NHS Standard Contract Guidance to Template Alliance Agreement

Version number:  Draft 1

First issued:  August 2015

Updated:  NA

Prepared by:  NHS Standard Contract Team
  nhscb.contractshelp@nhs.net

Classification:  Official

Publications Gateway Reference:  NA as draft document
Contents

Contents ................................................................................................................................................. 3
1 Executive summary ......................................................................................................................... 4
2 Alliance contracting ....................................................................................................................... 5
3 How alliance contracting can work with the NHS Standard Contract ....................................... 6
4 Using the template Alliance Agreement ....................................................................................... 8
5 Frequently asked questions .......................................................................................................... 10
1 Executive summary

Implementing the new models of care envisaged under the NHS Five Year Forward View will require innovating approaches to contracting for healthcare services, integrating primary and secondary care (and possibly also social care) to secure the best long-term outcomes for patients.

For two of the key new models of care, Multi-Specialty Community Providers (MCP) and Primary and Acute Care Systems (PACS), a lead provider approach is expected to become the norm, with a single provider entity (perhaps formed through a corporate joint venture between several existing providers, for instance) taking full contractual responsibility for the delivery of a range of integrated services for a specific population.

NHS England is aware, however, that there is also interest from NHS commissioners and providers in alliance contracting approaches, whether in the context of these new models of care or more generally. With this guidance, we are therefore publishing a model alliance agreement – as a starting point for further development within local health communities, where there is interest in taking forward alliance approaches in specific circumstances.

In some instances an alliance approach may be a useful stepping stone in the journey from informal integration to full organisational integration.

Alliance contracting means different things to different people, and different approaches to alliance contracting sit more or less comfortably in the context of NHS commissioning.

The alliance agreement we have developed is not a replacement for individual commissioning contracts between commissioners and providers; rather, our agreement aims to complement existing commissioning contracts, binding together a set of commissioners and providers, and their respective commissioning contracts, so that they work collaboratively to deliver shared objectives, with joint decision-making processes and shared risk and reward mechanisms.

1.4 This Guidance note and the associated template Alliance Agreement are intended for use by Commissioners considering the use of alliance contracting. The template Alliance Agreement is intended to be used alongside the NHS Standard Contract and, where appropriate, relevant primary care commissioning contracts.

1.5 This note sets out an introduction to alliance contracting before considering how the template Alliance Agreement can be used alongside the NHS Standard Contract. It concludes with some guidance on how to use/complete the template Alliance Agreement itself, as well as dealing with some frequently asked questions.
2 Alliance contracting

2.1 Alliance contracting involves an arrangement whereby a number of parties enter into an agreement to work cooperatively and to share risks and rewards. Performance is measured against a common set of performance indicators: these are usually pre-agreed outcomes-based indicators.

2.2 Commissioners and providers work together as a single "integrated" team in order to deliver a specific integrated service or project under a contractual framework that seeks to align their financial interests with the achievement of the agreed aims and objectives of the integrated service or project.

2.3 Alliance contracting aims to offer a more collaborative and collegiate approach than traditional contracting: it seeks to create cooperation between providers and commissioners with a mutual obligation (and incentive) to act in a way that is 'best for service/project' and not necessarily best for individual organisations.

2.4 An alliance contract seeks to create this collaborative environment without the need for new forms or structures. By having a single alliance contract, the intention is that all parties work to the same outcomes and are committed to the same success measures. There is a strong sense of 'your problem is my problem, your success is my success'.

Features of alliance contracts

2.5 Alliance contracts are typically characterised by a number of key features:\footnote{For further information on the features of alliance contracts see ‘Guide to Alliance Contracting' published by the Australian Government Department of Infrastructure and Transport July 2011.}

These are:

- risk and opportunity sharing
- a commitment to 'no disputes'
- a best-for-service, unanimous decision making processes
- a culture of 'no fault – no blame'
- a commitment to act in good faith
- transparency between parties including open book principles and reporting
- a joint management structure.

2.6 Some of these key features are explored in more detail at section 5 below.

2.7 These key features should operate in a coordinated way so as to ensure that the parties exercise common behaviours and pursue common goals to deliver the desired outcomes. It is this combination of features that makes alliance contracting different to more traditional arrangements where each party has its own independent goals, risks and rewards.
2.8 It is also important to understand that the success of any alliance requires committed leadership from each member of the alliance. Individuals identified to fulfill leadership roles within the alliance will require training/individual development and to understand and commit to the alliance principles (discussed below).

