

# NHS contracting in England and Wales: changing contexts and relationships

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## Glossary of terms/abbreviations

A&E	Accident and emergency services
AOF	Annual Operating Framework (Wales)
AWMSG	All Wales Medicines Strategy Group
CE	Chief executive
<i>C.difficile</i>	Clostridium Difficile
CEDR	Centre for Effective Dispute Resolution
CHAI	Commission for Healthcare Audit and Inspection
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CQR	Clinical Quality Review (meetings)
COPIs	Clinical Quality Performance Indicators
DH	Department of Health
DIG	Delivery Implementation Group
DoF	Director of Finance
DoC	Director of Commissioning
ENT	Ear, Nose and Throat (service)
FCE	Finished Consultant Episode
FEG	Finance and Efficiency Group
FRR	Financial risk rating
FT	Foundation Trust
GP	General Practitioner
GPSI	General Practitioner with Special Interest
HCAI	Healthcare Associated Infections
HCW	Health Commission Wales
HIW	Healthcare Inspectorate Wales
HPS	Hospital Provider Spell
HRG	Healthcare Resource Groups
IM	Information Management
ISTC	Independent Sector Treatment Centre (England)
IT	Information technology

JCI	Joint Clinical Investigations
LDP	Local Delivery Plan (Wales)
LHB	Local Health Board (Wales)
LHEs	Local Health Economies
LHG	Local Health group (Wales)
LTA	Long-term Agreement (Wales)
MRSA	Methicillin-resistant Staphylococcus Aureus (bacteria)
NafW	National Assembly for Wales
NPHS	National Public Health Service (Wales)
NICE	National Institute for Health and Clinical Excellence
PBC	Practice Based Commissioning (PBC).
PbR	Payment by Results
PCT	Primary Care Trust (England)
PEC	Professional Executive Committee (England)
PEDW	Patient Episode Database for Wales
RCU	Regional Commissioning Unit (term sometimes used instead of RCSU - Wales)
RCSU	Regional Commissioning Support Unit (Wales)
PRCC	Principles and Rules for Cooperation and Competition
PROMs	Patient Reported Outcome Measures
RTT	Referral-to-treatment (target)
SaFF	Service and Financial Framework (Wales)
SCCG	Secondary Care Commissioning Group (Wales)
SHA	Strategic Health Authority (England)
SLA	Service Level Agreement (Wales)
SUS	Secondary Uses Service
TFR2	Trust Financial Returns
WAG	Welsh Assembly Government
WHAIP	Welsh Healthcare Associated Infection Programme
WHC	Welsh Health Circular



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### Individual contributions

David Hughes co-ordinated work on the project and its planning, assisted in the Welsh fieldwork, brought together the elements of the analysis, prepared the first drafts of Chapters 1, 2 and 7, and wrote the final draft report.

Pauline Allen oversaw the English fieldwork and assisted in writing up and analysis.

Shane Doheny took primary responsibility for the Welsh fieldwork and wrote the first drafts of Chapters 4 and 6.

Christina Petsoulas took primary responsibility for the English fieldwork and wrote the first drafts of Chapters 3 and 5.

Jenny Roberts assisted in access negotiations, the analysis of quality issues and helped edit the final report.

Peter Vincent-Jones worked with David Hughes on the theoretical framework of the study, and revised large sections of Chapters 1 and 7. He also facilitated the co-ordination of the study with the EU F6 REFGOV project.

During his brief involvement in the project, Jeremy Segrott assisted in preparation of the application for ethical approval to the Wales REC.

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# Executive Summary

## ***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.

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# 1 Studying contracts in the NHS

## 1.1 Introduction

This is a study of how NHS purchasers and providers in England and Wales used contracts to arrange the provision of 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.

## 1.2 Study aims

The study set out:

- 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: risk allocation; quality (including infection control); targets and penalties; incentives (for example, CQUIN); 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.

## 1.3 Research questions

The general objectives mentioned above translated into a series of detailed research questions that we addressed via data from two English and two Welsh case studies:

- How are traditional facets of contract such as risk sharing, performance, 'presentation' (specification of contingencies) and dispute resolution handled in the two systems?
- Do higher level agreements in which service contracts are nested (e.g. performance agreements with higher-level NHS bodies or the authorization of foundation trusts by Monitor) contain contractual elements?
- Are the 'tracer' issues (see 'Aims') still specified in contracts or are they enforced primarily in other ways?
- If the former, how does contractual governance mesh with the requirements of performance management and clinical governance?
- What are the roles of different managerial and professional groups within networks, and how do networks relate to contractual governance?
- Do different governance mechanisms come into tension or conflict?
- Are contracting relations in the 'New NHS' characterised by 'partnership' or something closer to the 'adversarial' relationships observed in the internal market period?
- Where do foundation trust contracts fit in the spectrum of contract forms?
- Is there a clear distinction between NHS contracts and legally-binding contracts or a more complicated spectrum of contract forms?
- How do commissioners and providers utilise the different governance mechanisms?

## ***1.4 UK policy divergence***

The rationale for our England/Wales comparison was that, in the wake of UK devolution, the NHS systems of the two countries seemed to be developing in strikingly different directions. As we will explain below, at the time of the proposal we underestimated the speed with which policy divergence would undermine the system of commissioning and contracting in Wales. Nevertheless we were correct in our assessment that differences in the wider policy environments would lead to different operational policies on contracting in the period under study.

The NHS internal market of the 1990s provided a common starting point for subsequent NHS reforms in both countries. Arguably this system was less deeply 'embedded' in Wales than in England, but in essence both countries embarked on a similar retreat from the market following the Labour Party's 1997 election victory. Initially rather similar changes were made as GP fundholders and the health authorities were replaced by smaller locality-based purchasers (English primary care trusts (PCTs) and Welsh local health boards (LHBs)).

However, by the time separate 10-year plans were produced for England and Wales,<sup>1,2</sup> a significant policy gap had appeared. The details of the different policy paths are complex and multifaceted,<sup>3-6</sup> and our brief account will focus on integrated provision versus market elements, mainly as they affected secondary care.

It was the English NHS that broke ranks to take the reforms in a new direction. From about 2000 there was a return to policies based on markets and choice. By the time the Government legislated in 2003, a package of inter-related measures designed to develop a new supply-side NHS market had taken shape. The PCT remained the main purchaser, but five key measures were taken to increase supply-side competition: the creation of foundation trusts, more use of private providers, reimbursement based on standard tariffs, enhanced patient choice of provider, and an arms-length regulatory agency overseeing both public and private providers.

The first foundation trusts were 'authorised' in April 2004. When our study started in late 2007 sixty-five were in existence, rising to 129 at the time of writing (40 of which are mental health units). These hospitals are accountable to an arms-length regulatory agency, Monitor, rather than the NHS line-of-command, and must comply with the requirements of another regulator, the Care Quality Commission, in respect of national standards and inspections. Like independent providers, foundation trusts contract with NHS purchasers through legally-binding contracts rather than the non-litigable contracts previously used for transactions between NHS bodies.

The private providers in the new NHS market include conventional independent hospitals, but also a new category of independent sector treatment centres (ISTCs), dedicated largely to NHS work.<sup>7</sup> The first wave of ISTCs was commissioned by the DoH in late 2002. By late 2007, 24 first-wave ISTCs were operating, owned by a range of home and overseas enterprises. The period covered by the study saw a second-wave of ISTCs come on stream, but later there was an apparent loss of momentum in the growth of the private sector with reports that a planned third wave had been scrapped and suggestions that NHS hospitals might gain preferred provider status.<sup>8</sup>

The system of standard tariffs used to reimburse public and private sector providers is known as 'payment-by-results' (PbR). Providers are reimbursed according to fixed tariffs for procedures based on health resource groups, a simpler costing system with fewer categories than US diagnosis-related groups. The system is intended to end negotiation over price and shifts the emphasis to competition based on quality or access times. However, by the time of the study significant areas of non-PbR activity remained, and as we shall see there were examples where tariffs were not applied. PbR helps to build a supplier market for NHS work, because any accredited provider offering care at national tariffs can tender for NHS activity. Foundation trusts began using PbR in 2004 and, from 2005 all NHS trusts utilised it for elective care, representing about 30% of activity. The range of activity covered by PbR increased during the study period, so that at the time of writing mandatory tariffs applied to elective and non-elective admitted



patient care, outpatient attendances, some outpatient procedures and A&E services.

Another piece in the jigsaw of the emerging market was enhanced patient choice. England introduced a *Choose and Book* system in 2006, whereby NHS patients awaiting referral to hospital could select from four or more locations. The Brown Government announced its intention to widen this to a 'free choice' system, in which patients referred for most kinds of planned treatments can select any foundation hospital, ISTC, or independent hospital in the 'extended choice network'.<sup>9</sup> Although large numbers of patients seem likely to continue to opt for local hospitals, this may result in significant changes in patterns of commissioning since the purchasing PCTs will be required to fund treatments according to the patterns of service utilization generated by patient choices. Choice supports the growth of the English NHS market, both because of the possibility that many prospective patients will select the independent sector options, and because real choice will require over-supply and an expansion of provider capacity.

English policy makers did not plan to use the existing command-and-control mechanisms to regulate the new market, and instead entrusted the task to a number of arms-length regulatory agencies. In 2003 the existing NHS body concerned with standards and inspections, the Commission for Healthcare Improvement, was re-configured and given an expanded remit. The replacement, the Commission for Healthcare Audit and Inspection (CHAI), stood outside the central Department of Health bureaucracy and had wide-ranging responsibilities for promoting improvement in the quality of health and healthcare across both public and private sectors. Legislation enacted in 2008 merged the Healthcare Commission, Commission for Social Care Inspection, and Mental Health Act Commission to create the Care Quality Commission, a 'super-regulator' for health and social care, (though Monitor, the regulator of foundation trusts, remains separate).

The creation of this English supply-side market seemed certain to change referral patterns and resource flows. Under the old system patients were referred to hospitals on the basis of catchment areas in which they lived, unless they required specialist services not locally available. In the period under study there was the possibility that this would start to change as money followed patients according to which hospitals they used. In 2007 we were unsure about how far competition and the growth of NHS work in private hospitals might transform the nature of NHS contracting.

In contrast to the English system, policy in Wales during the study period stayed closer to the vision of an integrated state service. Major differences emerged because of the Welsh Assembly Government (WAG)'s unwillingness to replicate the five key elements of market reform in England described above. Thus the Welsh NHS had no foundation trusts or private treatment centres, and made no use of standard tariffs, except in some cases where treatments were purchased from English hospitals. In the study period, arrangements continued as before with purchasers buying care from conventional NHS trust hospitals on the basis of negotiated prices.

The former regulator, the Commission for Health Improvement, had overseen the NHS in England and Wales. With the transition to CHAI in 2004, the Welsh Assembly established Healthcare Inspectorate Wales, a division of a government department, to take responsibility for standard setting and inspection in the Principality. Welsh policy makers were doubtful that CHAI would be sufficiently attuned to the different Welsh standards and unsympathetic to use of an arms-length regulatory agency, which they believed reduced Ministerial accountability.

The issue of patient choice was also approached in a different way in Wales. There was no direct equivalent of the English *Choose and Book* system, although a *Second Offer* Scheme was introduced in April 2004 to offer an alternative treatment option for patients experiencing excessive delays on surgical waiting lists. However, policy makers saw this more as a scheme to reduce waiting times than a patient choice policy per se. The WAG's declared strategy is to: '... empower the community to have its voice heard and heeded, rather than simply being given a choice of treatment location'.<sup>10</sup> (p. 14)

In 2002 when the Assembly First Minister signalled that Wales would not follow the English policies, he spoke of the 'clear red water' that separated London and Cardiff.<sup>11</sup> In the early-2000s Wales adapted the internal market model by attempting to get purchasers and providers to work co-operatively in a system with strong elements of planning and better co-ordination between health, local government and the voluntary sector. The five pre-existing health authorities were replaced by 22 local health boards (LHBs), arranged within areas covered by 3 regional offices of NHS Wales. Initially these LHBs purchased health care from 14 Welsh NHS trusts, which over time reduced to 7 as mergers occurred. Services were also purchased from English NHS hospitals and, to a lesser extent, independent providers. Some commentators have detected a distinctive Welsh theme in the shape of 'localism'.<sup>2</sup> The LHBs were 'co-terminus' (i.e. shared common boundaries) with the 22 local government unitary authorities, responsible for social care, while the English PCTs map less closely onto their corresponding local government authorities. This helped to facilitate joint commissioning of community services, and was developed further by the formation of local service boards bringing together the service delivery organizations in each local government area.<sup>12</sup>

In the absence of foundation hospitals, private treatment centres and standard tariffs the Welsh system operated rather differently from the English one. This was so even allowing that health policy in England contains some discrepant non-market elements concerned with integration of health and social care and partnerships in commissioning, and that the immediate impact of market competition has been exaggerated by some commentators. In June 2007, the Labour and Plaid Cymru Parties entered a *One Wales* coalition agreement which pledged to end the internal market and eliminate the use of private hospitals by NHS purchasers in Wales.<sup>13</sup> Subsequently the WAG announced that the purchaser/provider split would be formally ended in Wales in April 2009.

