements for integrated care in time, so that the new primary care organisation can play an active leadership role.



Northumberland's accountable care organisation

Commissioners and providers in Northumberland have a long history of partnership working. For example, the county council and the then health authority pooled some budgets, created integrated teams and worked on joint strategies for community services in the 1990s. A care trust was set up in 2002, with most of the council's adult social care functions delegated to it. Since 2011 operational functions have been delegated to Northumbria Foundation Trust, while the council and the CCG have worked closely together as commissioners, with arrangements including delegation of NHS Continuing Health Care commissioning to the council.

The two commissioners started working with Northumbria Healthcare and other partners to develop these arrangements with the aim of establishing an accountable care organisation that would oversee the full range of health and care services for adults. The initial objectives were to address current deficits and ensure financial sustainability, with medium-term objectives around reconfiguring services and moving care out of hospitals. Longer-term objectives were to deliver improvements in population health outcomes.

System leaders explained that they were pursuing a number of key phases in establishing the model. The first was to reconfigure hospital services, in particular through opening a new emergency care hospital and separating the delivery of urgent and elective care on different sites; the second was to consolidate primary care and develop primary and community services to provide care out of hospital; the third and final phase was to make the necessary changes to budgets, incentives and the provider system necessary to operate an accountable care organisation.

Under the new arrangements, the CCG will transfer its funding for most core NHS services to an accountable care organisation, which will operate as a partnership between Northumbria Foundation Trust; Northumberland, Tyne and Wear NHS Foundation Trust; the mental health provider, and other providers. Northumbria Foundation Trust will hold the formal contract, but it will be managed through a type of partnership arrangement with the other providers. The delegation of the council's operational adult social care functions to Northumbria Foundation Trust will continue.

The accountable care organisation will make all 'tactical' decisions about the deployment of health resources, effectively taking over many of the detailed tasks currently carried out by the CCG. A 'strategic' commissioning function will remain



outside the accountable care organisation. This will be supported by a joint strategic commissioning unit hosted by the council and reporting to the statutory CCG board on NHS commissioning and to the council on social care commissioning. Funding for partnership arrangements between the CCG and the council, such as the integrated commissioning of Continuing Health Care commissioning, is expected to remain outside the contract for the accountable care organisation.

Northumbria Healthcare and the other providers will establish a board to oversee the accountable care organisation. As a condition for joining, providers will need to agree to the move to capitation and to work together to move care into the community. They will also need to agree how to share funds, including any savings or overspends.

Alongside these changes, local leaders are pursuing strategies to consolidate primary care so that it can play a stronger role. Primary care leaders in the county are debating which of five organisational form options could most effectively serve to support their role in the accountable care organisation from April 2017 and will conclude these deliberations later this year.

The intention is to bring these groupings together as a single entity to participate on the accountable care organisation board. The main motivation for GPs is to be able to influence strategic direction. There are no immediate plans to include core primary care in the accountable care organisation's pooled budget.

Commissioners envisage that the health and wellbeing board will continue to oversee the overall priorities and outcomes of health and social care commissioning. The CCG board will continue to oversee and make final decisions on the contract with the accountable care organisation and to monitor system performance.

Commissioners are in the process of developing an outcomes framework as a basis for monitoring and incentivising performance within the new system (rather than using financial incentives).

Finally, commissioners plan to establish a small joint commissioning unit within the council to make best use of commissioning resources, while transferring tasks such as contracting with and overseeing individual services to Northumbria Healthcare.



South Somerset's Symphony Project

In 2012, Yeovil District Hospital NHS Foundation Trust started to build stronger partnerships with local primary care providers to support practices and improve joint working between GPs and hospital services. It expanded the partnership to include commissioners and the council as well as community and mental health services. In 2015, it established a first 'Symphony care hub' with care co-ordinators and multidisciplinary teams for people with three or more long-term conditions. It also established an enhanced primary care model that sees additional roles, in particular health coaches, introduced into practice teams.

In 2015, commissioners and providers gained vanguard funding to develop the model. Commissioners are planning to contract with a single provider or partnership to hold a single budget for the population and deliver a range of primary care, community health, mental health and hospital services. The intention is to move over time to cover almost the entire health and care budget.

In South Somerset, commissioners and providers envisage that Yeovil District Hospital, primary care, and potentially other providers will establish a corporate joint venture to hold the budget and deliver services. However, they are currently exploring whether this would create additional VAT liabilities and other issues. An alternative may be for a foundation trust to hold the budget and act as a lead provider, working in partnership with primary care providers. Commissioners are working on similar approaches for the rest of the county with the aim of establishing a county-wide accountable care organisation by 2019.

Interviewees envisaged that providers might enter the joint venture on different terms – some as full partners sharing risk and reward, some with a gain-share agreement and some as consultative partners. This would allow a broad range of providers to share in decision-making, even if they were unable to invest or bear risk. The intention is that the lead entity will sub-contract with other organisations, including the parent companies, to deliver different services in the new system. This means they will not need to transfer staff and services into the joint venture.

At the same time, primary, community and hospital providers have continued to re-organise services. This has included introducing new primary care services and developing three new 'Complex care hubs' for people with complex needs.



Yeovil District Hospital has played a lead role in bringing together primary care practitioners so that they can participate in the new system. In April 2016, it established a subsidiary, Symphony Healthcare Services, to enable primary care practices to integrate into a larger organisation. GPs can now become salaried employees with access to shared services. All the GP practices in Somerset have also joined a limited company, Somerset Primary Healthcare, as a basis for working with other providers to improve the system.

Somerset CCG has launched a process to enable one or more provider entities across Somerset to hold a budget and oversee the system. It envisages entering a 5- to 10-year, outcomes-based contract.