**Alliance contracting is different to traditional arrangements**

2.9 Traditional approaches to commissioning and contracting for services usually involve the commissioner setting out its requirements and terms with the provider then proposing its solution, terms and the price to deliver those requirements. Each party factors in their own assessment of risks and stands to win or lose if the risk outcome is lower or higher than that predicted by them. This approach works well where the project or service has few unknowns and the outcomes are reasonably predictable. Where services or projects are more complex, with more unknowns, the parties are less able to predict outcomes confidently and will tend to price for higher levels of risk and/or seek numerous contract variations as work progresses.

2.10 Alliance contracting seeks an alternative approach under which the parties combine their knowledge and experience to address the complexities and unknowns with the objective of increasing their shared confidence in the outcome. They share exposure to the service outcomes through aligned financial incentives. In a health and social care context this will also require eliminating or mitigating perverse financial incentives in the system.

3 How alliance contracting can work with the NHS Standard Contract

3.1 As noted in the Introduction above, some forms of alliance contracting do not sit comfortably with NHS commissioning, given the responsibilities and forms of commissioning contract prescribed by legislation for different types of service. But the key characteristics of alliance contracting can be accommodated in a structure involving one or more NHS Standard Contracts or indeed other service contracts (e.g. contracts for social care, primary care etc).

3.2 The template Alliance Agreement published with this Guidance is designed to sit alongside and work with a range of health and social care service contracts including the NHS Standard Contract.

3.3 The relationship can be illustrated as follows:
3.4 In the case of healthcare services, the underlying service contracts will comprise the NHS Standard Contract and/or relevant primary care contracts (GMS, PMS, APMS etc) and therefore include provisions dealing with service standards, staff qualifications, CQC compliance, complaints handling, contract management etc. The overarching Alliance Agreement will contain the agreed governance arrangements for the working of the Alliance, the agreed outcomes and objectives, the alliance principles agreed by the Alliance members (see paragraph 0 below) and the agreed payment arrangements and risk/reward sharing mechanism. It will be important to avoid inconsistency between the service contracts and the Alliance Agreement and, in practice, matters contained in the Alliance Agreement that could also appear in the service contracts are cross-referenced rather than duplicated.

3.5 Early examples of alliance contracting in the NHS have involved specific services (such a mental health services or community elective care) and/or a range of services relevant for a particular identified population (over 75s with two or more specific needs or conditions, for example). There are examples of alliance arrangements involving more than one CCG as commissioner, and arrangements involving GP federations as providers. In some cases local authorities are also members of the alliance and there are some areas where ‘provider only alliances’ are being considered (this latter example involves a commissioner contracting with one provider which collaborates with other providers under arrangements based upon alliance principles).
3.6 Any commissioners or providers who are keen to discuss an alliance contracting approach are encouraged to contact the NHS Standard Contract Team via nhscb.contractshelp@nhs.net.

We would strongly recommend that any prospective participants in alliance arrangements take expert legal advice.

3.7 Commissioners are reminded that, in their procurement processes, they should have regard to The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and the associated Guidance issued by Monitor, and to the Public Contracts Regulations.

4 Using the template Alliance Agreement

4.1 The template Alliance Agreement has been prepared to provide commissioners with an illustration of how an Alliance Agreement can be structured and the typical areas that are addressed in alliance contracting.

4.2 It cannot be used as drafted and will require a significant degree of local discussion and negotiation to reflect specific service requirements, desired outcomes and agreed risk/reward sharing principles.

4.3 Use of the template Alliance Agreement is not mandated by NHS England. It is intended to be a helpful resource based upon early experiences of NHS commissioners and providers adopting alliance arrangements.

4.4 The template Alliance Agreement is intended to provide a structure which can be built upon by commissioners and providers in developing the terms of the Alliance between them. If particular provisions do not fit with what commissioners and providers are trying to achieve then they are able to develop their own specific drafting.