## **1.5 Approaches to commissioning and contracting**

As fieldwork began, these headline policy differences were reflected in the English and Welsh guidance and operational policies on commissioning and contracting.

English commissioning and contracting policy was developing to mesh with other healthcare policies, involving both a strengthening of population-based commissioning and greater reliance on market mechanisms. In 2007 a programme was launched to support the vision of 'world class commissioning' and promote a more strategic, long-term and community focused approach to commissioning services.<sup>14</sup> Alongside developing skills in areas such as needs assessment and priority setting, 'world class commissioners effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes'.<sup>15</sup> (p. 21) In December 2007, the DoH introduced revised principles and rules for cooperation and competition (PRCC) in commissioning and provision of NHS services. The PRCC articulated a clear role for competition and required providers to select the 'best' providers on the basis of quality and best-value.<sup>16</sup> It soon became apparent that this would involve a hardening rather than softening of contractual governance mechanisms. As the study progressed, quality improvement was emphasised as one of the key functions of commissioning. Plans for a *Commissioning for Quality and Innovation* (CQUIN) initiative included proposals for greater use of contractual financial incentives and penalties.<sup>17</sup> CQUIN was implemented in 2009/10 and introduced a payment-for-performance scheme, under which a small percentage of a provider's income depended on outcomes for patients. There were related plans for PCTs to be allowed to withhold payment for treatments in the case of serious avoidable adverse events. By the late 2000s the English NHS contracting environment was becoming more complex because of the growing involvement of private for-profit sector and 'third-sector' agencies. Through the process of contracting, commissioners might, in theory at least, have the ability to influence the number and type of providers in their local area, and potentially engineer significant changes in patterns of service delivery.

By about 2006 the Welsh NHS was using softer versions of commissioning and contracting based largely of ideas about 'collegiate contracting' and partnership working. Welsh purchasers still purchased treatments via NHS contracts, but did so within a framework which also emphasized planning. As we shall see in later chapters, the LHB's contracts – its Long Term Agreements - meshed with an Annual Operating Framework (AOF) agreed with the regional office. This in turn was aligned with the Health, Social Care and Well-being Strategies agreed with local government. Thus the horizontal service contract was nested in a set of vertical performance agreements between LHBs or hospital trusts and regional offices, which were enforceable through hierarchical management processes. Where England had highlighted the importance of 'world-class commissioning', Wales – by the end of the study – had stated its intention to leave the commissioning model behind. In effect it opted for a return to a fully

planned integrated NHS, albeit in the context of the small country governance model suggested by the *Beecham Review Report*.<sup>12</sup>

## **1.6 Theoretical background**

This study has been influenced by theory from institutional economics,<sup>18</sup> relational contract theory<sup>19,20</sup> and institutional sociology.<sup>21</sup> Theoretical development will be approached via journal articles, and for the purposes of this short report we focus more on descriptive findings and the impact of contracting arrangements in the English and Welsh health services. By way of brief explanation we should note, however, that the study is concerned with investigating intermediate institutional forms at two different points in the space between markets and hierarchies. A fuller explanation of the approach can be found in Vincent-Jones' analysis of contractual, near-contractual and non-contractual governance.<sup>22</sup> According to this analysis, whereas 'contractual' and 'near-contractual' exchanges are characterized by detailed planning and recourse to contract documentation in the management and adjustment of relationships, non-contractual governance proceeds through a variety of extra-contractual normative and non-normative devices, including trust, customs and conventions, and economic inter-dependence.<sup>23</sup> In the NHS context non-contractual governance involves hierarchical command as well as interactions with professional and managerial networks.

Both contractual and near-contractual governance involve 'presentiation' – the attempt to structure future relations by anticipating and providing for contingencies. The arrangements differ, however, in the role played by specifically legal norms, which serve in contractual (but not near-contractual) relations to reinforce the expectation of the parties that the contract is binding and ultimately capable of judicial enforcement.<sup>24</sup> The emphasis in this socio-legal perspective is on public service contracting as a set of practices through which relationships are managed and adjusted according to agreed plans. Such practices are supported by contract norms that may be legal and extra-legal, and by other normative and non-normative devices that are non-contractual in the sense of being external to the contractual exchange.

The focus in empirical research is on the role of contract norms in the broad sense in planning, and on the way in which contract documentation is 'used' *ex post* in the governance of relationships after *ex ante* planning. Whilst the legal enforceability of contracts may well be significant to the extent that it affects incentives and expectations, this quality is not definitive of contractual relations. As will be seen in subsequent chapters, the behavioural definition of contract helps explain the many similarities between contractual governance in practice in the NHS in England and Wales, in spite of fundamental differences in the legal status and enforceability of contracts.

Regardless of whether the form of governance is contractual or near-contractual, the success of contract as a governance mechanism is

dependent on relationality as a quality of the transaction process. This shorthand term denotes the presence of relational norms in commissioning relationships to the degree necessary to foster trust and cooperation, and which are necessary to deliver the joint-welfare maximising benefits associated with successful business and other private exchanges.<sup>25</sup> In this interpretation, it is not that some NHS contracts are essentially ‘discrete’ and some ‘relational’, but rather that both discrete norms (such as consent, choice, and planning) and relational norms (such as flexibility, solidarity, and reciprocity) are involved to a greater or lesser degree, and in a variety of combinations, in all NHS commissioning relationships. Where contractual relations are operating effectively, the discrete and relational norms are likely to be in equilibrium. By contrast, conflictual or adversarial relations are predicted where the discrete norms involved in contract planning and presentation have become unduly accentuated, at the expense of the weakening of the relational norms that support trust and cooperation.<sup>26</sup>

**Table 1. Economic organization of healthcare – England and Wales**

Type of service	← Wales    England →		
	(1) Bureaucratic	(2) Quasi-market	(3) Regulated market
Relationship governance	Hierarchical	Contractual/near-contractual	Contractual
State involvement	Traditional hierarchical integration	Purchaser-provider split Purchase-of-service contracting	Statutory framework Independent regulatory agency
Supply function	Publicly provided	Publicly provided, with some contracted private provision	Plurality of public and accredited private providers
Demand function	Representative government/state	Representative purchaser agency, competition/contestability	Limited consumer sovereignty, choice, competition
Funding and payment	Publicly funded, free at point of consumption		

In outline we argue that England and Wales occupy different positions in terms of our conceptual scheme of contract forms and indeed are moving in different directions (see Table 1). Three ideal-type forms of organization of public healthcare services in the UK may be distinguished. In the early post-1948 period the NHS was organized bureaucratically (cell 1), with no competition and no choice of supplier within the system of direct state provision. By contrast, the 'internal market' introduced in the 1990s entailed the beginning of the development of quasi-market organization (cell 2), with health authorities acting on behalf of consumers in purchasing services and exercising choice among competing NHS providers. In both cases the demand function, including trade-offs between price and quality and so on, remains concentrated in a public agency, with the links between such 'demand' and individual preferences being 'complex and contingent'.<sup>27</sup> A key difference in the governance of relationships is that while bureaucratic organization must by definition be non-contractual in the above sense, quasi-market organization may entail either contractual or near-contractual governance, depending on the extent of involvement of specifically legal norms and the legal enforceability of the contracts concerned. Finally, in regulated market organization (cell 3), which resembles the model employed in the UK utilities sectors, there is an enhanced role for competition and patient choice, with aspects of supply and demand including price, availability, and quality being subject to regulation by independent agencies in accordance with statutory frameworks established by the state. In this case the ideal-type form of governance of relationships is contractual.

From the perspective of neo-institutional economics, both the quasi-market and the regulated market may be seen as hybrid forms of economic organization in the space between bureaucratic and wholly private provision. The new English system, with arms-length regulation and significant private sector involvement, lies somewhere between the quasi-market, involving purchase-of service contracting, and the regulated market, involving provision by a private body under a public law duty or statutory regulation. In contrast, the Welsh system shifted in the early 2000s in the opposite direction towards a commissioning approach more compatible with direct state provision and planning. The ending of the internal market in 2009 sees further movement in the same direction towards traditional hierarchical integration, though it remains to be seen whether hybrid arrangements persist in the form of surviving elements of commissioning and cross-boundary purchasing. In spite of the growing divergence of formal structures and policies in England and Wales, the foregoing socio-legal analysis suggests that we may expect in practice to find elements of near-contractual relations 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.

Where we touch on theory in this short report, this is mainly in the context of the mix of horizontal contractual governance and hierarchical management controls. Vincent-Jones<sup>26</sup> has argued that the governance of public services in the UK is increasingly characterized by 'centralized decentralization', involving different combinations of continued hierarchical control with elements of delegation and devolution. In England decentralization has taken the form of the delegation of contractual powers and responsibilities to public purchasers and other agencies, in support of the government's agenda for marketization and increasing economic incentives, but as later chapters show local purchasers continue to be subject to central requirements such as use of standard contract templates and guidance on dispute resolution. In Wales a structure based on 22 local health boards that promoted close links between NHS bodies and local communities appeared to be under threat from a return to centralism as our study was completed, but during this period there were still significant spaces for local discretion in contracting practices.

## ***1.7 The impact of organisational turbulence***

When this study was commissioned there was little to suggest that a further period of NHS system disturbance was imminent. We knew that a fitness-for-purpose review of PCTs in England was beginning and in our proposal had written of the need to retain sufficient flexibility 'to accommodate rapid and unpredictable organisational change in real-world settings'. But we had not anticipated the degree of system disturbance that would affect both England and Wales, or the extent to which policy divergence would accelerate and the knock-on effects for purchasing organizations in the study period.

Three sets of events impacted on the study.

The PCT fitness-for-purpose programme (the 'McKinsey reviews') that took place in England in 2006-07, resulted in restructuring of many PCTs and the re-advertising and refilling of many senior PCT management posts.

In April 2008 there was a shift in Wales from LHB secondary care contracting based on Secondary Care Commissioning Groups to contracting based on Regional Commissioning Support Units, which meant that research access permissions had to be obtained from several new organisations.

Almost simultaneously the WAG published a consultation paper on the restructuring of the NHS in Wales<sup>28</sup> which was destined to result in the abolition of the NHS internal market and the ending of LHB/trust commissioning from April 2009.

These developments led to a series of practical access and field work problems that are discussed in Chapter 2, but they also forced some reappraisal of the aims of the study. In Wales in particular the winding down of the internal market after April 2008 meant that we were now observing a system in transition. We still believed that a rationale existed for comparing England's system of 'hard' contracting with the 'softer' Welsh

commissioning regime, because these remained as options that policy makers in public purchaser/provider split systems might well need to revisit in the future. Indeed the main focus of this short report remains on the comparison of those two approaches and the extent of real differences. However, we also collected data in Wales on how senior NHS managers regarded the impending change, their perceptions of the problems of moving back towards an integrated system, and their views about what lessons from 'commissioning' might or might not be carried forward into the new planning regime. We have no space in this report to discuss these issues in detail and they will be addressed in a future paper.

The remainder of this report is arranged as follows. Chapter 2 describes the methods utilised in the empirical fieldwork. Chapters 3 and 4 respectively present overviews of contractual processes in England and Wales. Chapters 5 and 6 examine the differing arrangements found in respect of the tracers in the two countries. Chapter 7 contains a discussion of the findings and their theoretical and policy implications.