The original intention was to include social care funding within the contract. However, the current plan is to consider how best to bring social care services into the new system at a later phase.

Finally, the CCG envisages restructuring its services so that it can play a more strategic role in overseeing the system. It expects a 'managed services organisation' will sit within the accountable care organisation and act as its 'engine room'.

The Modality Partnership in Sandwell and West Birmingham

In 2009, the partners from two GP practices in West Birmingham merged to create Modality Partnership. Since then, the partnership has expanded to become one of England's largest super-practices. It offers primary care services at 15 practices in Sandwell and Birmingham for a population of 70,000. Its initial objectives were to address variability in the quality of primary care services and achieve other benefits of operating at scale. It has developed a range of extended primary care services including urology, dermatology, rheumatology and x-rays.

Modality has established a partnership board with Birmingham Community Healthcare NHS Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust to oversee the project. The CCG and city council originally participated in the board, but withdrew so that providers could lead development of the new care model.



Modality's ambition is to use general practice as the foundation for a new community-based health and care system, with primary care providing a single point of access into a broader range of integrated community, mental health and social care services. Its projects focus on moving care into the community and reducing A&E attendance and unplanned hospital admissions.

The project currently includes four workstreams:

- developing extended primary care services, including multidisciplinary teams, for people with complex needs
- putting in place case-management services for groups with the highest need who need more intensive support
- a rolling programme to bring specialist services, including cardiology, respiratory, musculoskeletal, gynaecology and pain management clinics, out of the hospital into the community
- more effective joint working with the hospital system, including to avoid unnecessary A&E attendance and improve discharge planning.

Sandwell and West Birmingham CCG is now considering how it should commission the new model, including which range of budgets and services to bring together into a single contract. It is considering whether to commission a small number of providers to deliver integrated services within three or four local areas, and whether to include some hospital services.

Modality is willing to consider a pooled budget for core primary care services as well as extended primary and community services, providing that it is lead provider and has responsibility for managing the budget. Both the CCG and Modality see advantages in integrating health and social care, but they also see challenges in attempting to pool health and care budgets in the initial phase.

Modality and other local providers are considering how they might come together to manage the budget and deliver services. Modality is open either to establishing a corporate joint venture with other providers or acting as the lead provider and sub-contracting to others to deliver services. It has established a partnership with the US health services company, Optum, which provides health analytics, actuarial support, data tools, decision-support tools, and other services.



Dudley CCG's MCP project

Since 2015, Dudley CCG has led work with local providers and other stakeholders to develop a new model for integrated primary, community and mental health services. It is currently commissioning the new service, with the aim of selecting a provider in April 2017 and establishing the new system by April 2018.

Under the plans, a single provider will hold the budget for and manage a broad range of primary and community services, including core primary care, out-of-hours and urgent-care centre services, community physical health services, community mental health and learning disability services, some outpatient services, intermediate care and end-of-life care. It will also hold the budget for some hospital-based emergency services so that it has an incentive to reduce usage.

Commissioners envisage that the new model should improve access to care, continuity of care and care co-ordination. It should improve the population's health status, improve access to urgent care, ensure joined-up care for patients with long-term conditions, and provide more proactive care for patients with the most complex needs.

Commissioners have specified a number of features of the new model. For example, the new provider must put in place a new urgent care centre, specialist triage service, community hubs, a single patient portal, community-based consultants for people with long-term conditions, and extensive services for people who are frail or reaching the end of life. However, the intention is also that the organisation will have the flexibility to manage the budget and re-organise services to deliver agreed outcomes.

Commissioners want to ensure close integration between existing primary care services and other community services in the new system. They have specified that general practice should take overall responsibility for the care provided by other services, including multidisciplinary teams and other community services. They envisage that individual practices will join the MCP and take on an 'MCP contract', which will replace their GMS or PMS contracts. The MCP will hold a single population budget for all patients registered at those practices.



Commissioners intend to contract with a single legal entity rather than a partnership, which will both manage the budget and deliver the services, although some may need to be sub-contracted initially.

Commissioners plan to hold a competitive dialogue before entering a 15-year contract. The CCG will hold the contract with and be responsible for overseeing the provider. However, the MCP will also report to Dudley Metropolitan Borough Council's health and wellbeing board on progress in improving population health.

The plan is not to include adult social services within the contract. However, the CCG and the council have agreed to develop a plan for integrating health and care services by 2020. The council might, in time, use a Section 75 agreement to second social care staff into the MCP.



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Vanguard sites participating in the new care models programme are developing governance arrangements and partnerships to support integrated systems. Some are building on existing informal partnerships, but others are opting for more formal arrangements. Do some arrangements work better than others? And can efforts to strengthen collaboration succeed in a statutory context not designed to support those goals?

New care models: emerging innovations in governance and organisational form looks at how some of the multispecialty community provider (MCP) and primary and acute care system (PACS) vanguards are approaching contracting, provider partnerships, governance and monitoring performance.

The report finds that:

- many of the sites would like to bring together the budgets for core primary care services and other local services, but it seems unlikely that GPs will give up their core General Medical Services or Personal Medical Services contracts in the immediate future
- many of the sites would like to bring together the budgets and contracting for some health and social care services, but only a small number have made substantial progress in incorporating social care
- many commissioners plan to contract with a single provider or entity to hold the budget and oversee or deliver a broad range of services, although most are still deciding which organisation or partnership should do this
- commissioning and developing new care models involves risks as well as opportunities, underlining the importance of how these models are governed, their organisational form and how risks are shared
- building and strengthening collaborative relationships is just as important as focusing on the technical elements of integrated care.

These new models will take up to five years to show measurable improvements in care, so national leaders need to hold their nerve. They must also ensure that the work under way to transform care does not take second place to eliminating deficits and meeting performance targets.

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