Contracting for integrated approaches to NHS healthcare services

This article explores how the integrated health and social care services might be structured.

What do we mean by integration?

The Health and Social Care Act 2012 sets out an explicit focus on delivering integrated care in the NHS. There are now new duties upon many NHS organisations to encourage integrated working (including Monitor, NHS England and Health and Wellbeing Boards). For example, Monitor has a duty to consider how it can enable integrated care where this improves the quality (outcomes or efficiency of services) which is now flowed through into requirements in the provider licence. However, before we can address the issue of integration we need to be clear as to what we actually mean when we talk about integration in the NHS.

Integration or integrated care can have a variety of meanings (including introducing cost savings/economies of scale, closer working giving grounds to justify decisions to not compete various services or structural reform of a health economy) in different circumstances. A recommendation from the NHS Future Forum was to break through the various different definitions of integration (the King’s Fund counted 175 different definitions of integration) and NHS England commissioned National Voices to define a framework definition for ‘integration’ This is a good place to start and is based on the term “patient-centered coordinated care”.

The Department of Health is giving support to more coordinated health and social care through developing new “pioneer” integrator areas around the country – on the basis of innovative, practical approaches which they believe can achieve change as quickly as possible. These “pioneer” areas are expected to share and promote their integration experiences and ideas.

What are the forums for developing integration plans?

The intent is that local areas should be working together more effectively by utilising the existing structures like Health and Wellbeing Boards to bring together local authorities, NHS bodies, social care providers, education, housing services, public health and others in order to join up the approach to local services.

Primarily though, how local authorities, NHS England and CCGs tackle their different priorities in working together will be critical in any large scale development of integrated care. CCGs have already been asked to set aside a proportion of their non-recurrent expenditure to support integrated care and to work more closely with local authorities through the Better Care Fund.

How do we contract for these new approaches?

New approaches and innovation are possible through NHS contractual forms utilising routes such as prime contractor or overarching contracts. However, successfully introducing integration will also require the combination of commissioning alignment, effective use of contracting terms, developing an appropriate service specification and contract management.

Once the parties have considered the form of integration that they are seeking then they will need to assess the current contracts under which relevant services are provided. This should involve a review of opportunities to vary or where necessary break existing arrangements and any procurement and competition implications. There should also be consideration at an early stage of how any proposed integration might impact upon the duty to involve the public and/or consult with local authorities.

Whilst the current NHS regulatory and contracting model may not always readily lend itself to a simple integrated approach this is not to say that it is not possible to develop it across services.

For example, commissioners could look to adopt single contract approach with a prime contractor (or pathway integrator) though the choice of the form of contract could be complicated if there is a combination of service areas such as primary care and community services. This is due to a combination of factors, firstly the NHS Standard Contract is not currently designed to be compliant with the primary care regulations and directions which govern primary care contracts and therefore would need adaptation (additional terms incorporated) to become compliant with the APMS form of contract. There is then the risk of a conflict emerging between the additional APMS terms and the core mandatory standard contract terms.
Where you are dealing with primary care, these services (in general terms with limited exceptions) come under the APMS, PMS or GMS forms of contracts which are based on regulations/directions and are therefore restrictive in their form or terms (especially for GMS and PMS).

Another alternate approach to a single contract model, the NHS Overarching Contract, is already up and operating in respect of prison healthcare services. This has been achieved first by procuring all of the services with separate contracts entered into with the respective providers. The Overarching Contract then sits above all of the commissioned services contracts. All providers and the commissioner are parties to the Overarching Contract, which sets out how the services will operate in terms of integration, including, for example, making all payments through the co-ordinating provider, receiving one set of monitoring and reporting information, and requiring providers to produce an integrated service delivery plan.

This Overarching Contract could also include some elements of alliance contracting principles (which have been widely promoted to the NHS) but an Alliance Contract itself is not currently permissible under the NHS Standard Contract as it does not facilitate an alliance of providers under the one contract.

**How should the payment structure work for integrated care services?**

One of the fundamental challenges is how the financial reward is structured for integrated care. The issue arises in terms of how the budgets for developing integrated systems are tied up in primary care, hospitals and local authorities with multiple controls and how they can be unlocked.

The effective pooling of funds across commissioner organisations is likely to be a necessary step in delivering integrated care at any scale and certainly in delivering any wider outcome based objectives. There are already steps being taken to bring the health and social care budgets closer together through the Better Care Fund and greater involvement of local authorities and Health and Wellbeing Boards. The main contractual route to setting up pooled budgets between NHS bodies and local authorities remains the Section 75 Agreement. There are also steps to allow CCGs to take on the commissioning responsibility for primary care from NHSE which could also assist in aligning budgets and commissioning.

In terms of how this integrated budget is then delivered to the providers in a new integrated model, there is the potential local flexibility for the parties to agree to move to different and innovative financial models which depart from activity based payment structures (PBR Tariff or non-Tariff) and more towards alternatives such as the results/outcomes or “year of care” based models of remuneration.

**Conclusion**

There is evidence that new approaches and innovation are possible through existing NHS contractual forms (or overarching contracts) but the contract form is a defining point for a better integrated service. The integrated service will depend on the combination of commissioning alignment, effective use of contracting terms, developing an appropriate service specification, and payment structure and ongoing contract management.

There is not a one size fits all model for integration and different schemes (such as Torbay and the Oldham MSK) have adopted approaches which suited their specific circumstances. The integrated contracting model should be developed and refined to fit the parties’ requirements and not the other way around.

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