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## 2 The study methods

### 2.1 Introduction

The fieldwork for this project was undertaken during a period of considerable turbulence in the NHS, which changed the nature of purchaser/provider relationships in Wales and to a lesser extent England, and caused major difficulties for the study. In particular, we faced greater than expected problems in securing access and research governance approval, which led to slippage in our planned timetable and forced us to adapt our research design. Ultimately this meant that our England/Wales comparison comprised four rather than five case studies. The changes in the service also made it necessary to adjust our fieldwork strategy. Although we successfully collected a large body of qualitative data, the precise mix of interviews and observations was somewhat different than we had initially planned. In this chapter we will describe the original research design and the modifications we made, discuss certain problems that arose in fieldwork, and provide an overview of the methods utilised and the data collected.

### 2.2 The research design

As a prelude to describing how the study design evolved, we will summarise our original research plan. The intention was to complete three English and two Welsh case studies. Each case study was to involve ongoing fieldwork to investigate the work of an LHB or PCT purchaser and its local providers, followed by an interview study of other PCTs/LHBs in the wider local health economy concerned. The two-stage design was intended to yield detailed insights into the work of a limited number of organizations through regular contact with them over an 18 months period, and also to allow us to talk with additional organizations so that we could reach an assessment of the representativeness of the behaviour observed, at least within the areas (the local health economies) selected for the study.

The plan was to focus the observational case studies on contractual governance arrangements in a working sub-component of the local health economy: a PCT/LHB and its main providers, plus the overseeing strategic health authority or regional office. We expected this to centre on observations of relevant commissioning, strategy and planning groups within the different organisations. Our plan was to tape record, key meetings and supplement the observations with informal interviews with participants and analysis of relevant documents, including contracts, service agreements, LTAs, performance agreements, Health Improvement Plans, Health and Social Wellbeing Strategies and so on.

When the study was conceptualized, most PCTs and LHBs were operating on their own account as free-standing local purchasers, rather than as entities

within wider purchasing consortia or informal purchasing alliances. In Wales at that time purchasing of hospital services was managed through a Secondary Care Commissioning Group (SCCG) in each LHB. A typical SCCG included representatives from the home LHB, its main providers, social services and neighbouring LHBs, but the latter attended only as observers and might not be present at every meeting. In England, PCTs generally operated commissioning teams which again were largely under their own control. These were the fora to which we initially sought to gain research access, and which we assumed would be the main focus of the observational case studies. Indeed the first fieldwork in Wales involved observation of a SCCG meeting, and in England, a meeting between a PCT and its local trust providers.

Our original plan called for supporting interviews with additional PCTs/LHBs to be completed in the second year of the study, so that the questions could be set to take account of insights gained from the observations. We intended to develop a single semi-structured interview schedule which would cover the main facets of NHS contracting and other governance arrangements.

As a means of sharpening the focus of fieldwork we planned to supplement our general investigation of contracting arrangements in the two countries with special attention to a number of 'tracer' issues. These are essentially a series of key service issues that might be managed contractually or through alternative non-contractual mechanisms. Our initial candidate 'tracers' were quality specifications, infection control programmes, maximum waiting times, excluded treatments and resolution of disputes, but (as we shall see below) these were to be amended to include issues identified as important in the course of fieldwork. Some of these issues had been explored by members of the research team in previous studies,<sup>29-31</sup> so that we had a good idea of how practice had changed over time.

### ***2.3 The modified fieldwork plan***

The study went ahead during a period of greater than usual organisational turbulence in the NHS systems of both countries, which in turn led to significant access delays (see Appendix 4). In the light of access delays and the restructuring of the NHS in Wales, in particular, we were forced to adjust the study aims and change the balance between observations and interviews.

In England we proceeded much as planned but determined to pay special attention to healthcare system change and the direction of travel of any changes in contracting practices.

In Wales with contracting about to end, or at least to be restricted to limited areas of operations, we decided to divide our attention between the immediate past and the future direction of travel. Thus we have done our best to provide an account of the last two years of the internal market and contracting, which is the main focus of this report. But we also collected data on the problems of moving towards a planning framework in the

transitional period, and on actors' perceptions of what elements of the old commissioning framework will in practice be brought forward into the new system. Though there is no space in this report to describe this last area in detail, we plan to discuss this in a future paper.

Because the degree of change in the English system was more limited, we were able to stay close to the original plan of combining observations of contracting meetings with interviews with key actors.

In Wales the rapid winding down of contracting meetings and increased use of one-to-one meetings and letters in lieu of team meetings meant that we needed to use interviews to reconstruct what had gone on. We were still able to observe a range of more general meetings concerned both with ongoing commissioning work and the transition from the internal market to a planning system, but overall we put more emphasis on interviews than was originally planned.

The fact that Wales was undergoing a major system change also made the phase 1/phase 2 design problematic. We had intended to move from detailed case study data to a interviews with a wider set of actors that would allow us to assess representativeness, but now found that representativeness was less of an issue that the overall context of change and whether any elements of contractual governance would survive. After much thought, we decided to accept a looser linkage between observations and interviews (without a close mapping on to phases 1 and 2 of the study), so that the later interviews in both England and Wales are used primarily to set the case studies in a wider context. Since the interviews covered many different kinds of actors we did not use a single standard interview guide.

## **2.4 The 'tracers'**

We kept to our original plan to combine a general examination of the contracting process, with special attention to a number of 'tracers' that might shed light on the nature of governance arrangements. The tracers were essentially a series of key service issues that might be managed contractually or through alternative non-contractual mechanisms. As specified in our proposal, we made a final selection of the issues examined in the light of findings from early fieldwork, and eventually settled on the following:

- mechanisms for ensuring quality (using infection control as one example)
- use of contractual incentives
- allocation of risk between purchaser and provider
- demand management schemes
- use of targets and penalties
- contract dispute resolution arrangements

The tracers are discussed in Chapters 5 and 6.

## **2.5 Case study sites**

While it is not usually viable in case study research to select locations to be representative in the conventional sense, it is possible to make purposive selections so as to include different types of settings in a study. Our plan in England had originally been to include PCTs located in an urban Home County locality, a mixed area in south central England and a northern industrial city, and in Wales to include LHBs in a provincial city and a mixed rural/industrial valleys area. As explained the Northern English case study was dropped for practical reasons, and the access problems encountered with our first choice site meant that the Home County PCT included is on the edge of the London metropolitan area, covering a mixed urban/rural area. English case study B in south central England is more complicated than planned because we found that two neighbouring PCTs worked closely together, alternating the lead and associate purchaser roles with different local providers. Thus we decided to include both PCTs within this case study.

It is important to keep sight of the fact that the study sets out to investigate different regulatory regimes that are emerging in England and Wales as a result of increasingly divergent frameworks of legislation, policy and guidance. The different 'in-country' case studies did reveal some differences in local governance approaches within the 'envelope' of the national regulatory regimes. However, the main focus of our study is on national differences in contracting arrangements that relate in part at least to policy differences concerning matters like the use or non-use of the financial flows system, and the presence or absence of foundation trusts and independent sector treatment centres.

The characteristics of the case studies are summarised in Appendix 2.

## **2.6 Data collection**

The study follows a similar approach to other recent 'policy ethnographies' which utilise a combination of non-participant observation, interviews and documentary analysis to examine NHS management processes.<sup>32-34</sup> We observed a variety of meetings linked to the commissioning process and carried out interviews with relevant participants. Most meetings and all interviews were tape recorded and fully transcribed. In addition, we collected relevant policy documents (e.g. English and Welsh standard contract templates, individual PCT/trust and LHB/trust contracts, annual operating frameworks, and various national guidelines, commissioning intentions, CQUIN targets, financial statements) which were used to supplement data from other sources.

The study aimed to cover two contracting cycles, spread over the 2008-09 and 2009-10 financial years. This was achieved with English case study A and the two Welsh case studies. Observations for English case study B extended only over the 2009/10 year, but the interviews gathered data on the two year period.

Overall then, the fieldwork in England was more narrowly focused on the routine work of contracting, while that in Wales was concerned with reporting how commissioning was being taken forward in a system where routine contracting work was winding down and changes were being introduced. Interviews in both countries were carried out to supplement the observations, and also to provide information on the wider service environments. In all four case studies, we thought it important to explore how far contracting processes and relationships were influenced by national and regional policy contexts.

### **2.6.1 Data analysis**

The research fieldwork generated a large number of audio recordings of meetings and interviews. The majority of recordings were transcribed and put into Microsoft Word text files. This left us with a considerable volume of textual data in the form of transcriptions of meetings and interviews, field notes, and documents. We undertook content analysis of these materials, based partly on inductive analysis of themes and patterns in the data, and partly on the chronology of the contracting cycle<sup>35</sup>.

Based largely on the preferences of the research officers, we did not follow our original plan to use a specialist qualitative analysis computer application, but instead opted for the simpler approach of marking text passages in Word files. As analysis progressed, data extracts illustrating particular themes were cut and pasted into files containing data extracts on a given theme. We felt that the case-specific analysis of events over time needed to be handled by following an issue through a series of meetings. This required a process of manual analysis which was difficult to automate and meant going back to full transcripts of successive meetings.

Coordination of analysis across the English and Welsh teams was achieved largely by exchanging memos setting out proposed frameworks for analysis, and lists of provisional categories and examples of their application to emerging data. These were refined inductively as analysis of data proceeded. Although funding for team meetings was virtually non-existent within what was a very tight project budget, we 'piggy-backed' a number of project discussions on to the meetings of the associated REFGOV project and meetings of two cognate SDO projects involving some of the same team members.

## **2.7 Ethics**

This research focused on management processes and there was no contact with patients and no access to medical records. The main ethical issues concerned informed consent on the part of organizations and their staff, confidentiality (when required), anonymity, and secure handling of data.

We prepared appropriate information sheets and consent forms, and have taken steps to conceal the identities of individual participants (except where senior staff within organizations wished to be identified and speak on the record). Access to raw data was restricted to the research team, and tapes

and printed data have been stored in locked filing cabinets. We have used password protection for electronic data files. When tapes were transcribed into text files personal names were removed. The anonymity of participants will be preserved in publications and presentations. A few very senior respondents have indicated that they are willing to be identified by naming their posts, and here we use the position rather than name (e.g. Chief Executive, Health Commission Wales). As mentioned earlier, the study was subject to ethical scrutiny and gained approval from the Wales REC.

One unexpected ethical problem arose midway through the study as a result of the Welsh team's observations of Individual Patient Commissioning Group meetings. These were LHB meetings concerned with deciding on a case-by-case basis whether to buy high-cost interventions that are not normally commissioned. A patient who had been denied access to a high-cost drug sought judicial review of the LHB's decision. The LHB solicitors advised the LHB that it would need to tell the plaintiffs that three meetings in which the case had been discussed had been recorded for research purposes, and that we would need to provide the LHB with an audio recording, which it could then furnish to the court if necessary.

We were concerned that this might raise issues of informed consent for those members of the group – all LHB employees – who had given permission to use the recordings for research purposes but not to share them with third parties. There were also potential legal issues regarding our contract with SDO and our own liabilities that led us to seek advice from the Department of Health solicitors, Swansea University's solicitors and the MREC before deciding how to proceed. Both legal advisors, as well as the MREC advised that we would have little option but to make the recordings available. The MREC advised that, if possible, we should obtain individual written consents from all participants in the relevant meetings. This was done and consents were obtained, to our mind on a fully voluntary basis and without LHB coercion. We then handed a copy of the recordings to the LHB. In the event the application for judicial review was refused at a preliminary hearing, so that the content of the recordings never came into the public domain. As far as we know there were no adverse consequences for any of the parties. Unfortunately there was a limited adverse impact on the research in that the chair of the Heads of Commissioning Group in this case study area asked us to bring our recording of meetings to an end, for fear that circumstances beyond our control might force us to share data with third-parties.

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## 3 Contracting processes in England

### 3.1 Introduction

This chapter provides an overview of secondary care contracting processes in our two English case studies. We begin by mapping out the main features of the contracting cycle, contracting styles and relationships, centralisation versus decentralization, transaction costs, and clinical involvement and networks. A number of 'tracer' issues will be considered in more detail in later chapters.

