

NHS contracting in England and Wales: changing contexts and relationships

Executive Summary

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Background

After the establishment of the NHS internal market in April 1991, the NHS became a split organisation in which commissioners purchased clinical services from providers in line with the contracts negotiated. Contracting became a key governance mechanism for co-ordinating the work of purchasers and providers, and ensuring that the expected volumes of care were delivered in line with cost and quality requirements. This study examines the extent of divergence in contracting arrangements in England and Wales after devolution. It concentrates on contracting for secondary care services. The research examines contractual governance, in terms of the use of contracts to manage relationships and the purchase of NHS services, its practice and its limitations in the two systems.

Aims

The study aimed:

- To investigate the contracting approaches utilized by PCTs/LHBs (as commissioners) and NHS Trusts, how these relate to other modalities of regulation such as performance management and clinical governance, and the impact of the various governance mechanisms on the performance of these organizations.
- To achieve this by undertaking case studies in a number of 'local health economies' (LHEs) in England and Wales, so as to shed light on differences in the governance of commissioner/provider relationships in the two countries.
- To examine in greater detail a number of 'tracer' issues which potentially could be managed both contractually and via other mechanisms, and might be said to exemplify choices in local strategies of governance. Relevant tracers were to be identified in the course of the study and after investigation we selected: quality (including infection control), incentives (for example, Commissioning for Quality and Innovation), risk allocation, targets and penalties, and contract dispute resolution.
- To utilise these 'tracers' to consider the impact of organisation-level governance mechanisms on different organizational groups (such as managers and professionals).
- To contribute to the applied policy debate on these issues, and also to the socio-legal and social science literature on hybrid contractual forms and related issues of organisational governance.

Methods

We carried out two English and two Welsh case studies of contracting practices in local health economies. Each case study involved a commissioner (or, in one instance, a pair of commissioners working closely together), the network of main provider trusts, and the overseeing English strategic health authority or Welsh regional office. Additional data were gathered on the work of other agencies, such as CQC, Monitor, HCW and HIW, that made up the wider regulatory environment. Each case study involved a mix of observation of meetings, interviews with key personnel and analysis of documents. Data collection took place from late 2007 to summer 2009.

Results

Despite headline policy differences, there is a surprising degree of similarity of approach in many areas of contracting practice in the two countries. Many elements of the technology of contracting and the culture of management spill over from one system to the other. Both countries utilised national template contracts which imposed a measure of standardisation and set limits on the scope for local variations in the nature of agreements between commissioners and providers. While England tended to use HRGs and provider spells against Wales' average specialty prices and deaths and discharges, we found that English organisations did not always reimburse strictly on tariff and that price negotiation and block contracts could still appear in the English system, as they did in Wales. The two systems utilised broadly similar risk management and demand management strategies, and the way dispute resolution worked was not as different as we expected. Relational contract theory predicts that it is behaviour rather than rules that shapes contractual relations. This helps explain the many similarities in contractual governance practices in the NHS in England and Wales, in spite of fundamental differences in the legal status and enforceability of contracts.

The differences observed almost all related to areas of contracting policy that had been influenced by the English NHS's turn back to markets. While the use of financial incentives linked to CQUIN was gaining momentum in England, the reverse was happening in Wales, with the demise of the *All Wales Sanctions and Incentives Framework*. Financial penalties were a key tool supporting targets in England but were not implemented in Welsh LTAs. The Welsh regional offices operated with a broader conception of performance management than the SHAs, facilitating a three-way negotiation with LHBs and trusts leading to the signing off of the local AOFs, compared with a narrower focus on enforcing targets in England. This split widened when Wales ended the internal market in 2009.

Overall both systems combined centralised and decentralised governance mechanisms. In spite of the growing divergence of formal structures and policies in England and Wales, we found elements of near-contractual relations (such as the Long Term Agreement and Annual Operating

Framework) in the predominantly bureaucratic form of organization in Wales, and hierarchical elements accompanying contractual and near-contractual relations in quasi-market organization in England. While the combination may be different, in both NHS contexts the coordination of service provision is dependent on bilateral relationships in the commissioning of services coupled with hierarchical control and direction. We predict that bilateral relationships of a kind will still be significant within the new Welsh multi-divisional health boards, so that the foregoing analysis will apply to transfer payments and accountabilities within Wales' new planning system.

Conclusions

Although the contracting arrangements described in this study are already changing with the latest round of NHS reforms, we predict that spill-over effects from one system to the other, the interplay between centralism and decentralisation, and relationality will continue to be big issues on both sides of the border. The two countries have experimented with different combinations of hierarchical, and contractual or near-contractual governance mechanisms, but in broad perspective they both remain Beveridge-type healthcare systems with a great deal in common.

Based on the findings from our study we make the following suggestions for policy makers:

1. There is a need to clarify policies on cross-border purchasing, particularly by Welsh Health Boards from English providers and in the areas of reimbursement 'currencies' and quality standards. Currently this remains manageable because of the limited nature of system differences, but is an area that requires monitoring and future policy development.
2. The cultural dimension of contracting has been crucially important in both systems. Policy makers need to attend to the informal, behavioural aspects of contracting (and planning) and be alive to a possible implementation gap when new structures and rules are introduced.
3. Good relationships have been crucial in both systems in keeping organisations on track in the face of problems. Rules and performance management cannot take the place of trust and co-operation, which need to be built over time.
4. While the language of commissioning may have presently fallen from favour in Wales, many of its component elements, such as population needs assessment, prioritisation, investment and disinvestment, and demand management, will remain central to the new planning regime. The best practices from commissioning need to be carried across into the new framework. It will also be important to preserve an element of internal scrutiny and challenge in the areas of financial management and resource allocation.
5. English policy makers need to take account of behavioural aspects of contracting as they re-design the purchasing function in England. There is a

risk of a further loss of organisational memory when PCT purchasing gives way to purchasing by GP consortia, or specialist external agencies sub-contracted to undertake this task.

We believe that there is a need for future research to:

- Examine issues and problems that arise as a result of cross-border contacts between the English and Welsh NHS systems, especially regarding reimbursement and quality standards, and the best way forward.
- Investigate the effect in England on contractual governance (and spill-overs into Wales) of increasing purchaser and provider diversity, including changes in regulatory structures.
- Investigate the nature of the internal financial transfers, and frameworks of accountability, now being used in Wales instead of contracts.
- Investigate the ongoing effect in England on contractual governance of financial incentives/penalties and negotiated prices (as the latter come in).
- Investigate strategies for demand management in all its forms, and the results of the different approaches utilised.

Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme, and managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO), based at the London School of Hygiene & Tropical Medicine.

The management of the SDO programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Although NETSCC, SDO has conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.