4.5 A number of sections of the template Alliance Agreement are incomplete:

   a. A number of clauses in the Alliance Agreement are incomplete and will need to be carefully considered and completed. It will not be appropriate for commissioners and providers to simply accept the drafting as set out in the template. In some cases, we have included some example drafting from existing NHS projects so as to prompt thinking and stimulate debate. The incomplete clauses include:

      i. Clause 5.1: Alliance Objectives - this section should include the overarching objectives that the parties are seeking to achieve and could include, for example, the high-level health and care outcomes that have been agreed

      ii. Clause 6.1: Alliance Principles – these are the principles and behaviours that are agreed and committed to by the parties. The principles sit at the heart of alliance contracting and define the
relationship between the alliance members. Some example principles are included in the template Alliance Agreement (taken from an existing NHS alliance contract). When making decisions about the Alliance's activities, members of the Alliance agree to make decisions in accordance with the **alliance principles**: this is considered further in paragraph 0 below.

iii. Clause 7.1: Roles and Responsibilities – this section sets out the specific roles and responsibilities for commissioners and providers in relation to the operation of the Alliance. Some example roles and responsibilities are included in the template Alliance Agreement but it will important to agree locally specific roles and responsibilities for the relevant services.

iv. Clause 8.4: Alliance Leadership Team responsibilities

v. Clause 8.5: Alliance Management Team responsibilities – a typical alliance contracting governance structure involves an Alliance Leadership Team and an Alliance Management Team. The precise terms of reference for each Team will need to be agreed on a case by case basis but some example high-level responsibilities are included in the template Alliance Agreement.

b. A number of the schedules to the template Alliance Agreement are blank. Some schedules are included as a prompt for commissioners and providers to consider whether they wish to included specific provisions dealing with areas such as dispute resolution (Schedule 7). Other schedules will be required but will need local design, negotiation and completion such as the key performance indicators (Schedule 3) and the Risk/Reward Mechanism (Schedule 4). Where appropriate we have included a description of what can be included in the relevant schedule.

4.6 The template Alliance Agreement is drafted on the basis that the underlying Services Contracts will be based upon the Standard Contract. And so, for example, a number of provisions of the Standard Contract are incorporated by reference (Confidentiality and Freedom of Information, Change of Control etc.). Where not all of the underlying Services Contracts are Standard Contracts (e.g. some may be primary care contracts and/or local authority contracts for social care services) then it may be appropriate for these provisions/cross-references to be amended to reflect approaches to these issues under those various underlying contracts: this will be a matter for discussion between the parties and with legal advisers.
5 Frequently asked questions

5.1 In this section we consider some of the frequently asked questions that are emerging in the early stage of development of alliance contracting in the NHS.

How are decisions affecting the Alliance made?

5.2 At the heart of most alliance contracts is a commitment by the Alliance members to make decisions which are ‘best for service’. The best for service principle is based on the understanding that the members will direct their decisions towards the collective vision and objectives of the Alliance rather than their own self-interests or the commercial interests of their employing organisation. The framework underpinning individual initiatives should operate to ensure that, by acting in the best interests of service users, the members will also be acting to support their own best interests.

5.3 Generally, this will mean that decisions should:

a) be made in accordance with the *alliance principles* developed by the members;

b) drive the achievement of the alliance vision;

c) be made in a way that reflects the members’ behavioural commitments; and

d) fully take into account public sector standards of behaviour and protect the public interest.

5.4 In clause 5.2 of the template Alliance agreement reference is made to decisions being made to shift activity and change service specifications under the respective service contracts. Under alliance contracts, all members should agree how this is to take place and how they can collectively support the changes in line with the *alliance principles*.

5.5 Many alliance contracts include a decision making process that is based on unanimity and involves the commitment of all those involved. This encourages the members to find ‘win-win’ solutions and avoids the risks or one or more members becoming disengaged from the Alliance by feeling disempowered or out-voted under a model requiring a majority vote.

5.6 This can be difficult. It can effectively provide one partner with a 'right of veto' and result in the pace of progress being determined by the 'slowest' partner. However, this can be mitigated by the members committing to make decisions in accordance with the shared vision and the alliance principles.

5.7 Reserved Matters: the template Alliance Agreement includes a provision that, notwithstanding the commitment to make decisions on a best for service
basis, there are some 'reserved matters' where commissioners are not obliged to act on a best-for-service basis in relation to certain matters – recognising their statutory duties as commissioners and budgetary constraints. Examples include any decision that would involve a commitment of funds beyond an allocated budget or decisions by commissioners when exercising certain contractual rights (e.g. in relation to a provider change of control).

How are disputes under an alliance contract resolved?

5.8 Many alliance contracts include a ‘no disputes’ mechanism where the members agree not to pursue disputes or litigate, except in limited circumstances. The intention of this approach is to avoid the adversarial or ‘claims based’ culture of traditional contracting and, in turn, encourage the members to find solutions to problems, rather than to deny responsibility and seek to blame others.