### 3.2 Contracting cycle

In 2008, the DH introduced a 'new standard NHS contract for acute services' to be used between PCTs and their acute care providers, both foundation trusts (FTs) and non-FTs but which is, at least to date, legally binding only on FTs. The contracting cycle involves negotiating the terms of the contract, signing it and subsequently monitoring performance against the activity plan on a monthly basis.

In broad terms, the contracting cycle in England started in November or December with the publication of the DH's annual Operating Framework and the publication of PCT Commissioning Strategies and/or Commissioning Intentions. The contract negotiation period between PCTs and acute trusts did not start in earnest until early January and was expected to finish by the end of February. The signing of the main contract (i.e. baseline activity and Schedules) was expected to be completed by end of February, while agreement on the CQUIN framework (which was introduced for the first time for the 09-10 contract), could be delayed until the end of March.

Due to external or internal factors, this timetable was not always followed strictly. The contracting period for the financial year 09-10 was slightly extended in both case studies by delays and confusion related to the introduction by the DH of HRG4 (see below).

In case study A, due to problems with the trust's data quality, the contracting negotiation period continued well into the summer, until eventually a block contract was signed (see: Chapter 5).

Occasionally, external factors may intervene to speed up rather than inhibit the contracting cycle. In case study B, the teaching trust's application for FT status was expected to have the effect of streamlining the contracting process in general, as the trust and its main PCT need to present to Monitor and the SHA a co-ordinated financial plan. In other words, the trust has to present a viable financial position for eight years ahead and this plan has to be backed by proof of the main purchaser's support for the plan. As one participant explained:

*For next year, we are being helped tremendously in terms of planning the activity by a happy coincidence...The coincidence is that we are just about to put in our integrated business plan application to be a foundation trust...So, the processing time for doing that is that by the end of October we have to have agreed with the commissioners the activity plans and the value of that activity for the next eight years...So, if we get that done, in effect that means at high level by specialty, by type of activity, we've got the contract planned for next year, so we should be in a far better position than we have been previously. If it works, what I'm going to try to do is to have a similar process for at least three years.*

(BT3, Dir of Business and Planning) (for codes see Appendix 2)

### **3.3 Contracting styles and relationships**

According to our theoretical framework, the nature of the relationship between the contracting parties plays a significant role in successfully implementing the contract. Socio-legal theories and neo-institutional economics, predict that in an area such as health care, discrete relationships are not appropriate and need to be combined with what is called 'relational contracting'. Theorists have argued that where long-term contracts are involved, and in a context characterised by high specificity of assets, successful relationships depend on a high degree of cooperation and trust.<sup>25,36</sup> In this section we will consider how far these conditions were met in the organisations studied?

A review commissioned by SDO as background to the 'Studying Healthcare Organisations' theme suggested that the English NHS had moved through a period of quasi-market organisation in 1991-97, followed by a phase when a return to hierarchy coexisted with experiments with managed networks and partnership working, and after about 2002 a phase when market mechanisms again had a bigger role.<sup>37</sup> While studies have shown significant local variations, the evidence suggests that as the internal market settled in the mid-1990s hybrid contracting approaches developed that were significantly different from private sector contracting, and blended significant aspects of co-operation and trust with elements of command and control.<sup>38-40</sup> After 1997, the Labour Government's policy emphasis on integration and co-operation resulted in diminishing use of contractual controls and less recourse to mechanisms such as penalty clauses and arbitration. However, by the time of our study the pendulum had swung back to markets and the use of 'harder' contractual levers was once again featuring in managerial discourses. That is reflected in our English case study findings, though we also found indications of continuing differences in local approaches.

The hardening of the market did not result in a uniform trend towards more adversarial relationships. In both case studies, apparently friendly relations at the personal level co-existed with a significant degree of toughness and tension in the contracting process. But while one area saw a worsening of relationships in Year 2 of the fieldwork (2009-10), the other saw improved co-operation as purchaser and provider worked together to deal with common problems.



In case study A in Year 1 (2008-09) the meetings we observed were generally conducted in good humour and differences were resolved amicably. Nevertheless, disagreements arose over certain issues that came very close to arbitration, with participants seeking advice from the SHA and in a few cases from lawyers. During Year 2, there were significant changes in contracting personnel, especially on the trust side. This, together with escalating issues relating to the trust's data accuracy, led to relationships between the PCT and the trust becoming more formal and adversarial. The impact of the personnel changes was compounded by the fact that the PCT contracting team found itself severely understaffed. Some interviews with PCT members reflect frustration that appropriate staff were not available to negotiate or monitor contracts:

*You've gone from a block contract to really fine detail and I haven't got the resources to do it... but we're using external contractors too. So I've got two external contractors in the contracting team at the moment... I haven't got any substantive contracting staff and all they want to do is put somebody in above me and I'm thinking, but I need people on the ground doing the work.*

(AT1, Head of Contracting)

PCT staff complained that the trust was not delivering adequately on a number of contract requirements, especially those related to data accuracy and transparency. Failure to provide credible or detailed data concerning activity on the part of the trust resulted in failure to reach agreement on activity forecasting and therefore on the overall contract value. The PCT felt that the trust, instead of admitting the poor quality of its data, simply delayed the process by refusing to acknowledge its weaknesses:

*The problems were to do with the quality of the data from the trust, and in my opinion...I recognise it's very much a one-sided opinion, we could have avoided quite a lot of the issues if there'd been an acknowledgement up front by the trust that actually the data was... you know... wasn't good. Because that was the situation we got to in June-July, and actually we could have been there a lot earlier. So that certainly didn't help. Also the financial pressures that the trust were under obviously hindered things. And I think perhaps there's not a history of openness between the two organisations that might have helped us to speed things along a bit.*

(PCT A, Director of Finance, 2nd interview)

After a number of successful data challenges by the PCT, the trust's new Director of Finance warned that a reduction in the expected contract value would endanger the trust's financial viability. After further negotiations, and taking account of the trust's financial problems, the parties agreed to sign a 'block contract' containing less stringent data requirements. When we left the field, the trust was improving its contract information system and efforts are being made on both sides at rebuilding relationships.

There was a notable difference in contracting styles between case study A and case study B, reflected in the composition of the contracting teams. While in case study A the Directors of Finance of both organisations played a leading role in the Directors' meetings throughout the contracting year, in case study B the Directors of Finance in PCT B2, BT3 and PCT B1 were closely involved only towards the end of the contract negotiation period, after the groundwork had been completed by the contracting teams and before the total value of the contract was agreed. The Directors of Finance,

in other words, were called in to reconcile the disagreements which nearly always exist between PCTs and trusts, over the value of the contract to be signed. Similarly, the Directors of Finance were not directly involved in the performance monitoring of the contract throughout the year but were normally called in to intervene when unresolved differences occurred, for example, over payment issues. This did not mean that they are not kept informed by the contracting teams about outstanding issues, but simply that they did not themselves as a rule attend the contracting meetings in person.

By contrast, the Directors of Finance of both District General Hospitals in the case study (BT1 and BT2) were, as a rule, present in Directors' meetings throughout the year and visibly leading their respective contracting teams.

Relationships in case study B ranged from civil and formal to very friendly. Close personal relationships between some of the Directors of Finance proved on occasion very helpful in reaching a mutually attractive deal for their respective trusts.

One of the key features of this case study was the difficult financial position in which one of the PCTs found itself. This created problems affecting its relationship with the trusts as well as the other PCT. Because PCT B2 was in a healthy financial position, while PCT B1 was not, BT3 found that only one of its two partner PCTs could contribute to service developments. Fortunately for the trust, its main purchaser was the financially healthy PCT. Among other things, the situation meant that trust staff became concerned about postcode-based differences in the services provided:

*I think there's a risk anyway because [PCT B1] are stony broke compared to [PCT B2]. In which case, we will have to get used to, as long as it doesn't compromise required clinical safety protocols, we will have to get used to providing a different care to PCT B2 and to PCT B1, not in terms of the quality of care that is provided to the patients, but PCT B1 might have a longer waiting time than PCT B2. PCT B1 might say, no, we're not going to treat conditions A to X; PCT B2 might say, we don't treat A to F, so we'll be treating patients, some of them, by postcode.*

(BT3, Director of Business and Planning)

This situation also complicated the arrangement whereby the (richer) lead purchaser PCT commissioned services with the common protocols on behalf of the (poorer) associate. The poorer partner was sometimes reluctant to agree arrangements that involved additional expenditure. As one participant said:

*[PCT B1] are in a slightly strange position because they're an associate PCT to us (...) they would like to take a much more lead role or equal role in the contracts with [BT3], as we do. So there's always been that tension there... What clearly has made it very difficult through the negotiations last year and the start of this year is just the very different financial positions and we've been in a number of positions when we've had to take a different line to [PCT B1].*

(PCT B2, Assistant Director of Contracting and Performance)

Although respondents reported the relationship between PCT B2 and BT3 to be good, and mentioned the PCT's support for the trust's application for FT status, there were evident tensions. Trust respondents suggested that the

PCT's management of the contracting processes has been rather weak, manifested for example in its failure to put in place a proper structure for the contracting cycle. The PCT in turn had been frustrated with the trust's delays in submitting data (an issue that resulted in threats to go to arbitration). Some respondents suggested that this was damaging the relationship by undermining trust.

*I do think there's (...) at a deeper level, a lot of mistrust in terms of sharing information...I mean the view from people here is that for a long time, the [trust] have been very hesitant about sharing information and data...At a deeper level there is a lot of, well, we feel they're sometimes covering things and not being quite as open as we should be.*

(PCT B2, Assistant Director of Contracting and Performance).

Nevertheless local circumstances bound these two organizations together. BT3 was the single major secondary and tertiary provider in PCT B2's catchment area, so that there was a strong incentive to maintain a cooperative relationship. The option of purchasing services elsewhere made less sense than in a situation where a PCT was close to multiple competing acute trusts. Likewise, the trust's viability depended on the support of its main purchaser. This mutual dependency meant that the two organisations were locked into a relationship where non-cooperation was not an option.

*When you look at local health economies, the situations are all very different, so if you have a local health economy that primarily just consists of one PCT and one trust, you know, and for the trust, 85% of his income comes from the PCT; and for the PCT, 85% of his expenditure goes to the trust, you've got no choice but to work in harmony. Because, unless you think that somebody outside is going to come and bail you out, those two organisations have got to sort it out.*

(BT1, Dir of Finance).

PCT B1 was the coordinating commissioner (lead purchaser) for two other trusts (BT1 and BT2). Relations with these were also reported to be generally good, but here too stories of tensions emerged, in this case centring on PCT staffing problems and accusations that this had affected contract management.

*But, they do seem to be getting much more business-like and getting their act together. I mean, [the PCT's] real issue is, has been retention of staff, really. You just about get a relationship with somebody and they've gone. It seems to be settling down now under the new CE but before that it was quite difficult. I mean, you just about got used to dealing with somebody, built that relationship up, and then they're gone.*

(BT1, Commercial Director).

There was also unhappiness in trust BT1 because the PCT had not supported its application for FT status because of reservations regarding quality issues. Both BT1 and BT2 had been deferred in their FT applications in the past and were preparing to re-apply at the time of fieldwork.

The paradox in both case study areas was that apparently good surface relationships did not prevent a series of disputes arising that often came close to arbitration (see section on dispute resolution). In the words of one participant,

*On the surface, we're all lovey-dovey, cuddly-furry etc, but actually, they [relationships] can't be that good, can they, if we nearly go to month one arbitration?*

(BT3, Director of Business and Planning)

For some respondents the framing of relationships as contractual relationships in itself encouraged discrete and adversarial relationships:

*But I guess the problem is, once you've got a formal contract in place, it almost drives you down that sort of route, doesn't it, of having two parties trying to get the best deal for themselves out of it. So I'm not sure that can ever go away entirely.*

(PCT B2, Assistant Dir of Contracting and Performance)

*The contract actually kind of reflects a confrontational kind of position between the organisations and, in a sense, establishes and embeds a more confrontational kind of relationship. But we're all human beings and we have to get on and work together, so we probably work around that.*

(BT1, Dir of Finance)

In all the case study sites managing this tension between formality and the maintenance of practical working relationships lay at the heart of the contracting process.

### **3.4 Centralism versus decentralisation**

#### **3.4.1 Contractual and hierarchical governance**

The contract in England operates within a policy environment characterised by the operation of mixed forms of governance. On the one hand, the latest 'standard' contract was conceived as an instrument better fitted to the recent market reforms, when compared to the older form of 'block contracting'. Yet on the other hand, the contract operates within a top-down bureaucratic environment, in which multiple regulatory bodies influence its operation. The overseeing bodies that most directly influence NHS contracting processes are the SHA, Monitor, the Care Quality Commission and NICE.

#### **3.4.2 Strategic health authority (SHA)**

Although not independent regulatory bodies as such, strategic health authorities (SHAs) are an intermediate level of governance between the DH and PCTs. One of their main functions is performance management of the PCTs in their areas, a responsibility that impinges directly on contracting. One SHA participant explained:

*Our job is to performance manage the commissioners within the SHA. And by performance management... there are two elements to it: one is enabling; so supporting their development, and the second is reviewing their performance. And we do that in particular for commissioning now through the World Class Commissioning assurance process.*

(SHA, Director of Commissioning)

In relation to contracting, SHAs make sure that contracts are signed on time, and that the PCTs have the necessary skills and personnel to deliver adequately on the requirements of the contract. Specifically, as the above quotation indicates, SHAs must ensure that PCTs comply with the DH's World Class Commissioning competencies. Competency 10 (out of 11)

refers explicitly to effective contract management: 'Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes'.<sup>41</sup>

Asked whether the SHA becomes involved in the contracting process, the same participant replied:

*We only become directly involved in the processes – and by the processes it should be clear what we're talking about, the process of a commissioner commissioning services from a supplier – we only become involved in those processes normally when there is a dispute between two parties....The first thing to say is there are very clear expectations about how the process should be managed and the timescales for that. So, for example, there is a very clear expectation that contracts should be signed by the end of February. So, part of our responsibility is to make sure that happens. The contract requires certain behaviours and acts on behalf of commissioners and providers.... So, for example, a requirement to carry out monthly clinical quality review meetings, so we review those processes. And one of the things that we are currently doing is helping to build the capacity and capability of PCTs to lead that particular process. So, we've got a responsibility to make sure it's happening, it's happening when it should be.*

(SHA, Director of Commissioning)

Several of these requirements are set out in the annual NHS Operating Framework, which provides a reference point for SHA performance management of PCTs and trusts. This generally appeared to take the form of direct monitoring and command, rather than negotiation and joint signing of performance agreements. As we shall see in the next chapter, Welsh PCTs are required to agree a local OF with the regional office, but this is not mandatory in England. The case study B PCTs prepared Commissioning Intentions documents linked to the OF, but the case study A PCT did not.

*Not all PCTs produce Commissioning Intentions – for example, ours doesn't. They just set out somewhat vague demand management schemes based more on hope than experience!*

(Assist. Director IM, PCT A, e-mail).

SHAs are also required to ensure that CQUIN schemes, which incorporate contractual incentives, (see: Chapter 5) contain deliverable indicators. According to the 2010\11 NHS Operating Framework, 'SHAs will be responsible for assuring that schemes adhere to the CQUIN framework guidance for 2010/11' (DH, Operating Framework, Dec 2009). SHAs are also actively involved in bringing together all the organisations in their areas in relation to drawing up CQUINs which are aimed to deliver regional targets and services.

SHAs intervene when organisations run into financial difficulties. In cases where FTs run into financial difficulties, SHAs work in conjunction with Monitor to ensure that a viable recovery programme is put in place. Similarly, SHAs can allow contracting parties to temporarily suspend or alter current contracting arrangements to ease pressures, for example, by temporarily reverting to 'block' contracts. Additionally, as provided in the standard contract, SHAs are closely involved in 'dispute resolution' between contracting parties (see: Chapter 5).

### 3.4.3 Monitor

Monitor, being the regulator for foundation trusts, is responsible for ensuring that an FT's financial management and quality of services conforms with specified national standards. While Monitor is not directly involved in the contracting process, it helps shape the contracting environment. Both the contract and Monitor can be seen as different mechanisms of regulation, ensuring that FTs are financially viable and able to meet the national quality targets. If a FT became financially weak or its quality ratings worsened, Monitor intervenes and seeks an assurance that the FT has a strong and credible recovery plan. One participant from the FT in case study A, described Monitor's involvement when FTs fail to meet standards:

*They [Monitor] will intercede. First, they will give the trust an opportunity to put its house in order. So what they are interested in is the assurance process that you put in place... And that is where there is ongoing meetings to ensure that the programme plans that have been developed are being met... Typically, if you are performing and everything is fine, you don't see Monitor till every quarter. The minute there is a problem, if you are unlucky, you'll be seeing them every week. Which is something that no Chief Exec actually wants.*

(AT1, Head of Contracting)

### 3.4.4 Care Quality Commission (CQC)

The CQC is the new independent regulator of health and social care provision in England. Like Monitor, it is not directly involved in the contracting process, but, alongside the contract, it forms part of a range of interlinked mechanisms of regulation of health care services. Specifically, it regulates care provided by all NHS organisations, local authorities, private companies and voluntary sector organisations in England. From 1 April 2010, all organisations providing health and social care in England were required to register with CQC, thereby in effect acquiring a licence to provide services. The CQC has stronger enforcement powers compared to its predecessor (the Healthcare Commission). If it is determined that a trust is not meeting essential standards on issues relating to public involvement, patient experience, clinical quality and safety, it will initially receive a warning notice which, in the event of continuing failure to meet standards, can escalate to fines, prosecution, restrictions on activities, and even closure.

The CQC is responsible for making sure that health and social care services are of high quality. It discharges its duties by collecting annual self-assessment information from providers, performing on-site inspections, and collating data from members of the public relating to their experience of health and social care services. Although the CQC is not directly involved in contracting, the standards of service provision on which it focuses are routinely included in contracts (e.g. MRSA and C.Difficile rates, and CQUIN indicators and metrics). PCTs monitor the extent to which their providers meet such standards. In part, the work of CQC provides an additional mechanism for monitoring and regulating quality and safety of provision, but this may in practice reduce transaction costs for PCTs, since the latter

have access to CQC reports and recommendations and do not need to duplicate that effort.

### 3.4.5 National Institute for Health and Clinical Excellence (NICE)

Another body which impacts indirectly on contracting discussions is NICE, the independent organisation with the responsibility of issuing national guidance on good practice for the promotion of public health, and on the use of new and existing medicines, treatments and procedures within the NHS. NICE undertakes work on quality, outcomes and standards which is relevant to NHS organisations, including guidance that is adopted both by providers and commissioners. A number of Commissioning for Quality and Innovation (CQUIN) indicators, for example, have been influenced by NICE guidelines on clinical effectiveness, patient safety and patient experience.

Interpreting NICE guidelines relating to drugs (especially expensive drugs such as Herceptin) was another area that created uncertainty and disagreement between contracting parties. PCTs were required to commission services recommended in NICE technology appraisals but had local discretion to decide when and to what extent to implement NICE clinical guidelines. Often in meetings it became apparent that the contracting parties were not clear about what precisely they were supposed to be monitoring or implementing. One interviewee said:

*I don't find the PCT entirely helpful because, you know, saying, we want that data as it's written down in the contract, yes, okay, that's absolutely fine, but what do you...? What does that actually mean, and what do you actually want?... Okay, well take another maternity example, the NICE antenatal guidelines, it's 126 guidelines. What do you want in relation to those 126 guidelines? So, you know, there's no... It's what's written down.*

(AT1, Deputy Dir of Operations)

### 3.4.6 The NHS standard contract and the PCT

The standard NHS contract was introduced in England in 2007 as part of the wider market reforms in health care (see: Chapter 1). The standard contract was drafted centrally, by the DH, and contains elements which are 'mandatory and non-variable', such as the national targets on infection control, the 18 week pathway, and the four hour A&E wait. It also contains elements that are 'mandatory, but for local agreement and definition'. Finally, it contains sections which are 'non-mandatory, and for local agreement and definition' (DH, 2007). For example, locally-agreed clauses may relate to quality, service changes and clinical pathways.

Consequently the new contract represents a mix of centralisation and local autonomy. The government intends the contract to be 'an important tool for assuring accountability between Providers and PCTs and for improving performance.'<sup>42 (p.4)</sup> Seen in this light, the contract is one amongst a variety of means to achieve nationally-defined targets and policies.

The standard contract is a long document (139 pages) with detailed instructions and explanations relating to a variety of issues such as, activity and risk management, information requirements, performance

management, prices and payment, quality, dispute resolution, monitoring, clinical quality review, contract variations. The main body of the contract (clauses 1-60) contains mainly mandatory and non-variable requirements. The contract also contains a number of Schedules and Annexes (21 in total), dealing with issues such as methods of managing activity and referrals (Schedule 3), specification of information that providers are required to supply to PCTs (Schedule 5), variation procedures (Schedule 6), description of procedures for dispute resolution (Schedule 9) and performance incentive schemes (Schedule 18).

Getting the balance right between centrally-imposed policies and requirements tailored to local circumstances is not always easy. Often tensions are created between these two forces. Some arise from ambiguities or lack of clarity in the contract itself. Participants found, for example, that the contract was not always helpful when it came to the question of the action a PCT was expected to take in the event of late submission of data by its acute providers.

*The contract is actually fairly ambiguous in terms of, you know, if data is sent after the point at which it's meant to be sent to you. You know, what do you do? Can you not pay for that data, you know, does it just not exist? Or it does talk about, you know, maybe withholding monies for late data submission, but it doesn't say anything about, you know, not paying... Our view of reading the contract, as I said, was, you know, it said different things in different parts of the contract. It certainly wasn't clear.... We felt that, you know, that this was a bit over the top. You can't just send us data at any point, at any time in the future, and expect us to pay for it.*

(PCT B2, Assistant Dir of Contracting and Performance)

One of the elements in the contract that is centrally determined is the setting of prices. Specifically, the introduction of PbR, meant that specified healthcare activities were categorised into 'Healthcare Related Groups' (HRGs) and a price fixed calculated on the basis of average costs. Prices relating to specific HRGs were national, which meant they were fixed for all acute care providers and were therefore no longer subject to local negotiation. The introduction of PbR and the national tariff were intended to incentivise providers to become more efficient by reducing costs and making commissioning of acute care services more transparent.<sup>43</sup>

Poor coordination between the timing of release of DH documentation and existing deadlines that commissioners and providers were required to meet, resulted in frustration and confusion in PCTs and trusts. One such example was the introduction of HRG4 just before the start of the 2009-2010 contracting round. HRG4 was a new, more refined and detailed version of PbR prices which replaced the earlier HRG3.5. The attempt to incorporate the new prices into the contracting round at short notice created confusion and delays:

*There were a number of things that were not entirely in our control, that put us back time-wise. That's not making excuses, but you know the change to HRG4 messed up everybody's plans across the country really and put everybody back and made it very difficult for us to keep to our original plans and timescales.*

(PCT B2, Assistant Dir of Contracting and Performance).



The problem was exacerbated because of difficulties in translating activity recorded in the old HRG3.5 groups to the new HRG4 categories. As participants explained:

*The problem we had was that we were trying to compare apples and pears, because we were getting something out, coming out in HRG4 and last year's data was in HRG3.5, and what I kept asking was, can somebody actually do me a reconciliation to show me what it would look like if it was in last year's currency or vice versa; what would last year's look like in this. And I never got that because it was deemed too difficult to do it.*

(PCT B2, Assistant Director of Contracting and Performance).

The introduction of HRG4 contributed to additional, and seemingly unnecessary, work for the participants because certain elements, such as the 'unbundling' of diagnostic services, proved too costly to implement. As one participant described it:

*We basically had to have a brand new model for a lot of things and as well as HRG 3.5 to 4, they did all sorts of other things like they unbundled the diagnostic out-patient scans which, of course for 10/11 they're re-bundling back again. Because it was too expensive. It cost more therefore, oh dear, and it was damn complicated... We've now got to re-bundle it all again, which is great, isn't it?*

(BT3, Director of Business and Planning).

Here bundling refers to the grouping of different components of care within a given HRG (i.e. where a number of care components are bundled together and attract a single payment). HRG4 introduced more 'granularity' into the tariff structure by making some components of care separately chargeable (unbundling), something that was deemed desirable when high-cost, low volume items were unevenly distributed across contracted activity. But as indicated above, this often introduced major problems.