5.9 Where disagreements arise (and they will) the members agree to resolve such issues by reference to the agreed alliance principles. We recognise that it is not possible to prescribe or mandate collaboration amongst members but it is possible to create a framework or environment in which collaboration is encouraged.

5.10 It is important to remember that ‘no disputes’ does not mean ‘no disagreements’. Healthy challenge and debate is a sign of an effective team. The success of the alliance will be highlighted by the manner in which disagreements are addressed and resolved by the members.

5.11 Wilful default: Notwithstanding the commitment to avoiding disputes, there may be occasions where a member or its representative(s) are behaving in a non-compliant way. In the first instance the member/individual will need to be reminded of the commitments to act in good faith and in accordance with the agreed alliance principles. If other members remain concerned about ongoing and wilful non-compliance then they will invoke an escalation procedure that could see an individual excluded or ultimately a member organisation excluded from the Alliance (see clause 18 of the template Alliance Agreement).

How are liabilities of the parties dealt with?

5.12 In practice, most responsibilities and liabilities when things go wrong will be addressed and governed by the relevant service contract. The template Alliance Agreement (clause 16) is concerned with responsibilities and liabilities that are not covered by a service contract. These occasions are expected to arise infrequently and include alliance level commitments such as confidentiality and default by an Alliance member leading to exclusion.

5.13 In all other circumstances, the template Alliance Agreement proposes that the members of the Alliance agree that there should be no liability to each other in respect of the activities of the Alliance itself.
What happens if a provider is excluded from the Alliance?

5.14 It is recognised that where an Alliance member is excluded from the Alliance (clause 18 of the template), then there will be consequences for the underlying service contract. The circumstances of termination may be such that the commissioner also terminates the underlying service contract but equally, it may that the provider is asked by the commissioner to continue to provide the services under its service contract outside the scope of the Alliance. The template Alliance Agreement is not prescriptive about what should happen in these circumstances other than to propose that the parties agree to work together in good faith and to ensure that any changes are for the benefit of service users.

5.15 The template Alliance Agreement includes indemnity provisions (clauses 18.9 and 18.11) that are designed to support and expand upon the principles of the underlying service contracts and not to create a situation where such liabilities might be avoided. Accordingly, provisions are included to provide an indemnity in favour of the innocent party where a provider is excluded from the Alliance as a result of the termination of the underlying service contract.

How do the payment arrangements and risk/reward mechanism under an Alliance Agreement operate?

5.16 In alliance contracts used in the NHS to date, the parties have sought to create a fund of monies which can be used to incentivise/reward the alliance partners for the achievement of agreed outcomes.

5.17 Clearly, each alliance will have its own considerations and the risk/reward mechanism is typically an area which takes some significant work between the partners.

5.18 Examples to date have included:

- Arrangements under which CQUIN monies and identified savings are pooled together to create the fund out of which the incentive fee can be paid.

- Arrangements under which a stated percentage of the base fee for services is retained by the commissioners but which can be earned by providers in addition to the base fee if the Alliance outcomes are achieved.

Does each provider need a discrete service contract for each Alliance Agreement? Or can an Alliance Agreement for a specific purpose or patient group overlay services contracts covering a broader range of services and patients?

5.19 Experience to date is that the members of an Alliance generally enter into the Alliance Agreement at the same time as new service specific service.
contracts: one underlying service contract for each provider, each covering only those of the Alliance services which are the responsibility of the relevant provider. That seems to be easier to manage and allows the parties to focus on the activity shift and services changes required as part of the Alliance’s activities.

5.20 However, there is no reason why for any individual provider the services within the scope of an Alliance cannot be commissioned under a service contract that covers a wider range of services than those services covered by the Alliance Agreement (for example, the Alliance may relate only to the needs of over 75s, but participating acute providers and general practitioners will hold commissioning contracts covering a full range of services for all patient groups). The underlying service contract could in those circumstances be amended to distinguish between those elements of the services that fall within the scope of the Alliance and those which are covered by the standard commissioning contract payment provisions, performance indicators etc.

5.21 Recital F in the template Alliance Agreement envisages either or both of these situations.

**How are services/parties added to the scope of an Alliance?**

5.22 It is important for commissioners to remember that, in considering the expansion of the scope of an Alliance (either through increased services or membership), such decisions are taken in compliance with the prevailing procurement and competition law at the time that such services are being commissioned. Whilst the objectives of the Alliance Agreement encourage greater cooperation between members of the Alliance, they will also need to ensure that nothing is done that could preclude competition between providers or that could hinder the commissioners’ compliance with their obligations under procurement and competitions law.