### **3.4.7 Local prices**

Not every healthcare activity has yet been categorized under HRGs. Certain types of activity are reimbursed on the basis of 'local prices' or 'non-tariff prices' which are linked to a trust's 'reference costs'. Local prices represent an element of de-centralisation in contracting since they remain subject to local negotiation and agreement, 'on the basis of the properly incurred costs of providing those services' (standard NHS contract, clause 7.2). They provide a good example of the different effects that centralised and decentralised elements have on contracting activity.

Because local prices are not standardised they can give rise to uncertainty and disagreement between the contracting parties, and therefore require the PCTs to trust their providers not to inflate their prices. According to the contract, 'the calculation and basis of the Non-Tariff Prices shall be transparent, equitable and open to revision annually by Review by 31 January in each Contract Year' (standard NHS contract, clause 7.3). In cases where the two parties cannot reach agreement on setting the local prices, each may refer the matter to dispute resolution. Alternatively, in cases where PCTs think transparency in setting local prices is lacking, they have the right to appoint an independent third party ('Auditor') to conduct

an audit on the calculation of such prices by the provider (standard NHS contract, clauses 19.6-19.8).

In case study A, disagreements arose during negotiation of the annual local prices revision which contributed to delay in signing the contract. The PCT had suspected since at least 08/09 that the trust's non-tariff prices were too high. After much debate between the two parties and with the trust's agreement, the PCT commissioned an audit which found that the trust's local prices were not set appropriately. This audit concluded that the trust's process of calculating its local prices was defective and highlighted the need for a systematic pricing review before agreeing local prices for the 2009-10 contracting year. Although the trust agreed to conduct the systematic review, for various reasons it failed to do so. The PCT responded by refusing to sign the contract until the local prices issue had been resolved. In the end, in the light of the trust's financial difficulties (mentioned earlier), the PCT agreed to sign a block contract, accepting the status quo on local prices for 2009-10. It insisted, however, that in order to re-open the contract negotiation for 2010-11, the trust's local prices would have to be reviewed. The trust, in return, undertook to conduct an internal local pricing review before the contracting year 2010-11.

The mixture of centralised and decentralised elements in the contract often resulted in confusion amongst local stakeholders. One such area was related to data quality and deadlines for data submission by providers. In one of the case studies participants debated the exact definition of a 'minimum data set'. In the other case study, there was uncertainty about the consequences that would follow from late submission of data by providers. (See below section on data). Asked whether they ever approach the DH for clarification on policies, one participant replied:

*We often go to the Department of Health and ask them to clarify things and they're incredibly bad at it. So they very rarely clarify it so it's really clear, so we read one thing into it and the PCT reads something else into it.*

(AT1, Commercial Director and Head of Contracting)

### **3.5 Transaction costs**

With the introduction of the new standard contract, transaction costs have increased both for PCTs and acute trusts. Although, on the one hand, the introduction of PbR and the national tariff resulted in reducing transaction costs associated with price negotiation, on the other hand, the requirement for monitoring the contract and the associated need for data accuracy and detail (e.g. patient level data), resulted in an increase in the transaction costs of contract management. High transaction costs, combined with limitations in PCT resources, help to explain why relational contracting (i.e. relations based on trust and close co-operation, with less need for monitoring) is so important, as we found in our case studies.

Participants in our study expressed mixed views regarding the effect of the contract on transaction costs. On the whole, participants seemed to be in favour of the new contract, recognising its many advantages.

*I think it's got to be positive, hasn't it. I mean, a contract is going to be something that you agree to, you get an opportunity therefore to discuss and debate it, and you get a performance framework out of it, so I think it's only got to be a positive. And it also gives you that, kind of, coat hanger on which to hang all your other discussions and information exchange around patient care. So I think it's got to be a positive.*

(AT1, Dir of Nursing)

Yet, they also recognised the costs of increased formality and specificity. Negotiating and monitoring the contract needs the involvement of dedicated teams with a variety of skills and expertise. Finding high calibre staff with the required expertise or the appropriate skills is not easy. As mentioned earlier, one of our PCTs had a relatively high staff turnover, while another had difficulties with staff recruitment, employing in the meantime external consultants on a temporary basis. As one participant described it:

*I suppose what the new contract has done is it's meant that we've both had to invest more people staff time, because it is much more manpower hungry. Because you have to monitor everything and produce so much more detail and more data.*

(AT1, Commercial Director and Head of Contracting).

Sometimes the gain of devoting precious resources to such detailed monitoring was called into question:

*[The contract] is very long and complex and detailed and therefore is driving us into a level of contractual management that I think doesn't always add value. But as long as you have a commissioner/provider split and as life gets tougher for both of those organisations, the contract is going to be the vehicle that, if you like, makes that relationship work. From a trust point of view, you could read it that the contract is quite strongly weighted in favour of the commissioner.*

(BT1, Dir of Finance)

*I think it's added a rigour into the system, which I think is good. I do think it's good to have rules, I think it's good to have discipline. I think it's overly bureaucratic. I mean, that's the contract. It's too big. I think at the end of the day, we're all in the NHS. And, I think that's, you know... What we seem to be creating is a bureaucracy for two NHS organisations to fight each other. And, you do question, in an economic downturn, is that a sensible use of public money? Would we not be better off scrapping that and just spending it on treating patients?*

(BT2, Dir Finance)

A number of participants thought that the emphasis of the contract, at least the way in which it was implemented by PCTs, was on financial drivers rather than on commissioning better services for patients. There was a feeling that PCTs concentrated on the cost and volume aspect of contracting instead of adopting a more strategic commissioning approach for improving quality of services.

*I suppose for me, in terms of performance management as well, it is more than just the data. It's much more than just looking at the cost and the volume, because I don't believe that's what a contract is all about. Whilst that's definitely parts of a contract, you know, I don't believe it's the totality of a contract and... To me there's something about the performance and the management of patient care and health economy funding, across the whole of the economy, and, you know, surely we should be commissioning for better outcomes for patients. I'm not sure we're commissioning for better outcomes for patients...if we take a maternity example, what does six antenatal visits give you in terms of patient outcomes?*

(AT1, Deputy Dir of Operations)

Another participant said:

*...commissioners and providers are spending a lot of time and money just battling queries back between each other...And those queries are not there to help understanding of commissioning, those queries aren't there so they can think about better ways of commissioning, they're there to see if they cannot pay for activity...You know, I accept totally that the PCT shouldn't be paying for things that are inappropriate but we're making an industry...we're making an industry out of contracting instead of commissioning.*

(BT2, IT Manager)

Arguably the transaction costs would be even higher if PCTs had the resources to monitor or audit in great detail the quality of services of their providers, though this might be balanced to some extent if improved governance reduced poor practice. A lot of such monitoring relies on providers assessing themselves and PCTs trusting the evidence provided. As one participant said:

*A lot of it is self-assessed anyway, and Standards for Better Health is self-assessed so they produce reports saying we've assessed ourselves against these criteria, and as far as we're concerned we've met them all...We could audit it. But that's where it really does get cumbersome, though. I mean, we've got the right to audit anything. But we'd need a team of auditors in there all the time, auditing things...If you wanted to really manage the contract to the best of your ability as a PCT, you'd need a team of clinical coders, for example, and you'd need a team of auditors, both clinical and management auditors, if you wanted as well, to go into trusts and check out exactly this stuff.*

(PCT A, Consultant)

A few took a contrary view. One respondent indicated that the fact that the contract is now standardised, allowing NHS staff to concentrate on tasks that related more directly to quality for patients.

*It is better, because we are not spending man-weeks writing turgid scripts that are only slightly different from other contracts. We're actually spending more time, believe it or not, on protocols, models of care, talking about services etcetera.*

(BT3, Director of Business and Planning)

This participant accepted that the burden of contract monitoring had increased substantially in recent years, but felt this was a price worth paying because quality of care had increased too:

*If you go back four or five years, [the NHS] wasn't monitoring sufficiently the quality of care that it was delivering and therefore, over that period of time, along with other externally-driven elements/new policies like control of infection etc. has, you know, multiplied massively the amount of monitoring, but actually quality of care is the most important thing. Whereas, if you go back five years, you would have thought, counting the pound notes was the most important thing, to be honest with you. So, yes, it is worth it because it also increases our ability to engage the clinicians in the management process because we're now looking at things they care about, so that helps.*

(BT3, Director of Business and Planning)

One factor that inevitably results in an increase in transaction costs is the need to collect accurate and detailed data. This is indispensable to activity forecasting and performance monitoring, but also contributes to quality improvements by providing greater transparency. The move towards more formality and specificity in contracts cannot happen in the absence of

accurate and detailed data. For these reasons, the standard contract contained specific clauses relating to the kind of data providers were required to share with commissioners, the regularity and frequency with which PCTs should receive data, and the consequences if trusts failed to provide required data.

Our study showed, however, that accurate and detailed data are not always available to NHS providers. In case study A, there were issues relating to data quality which seriously affected the contracting process throughout both years of our observation. Both the PCT and trust came to accept that this problem arose from inadequacies in trust data recording systems rather than any attempt to withhold information from the commissioner. In this case improving data systems was the trust's interest too, since the implementation of PbR meant that a trust's income depended very much on accurate data:

*So by Quarter Four, the income had really dwindled to the extent that a recovery was required. There was no two ways about it. And it hit particularly in the final quarter because of all the successful challenges that the PCT were doing. Which begs the question of the quality of data that we had, the systems that we had to record the data on and the whole process that supports the data collection, manipulation and reporting.*

(AT1, Head of Contracting)

Good data were also required if payments for achieving CQUIN standards were to be received. One participant said:

*We're working much more closely with the PCT commissioners around the data, so I think we are moving forward with the CQUINs. It's whether we've captured the right data and it's accurate enough for us to be able to get the financial rewards from that.*

(AT1, Dir of Nursing).

Data quality or transparency was also an issue in case study B. Late submission of data by one trust led the PCT to consider going to arbitration. The main reason arbitration was avoided was that it was strongly discouraged by the SHA.

*And we were also told that if then, if nothing could be agreed at that point, then it would go to a pendulum arbitration. So the SHA would decide one way or the other, how they do that I don't know, but it's a real disincentive to people to go through that process. And the clear message was, we want you to sort this out locally.*

(PCT B2, Assistant Dir of Contracting and Performance)

Because of the importance of data systems, the SHA in case study B suggested that the PCTs should contribute part of their budgets to support the establishment of a regional centre for data gathering, analysis and modelling, which would function as a common resource for both the PCTs and trusts. This would fill in gaps in the PCTs' present data handling capabilities and facilitate comparisons and benchmarking across the SHA area:

*And the rationale behind it, and I think it's a rationale that needs extending to other areas of commissioning support, is that, at the moment it is predominantly focused on providing support to what I would describe as transactional activity. And, there is,...there was overwhelming evidence, especially at that time, that PCTs didn't have the organisational*

*capacity and capability to manage that transactional activity to a high standard. Some of them were doing it to a high standard but most were not. And, it certainly makes, I mean...it certainly makes more sense for the PCTs in this SHA to come together to be clear about...across payment by results, for example, what is happening, across the whole of the area, and to understand the variances, and to seek to ensure consistency by working together, than to be working in isolation. So, there is something about the economies of scale, the scarcity of supply of skills, and making the commissioners more powerful.*

(SHA, Dir of Commissioning)

Although the PCTs differed in their enthusiasm for this initiative they all eventually agreed to support it.

### **3.6 Clinical involvement and networks**

Since the early days of the internal market clinical professionals, such as public health medicine physicians, clinical directors and nurses have played important roles in contracting teams on both sides of the purchaser/provider split. On the commissioner side, PCTs needed to work very closely with general practitioners (GPs) in their area, if they were to successfully manage demand and hospital referrals – a key requirement of the contract (standard contract, schedule 3). Similarly, providers, perhaps through the divisional managers, had to make clinicians familiar with the requirements of the contract, such as the need for accurate coding and recording of activity, the need to follow agreed procedures for consultant-to-consultant referrals, knowledge of any Prior Approval arrangements and similar agreements with commissioners.

However, in the first two years of the introduction of the new contract, we observed that clinical involvement, both on the provider and the commissioner side, was quite limited. There were signs that PCTs were starting to take the opportunity, through Practice Based Commissioning, to engage GPs in an active way by providing appropriate incentives (see also Chapter 5). Providers, similarly, expressed the intention to involve and familiarise clinicians with the contract. The acute trust in case study A realised, for example, that one of the areas that needed improvement related to referral processes by clinicians.

*I think consultants have historic referral patterns and yes, they refer without going through the Contract Department, or wherever... I mean everything now should go through the Contract Department, and I mean there's a big piece of work trying to make sure that everything does go through the Contract Department. And consultant education in terms of, much more this year, in terms of what the contract requirements are, what they need to do, what every... not just consultants, but what everybody's part in it is, in terms of adhering to what we need to do.*

(AT1, Deputy Dir of Operations)

Another interviewee in the same case study confirmed that, while nursing and midwifery involvement has been prominent, clinical involvement had been so far rather slow and weak:

*It's a bit of everything I think. It's very difficult to juggle that with their clinical caseload. I think they're... they have a lack of understanding around commissioning and contracting, and assurance and compliance actually, because I've just done a piece of work with them all*

*around CQC and that has been a big education. And I think it's... so it's lack of understanding as well, and I think it's also lack of systems and processes and structures in place so they know yes, today I'm actually doing this and I feed that into so and so. So I think it's a number of reasons.*

(AT1, Dir of Nursing)

A third participant expressed a similar view:

*A limited amount, when we get the contract, the bits that have quality in it or anything remotely clinical, gets sent round the good people to check it, and see whether they think it's sensible or not. Any commissioning policy does have some clinical input, normally. And, where we can, we involve the divisions in volumes of activity. Well, we go through a process, a cycle. So, if you like, the contract is part of the cycle but, budget setting and capacity planning, internally for the trust, follows on from that. So, in essence we set budgets based on the level of activity we're expecting to do in the contract. And, in theory we set capacity to meet that level of activity as well.*

(BT2, Dir of Finance)

Clinical involvement, on the side of commissioners and providers alike, is more prominent on issues related to quality. It will therefore be analysed further in Chapter 5.

Clause 12 of the contract, refers to the fact that any clinical networks or screening programmes in which providers participate should be set out in a later Schedule, but does not make this mandatory. The issue of participation in clinical networks did not emerge as a prominent theme in contracting in England.

The idea of networks can also refer to the presence of collaborative relationships between NHS organisations in general. Although building collaborative relationships and networks is encouraged by policy makers, one acute trust participant felt that current government policies tend to encourage competition rather than collaboration:

*However, you know, what has been established in the NHS is this kind of competitive aura really which says that, you know, trusts won't share information between one another anymore because that would give them insights into one another that would be in breach of their freedoms, particularly with foundation trusts. And perhaps we work around that to some extent, because of just building networks and relationships with colleagues. We don't feel as competitive as some people think we are, but we are. But nevertheless, you know, there are organisations that wouldn't share some information with us, I can assure you.*

(BT1, Dir of Finance).

In general, we found that the significance of networks in contracting has now diminished compared with the past. In contrast to the situation described in a previous study,<sup>29</sup> we have not found, for example, strong networks for infection control. It now seems to be the case that infection control is managed more through formal mechanisms, such as the national targets, which are, inter alia, inserted into the national standard contract. Furthermore, the inception of the Health Protection Agency and the moving of staff to more centralised locations seem to have disrupted (to some extent) the local networks of infection control professionals which we found in the earlier study.

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## 4 Contracting processes in Wales

### 4.1 Introduction

Having outlined the main features of the contracting process in England, we now turn to Wales. Again our focus is on secondary care. Unlike England, Wales during the study period had a separate institutional arrangement for the purchasing of tertiary care services via a specialist commissioner, Health Commission Wales. That level lies outside the scope of the present study, which is concerned with the purchasing of services by the local health groups. Wales established no foundation trusts and has a relatively small private health care sector. Thus this chapter is concerned mainly with agreements between LHBs and NHS trusts.

### 4.2 Contracting cycle

Shortly after the introduction of LHBs into the NHS in Wales, the Welsh Assembly Government (WAG) issued guidance on commissioning and contracting arrangements which required trusts, LHBs and local authorities to work together within Secondary Care Commissioning Groups (SCCGs). The chief purpose of these Groups was to provide a forum within which contracting and commissioning arrangements could be decided and arranged (WHC, 2003 (063): 6). To achieve this, a given SCCG would work to implement the LHB's Annual Service and Commissioning Plan for the delivery of secondary care services, which the associated trusts would then take account of in their annual operating plans. The vision was for an annual commissioning cycle which would begin in April when the SCCG would identify service issues for change or development, followed by a period in which the LHB would formulate its annual plan, and would engage in dialogue with providers to help shape trust plans. The WAG would issue its Service and Financial Framework (SaFF) guidance in October and by March all organisations would sign off the resulting SaFF and Long Term Agreements (LTA).<sup>44</sup> (p. 14-18)

After 2007 with the introduction of regional commissioning<sup>45</sup> certain modifications to this timetable were introduced. The amended commissioning cycle began with the publication of the national Annual Operating Framework at the start of the commissioning round. LHBs and trusts were expected 'to draw up their service response' demonstrating how the AOF would be delivered.<sup>45</sup> (p. 14) By April, LHBs and trusts were to have formed a 'Community Partnership Agreement' (detailing how the LHB, trust and Local Authority would deliver primary care services) and a 'Secondary and Specialist Care Agreement' between the regional commissioning unit (RCU) and the relevant trust on behalf of all LHBs:

*It tends to be...the contract would be negotiated...when the allocation letter comes out from the Assembly saying this is how much money is in the NHS pot for next year. This is the allocation uplift for trusts. That would come out somewhere around Christmas time so in the 3 months*



*leading up to the beginning of the year you would have your discussions then on finances and any spin off of that into activity with the hope that by the end of March, beginning of April, you had an idea of where you were in terms of an agreement. You tended to actually then get a financial agreement very early on into April, that's been my experience. And then the documentation would probably take about a month more to agree the terms of it, although those terms as our discussions have gone are rarely exercised. But there is a different thing of actually having it in writing saying we will do this and sign it, and the understanding that they are very rarely exercised really. So the documents take about a month to 6 weeks really to agree. So therefore within the first quarter the documentation will have actually been sorted as well but the finances and the activity are largely sorted around the beginning of the year.*

(DoF trust CT, round 1)

Generally these negotiations were split into a number of key areas such as the AOF, the LTA, the uplift received by the LHB, the activity implications of waiting times targets, service standards and specifications and so on. The process was performance managed by the regional office which would oversee the signing off of the AOF and contractual documents by the target date.

### **4.3 Contracting styles and relationships**

In Wales, contracting styles changed markedly over the lifetime of LHBs. A study of Health Authority contracting completed by one of the authors in the 1990s found a cycle of adjustment in which more adversarial contracting relations gave way to more co-operative ones,<sup>46</sup> and this pattern was repeated after the establishment of LHBs

In the period from 2003 to 2006, contracting styles took a reportedly adversarial and combative tone. According to respondents, purchaser/provider relations became more strained for several reasons: an 'immaturity' and lack of capacity in commissioning organisations, an absence of clear policy guidance on the funding responsibilities of secondary and tertiary commissioners and of providers (following the establishment of Health Commission Wales), and the pressure on commissioners to achieve financial break even. This led in some instances to a breakdown of trust between senior staff. For example, one LHB Director of Finance talked of a dispute with the trust in the 2007/08 contracting round which was only resolved when he arrived to replace the previous post holder:

*DoF: They [the LHB and trust] were arguing about bloody piddling things (...) and within a week we need to try and agree...either we know we're not going to get agreement because it is a fundamental problem or how we're going to treat it. Actually it took us two days and we'd agreed it because there was a willingness to agree, and I think that was the problem, there had been a tension, there'd been a lack of trust between the two organisations.*

*Interviewer: But there's a lack of trust and then there's a complete animosity...*

*DoF: Yes, you sort of go down that spectrum and when you go down that spectrum you sort of take stages don't you. I think it went from challenge to lack of trust to animosity. I think there were people who, they couldn't be civil to each other in rooms. I don't know in terms of your background, but when I first worked in the NHS and GP fundholding was around and proper...you know...in theory...Wales has been down some of the contracting routes and at that time I remember seeing correspondence which was the most vitriolic. People were shouting at each other in meetings and stuff like this. I've not seen that since, but some of the relationships here were at that level.*

(DoF, LHB C, round 1)

According to another interviewee, '[the former LHB chief executive] and the chief executive of the trust had an abysmal relationship, I mean just terrible, they ended up not being on speaking terms' (round 2, CE, case study C). During this period, financial pressures led the LHB to press the trust to reduce the value of the contract in certain areas which it was not prepared to concede.

*Basically there seems to be a general inability to agree contracts between the trust and the LHB. Why that was, I don't know. I think there is a lack of trust between the two parties. There was a big debate [in the 2007/08 contracting round] in terms of who would hold the deficits, shortfalls. I think that became part of the problem in terms of agreeing the contract.*

(DoF, LHB C, round 1)

Although our trust and LHB interviewees gave differing accounts of the precise course of events it appears that the LHB initiated action to take the dispute to arbitration but that a settlement was reached before the process reached its final stage. This resolution came only after the new Finance Director arrived. Subsequently the LHB rewrote a LTA clause concerned with marginal payment rates to rectify a weakness exposed by the case.

Partly because of a perception that there were too many disputes in the system, the Department of Health and Social Services introduced a model LTA document in 2007, followed by new guidance on commissioning which foreshadowed the establishment of three Regional Commissioning Support Units (RCSUs). In addition, the financial planning regime was changed so that the Service and Financial Framework (SaFF), which had existed from 2002-03, was replaced by an Annual Operating Framework (AOF). The model LTA, though not mandatory in all its particulars, helped to bring more consistency in contracting practices and ended a situation where documentation had often been unsatisfactory or incomplete. The RCSUs beefed up earlier (largely unimplemented) proposals to introduce 'collegiate' contracting via lead organisations, and were intended to increase co-operation among LHBs, make them better able to negotiate on equal terms with trusts and achieve lower transaction costs. The AOF promoted a greater focus on performance against targets and quality improvement as opposed to the looser delivery plans with targets in the SaFFs. In the first transitional year the AOF brought together the various SaFFs in one document for each local health economy. The new framework was intended to encourage a more strategic approach to service planning associated with the structured tri-annual planning system advocated in the WAG's *Designed for Life* strategy.<sup>10</sup> From 2008./09 each NHS organisation was required to agree an AOF with the WAG regional office containing national and local targets.

The introduction of an AOF with an enhanced set of national targets and the pressure to reduce local variations in practice had the consequence of strengthening performance management and somewhat weakening contractual governance.

*So there was no link between the targets or the service standards that were being aimed for and the financial means of getting there. So rather than it being an integrated financial and*

*service plan, it was like the AOF was done in one room and the finance to come out of the NHS was done in a separate room. When it is clear that it is as disjointed as that, it is difficult for the services to say, 'well I have had the money. I just can't get there, or you think I can't get there and I haven't had any money to get there'. You just feel as if the situation is starting to become a bit undoable really. So it is that lack of linkage between the means of achieving the targets. So therefore it is difficult for commissioners to sit down to say, 'I want you to achieve this target and I think I should pay you £50k to achieve that target'. But the commissioners sit down and say, 'I want you to achieve that target. It is going to cost you £50k to do it, but I haven't got anything to give to you'. So it undermines really the ability to link finance and service requirements and it just feels it is becoming undoable*

(DoF, trust DT1, round 1)

The Welsh approach remained softer than the English 'targets and terror' regime (a term that refers to the strong management action, including sackings of senior staff, taken to ensure compliance with central NHS targets).<sup>47,48</sup> Partly under the influence of the Wanless Report,<sup>49</sup> Welsh policy makers had emphasised the need for a rounded assessment of performance that combined use of targets with audit and inspection, including self-assessment.<sup>50</sup>

The sharper focus on targets after the introduction of the AOF system put new pressures on senior managers. A Finance Director told us that he found himself 'concentrating on waiting times numbers more than you are concentrating on the contract activity levels' (trust CT, DOF, round1). On the commissioner side, LHB Finance Directors needed to work on developing service specifications linked to AOF targets:

*It isn't straightforward to actually design a quality spec, because a lot of it is down to shifting from the status quo to a new better way of working which drives the outcome requirements you come up with: like an outcomes-based spec which you then commission for, and the commissioner isn't necessarily spending money. It is about changing the way things are done as well as maybe a little bit of pump priming, (...). The other bit of quality being driven is around the performance efficiency agendas. So you may have clinicians disagreeing with me, but things like day case rates being pushed as a norm drives up efficiency, reduces costs overall. Plus the patient is in and out - more convenient for them blah blah blah. That is the speel, you know, the methodology behind it.*

(DoF, LHB D, round 2)

The emphasis on national targets seems to have diverted attention away from some of the old tensions in the LHB/trust relationship, and encouraged shared perspectives on common problems. There was a shared realisation that disputes and unfair risk shifting via mechanisms such as penalty clauses might reflect badly on both organisations. Certainly many respondents painted a picture of growing co-operation at this time,

*If you ain't got enough money to come to the table to buy what you are ready to buy, then there is going to have to be a goodwill basis. We need to move into a planning process, we need to reduce variation across Wales.*

(CE, trust DT2, round 1)

The 2007 commissioning framework left LHBs with responsibility for commissioning secondary care for their resident populations, but required them to work with RCSUs. The guidance indicated that 'LHBs may act separately, together or through the RCUs, depending on the issue'.<sup>45</sup> (para 2.7)

This opened up discretionary space for variations in local approaches. In case study C the RCSU was set up to undertake a more general co-ordinating and support role, while the LHB in case study D agreed, initially as least, that it would use the RCSU to manage contract negotiations and agree contracts.

*That was seen very much as the way forward and some of the added value of the Regional Commissioning Support Unit could have achieved on behalf of the LHBs which was to try and I think develop a much more whole systems approach to commissioning, because my sense really is that commissioning in Wales up until that sort of point, had been much more contractually-led and therefore to a large extent finance driven. Rather than if you look at the whole systems approach to commissioning, identifying need, developing service specifications and then commissioning on the basis of those service specifications. Obviously looking for efficiencies and value-for money but not going straight in if you like at 'let's just buy a bit more of what we have been doing before and squeeze a bit more out of it'. So our ambition was to use the RCSU much more as an added-value resource to develop service specifications on the basis of which we could then commission. And it would also mean that completing the commissioning cycle, I think, we'd have had a much more robust way of performance measuring and managing the contracts because not only would we have been looking at the financial aspects which we tend to do relatively well anyway, but we would have been looking at some of the quality of services much more, and you know, used that to drive forward continued service improvements. So part of the reason we were trying to associate the clinical networks into the RCSU was to use those clinical bodies to help drive the service specifications for the new system, if you like, of commissioning.*

(Manager RCSU, case study D, round 2)

Regional commissioning involved commissioners working closely together to understand needs and activity in specific services, and sharing this capacity so that they could provide an effective challenge to a trust. The aim was for LHBs to collaborate on performance targets and contracts, and evaluate funding requests made by the trusts. This meant that for the trusts, much of the contracting work was already carried out by the commissioners, who negotiated their requirements for service delivery and capacity among themselves before presenting a contract to the trust. However, in the event the case study C LHBs decided early on against using a single shared contract, while the case study D LHBs made some efforts in this direction but eventually determined to sign individual LTAs.

The final days of the internal market saw an acknowledgement that contracts would now only have a brief life in the transition to a system based on planning, and the running down of the negotiating and monitoring mechanisms built up in previous years. This was a period when many meetings were cancelled and tasks that had been carried out in team forums were instead handled in one-to-one meetings between Chief Executives or Finance Directors. It was not so much that cooperative behaviour per se increased, but that LHB staff realised they would soon be subsumed into the larger trusts and became more willing to compromise on contractual requirements. Although the most recent guidance required NHS organisations to enter cost and volume contracts for most services, it became apparent to most staff that there would be little possibility of holding providers accountable for non-performance and in consequence many of these contracts took a very loose form.

With the publication of plans to restructure the NHS in Wales, the underlying rationale for robust scrutiny and challenge was removed and the impending organisational changes came to the fore. One interviewee recounted how the entire relationship altered:

*There is more trust with a small 't' between the organisations and where in the past I might have held my ground and not necessarily believed what I was being told in terms of certain information that had been received from the trust, because they would be you know in a negotiating position as well, I'm less concerned about it this year. Because if they fleece the LHB they are ultimately wasting money and fleecing themselves, which is a dynamic change which I think has allowed us to get further in terms of an agreed position, but I don't believe has allowed us to nail down that position to a lower cost because we haven't had the scrutiny as a result of negotiation put in place. So if you like it has all been very cosy, everybody smiling at each other and holding hands round the table without anybody asking hard questions. And where in the past I may well have been across a table from one of the trust directors arguing with them face to face and showing stats and stuff which supports my argument, they would be doing the same and...we haven't had that, and I think I don't think that has helped the overall position.*

(DoF, LHB D, round 2)

Contracts effectively became schedules for the transfer of resources within what would soon to be integrated organisations. This led to a simplification of contractual documents, with little attention paid to issues like marginal pricing and floors and ceilings set so wide as to be nominal:

*So this year now, we were told there must be cost and volume contracts, but of course now the trusts haven't got a desperate [need], the only advantage of the cost and volume contract would be, that you could negotiate cost and volume contract with a variance and agreed under and over performance marginal cost, but that would have to be balanced out after next year when we probably won't exist anyway. So, to a certain extent although this year we haven't been told it's got to be block, what a lot of LHBs have done is negotiate contracts that are, that have got high ah, that have low marginal rates, so you know, over and over performance becomes irrelevant, and percent and tolerance, you know, and huge tolerances. So basically what we've agreed is block, although they are, if you read them they are cost and volume contracts, when you look at, the way you can tell is if you look at the marginal rate look at tolerances look at the percentage tolerance, and you'll know whether it's a block or not. It's a block by every other name, but they are cost and volume.*

(DoC, LHB D, round 2)

With organisations integrating, it made little sense for one division to recoup monies for under performance from another, and there was a feeling that there was now little incentive for gaming or misrepresentation in contractual negotiations. But the insecurity and turbulence associated with the impending changes also had an impact on behaviour. An LHB Finance Director negotiating hard with a trust opposite number could not help but reflect that he might well be talking to his new boss. Moreover the move from 22 LHBs and seven provider trusts to seven unified health boards meant stiff competition for senior posts, with ample scope for persons perceived to be rocking the boat to be excluded. This gave rise to a curious mix of apprehension and co-operation. At one level there was increased trust linked to the perceived absence of incentives to disadvantage the soon-to-be-merged partners, but also a sense of suspended hostilities rather than simple co-operation.

*Before it wasn't a perfect system but at least there was some challenge in it you know and [names an LHB DoF] has been to see me endless times saying I'm really frustrated because he said I am going to these scrutiny meetings and he said nobody is really pushing these clinicians and I am being told keep quiet we don't want to upset them because if you upset them they won't do the waiting list initiatives on Saturday and you know this kind of... it is almost a collusion.*

(CE, LHB C, round 2)

In Wales, commissioning and contracting developed from a system which drew significantly on discrete contractual norms, into one that placed greater emphasis on relational norms, and ultimately one that relegated contractual governance to a peripheral role. Unsurprisingly, a top-down imposition of relational norms did not end purchaser/provider tensions overnight, though there were examples, as in case study C, of improved working relationships. However, rather than developing organically, the relationship between purchasers and providers were further transformed by the political changes of 2008. The final stages of fieldwork saw a kind of forced collaboration between neighbouring LHBs, and between LHBs and trusts. During this period discrete contract norms were almost entirely removed from the system and, though the language of partnership and co-operation was much in evidence, this was not so much a reflection of the growth of relational contract norms but the diminished importance of the contracting framework.

## **4.4 Centralisation versus decentralisation**

### **4.4.1 Contractual and hierarchical governance**

Contracting in the Welsh NHS sat within a nexus of cross-cutting centralising and decentralising mechanisms. At face value the 'localism' of 22 LHBs resulted in a highly decentralised organisation, in which there was the potential for close co-operation between the NHS and local government, and commissioners could arrange care with local trusts based on local plans. Yet in Wales' small country context, the links to the central departments were close and direct, so that effective instruments for central control also existed. Here we need to consider the three regional offices, and the NHS financial planning and performance management framework.

Day-to-day performance management of trusts was carried out by the regional offices, which were outposts of the WAG Department for Health and Social Services. The role of the regional office was to hold LHBs and trusts to account on behalf of the Department. In practice, this meant that the regional office would act to ensure that each AOF and LTA was signed by an agreed date. In large part, the AOF comprised a set of targets that trusts and LHBs were expected to achieve. Trusts and LHBs would engage in a dialogue to produce Local Delivery Plans detailing how they would achieve the targets contained in the AOF. The responsibilities of the regional office included ensuring that these plans were appropriate and realistic and satisfying itself that the LHB and trust could deliver on their LDP commitments.

The regional offices are tasked with managing the performance of trusts and LHBs. However, the levers available to manage the two types of organisations are different, and according to respondents those applying to LHBs are in practice weaker:

*The trouble we have is, we've had performance measures for trusts, but to be frank we haven't got much in the way of performance measures for LHBs. What we've done is - by default - said that LHBs, you're responsible for the waiting times targets, you're responsible for the A&E targets, you're responsible for...well anything we've given as a target, you're responsible for it. When you get down to the nitty gritty of that, the reality is LHBs don't have much influence over A&E performance. LHBs, not directly, don't have much responsibility for waiting times performance apart from being required to provide extra money to deliver them, because something has fallen apart at the edges. Is that commissioning? I don't know. I'm not so sure that's a genuine arrangement.*

(RO, case study D, round 1)

Thus, although the formal position was that the regional office would manage the performance of both trusts and LHBs against AOF commitments, the reality was that LHBs were judged against middle-level outcomes – waiting times or A&E performance targets – over which they had little direct control and where de facto responsibility was shared with the trusts.

This meant that, although the regional offices could intervene to affect local behaviour, the monitoring information available and the levers they could use related more to service provision than commissioning processes per se. Trusts would find that their day to day activities could be scrutinised by both the regional office and by the LHB, but that each might take a different view on the same service. This gave rise to inconsistency and tensions within the system.

The degree of regional office involvement in contract negotiations proper was quite limited. The general approach was to require LHBs and trusts to submit a signed AOF to the regional office by a certain date, and to ensure that the LHBs and trusts have agreed appropriate LTAs. The regional office might become involved to ensure that the parties to the agreement remained in dialogue, and to intervene to overcome particular problems that might arise. From respondents' accounts one of the two regional offices included in the study took a more active role than the other. Thus one office put more emphasis on 'facilitation':

*That might mean some facilitation, we've actually just signed the raft for 08-09, the process this year of making it very clear to the organisations how much money they have, what the targets are and then they had to come up with plans that made sure that they deliver on the targets that are robust.*

(RO, case study C, round 1)

*This degree of involvement was not welcomed by many senior health service managers. One LHB Finance Director opined that the regional office's involvement in LTA/AOF negotiations was not 'need[ed] that and their presence was likely to put us back rather than take us forward'. This respondent considered the approach heavy-handed and expressed his preference for the management style of an earlier post holder who 'just did his role appropriately as regional director in looking at the whites of the eyes of the chief execs and saying, 'Is this happening?''*

(DoF, trust case study D, round 2).

During the study, Welsh NHS contract disputes were resolved either via the standard NHS dispute resolution process<sup>51,52</sup> or a special procedure for debtors' arbitration introduced in 2007.<sup>53</sup> We will consider dispute resolution in more detail in Chapter 6, but in both cases disputes that cannot be settled by negotiation or conciliation are subject to binding arbitration by Regional Directors.

#### **4.4.2 The all-Wales LTA and the LHB**

As discussed above, the regional offices had responsibility for the performance management of both trusts and LHBs. The regional offices laid responsibility for key performance measures such as waiting times and A&E targets with the LHBs, and sought to enforce that responsibility through line of command management. However, LHBs were expected to manage the trusts mainly through the contract. The difficulty from the perspective of the LHBs was that they were effectively prohibited from using the contractual and other market levers that make contracts an effective control mechanism in other contexts. LHBs perceived that they were not supported by WAG when they sought to use harder-edged contractual mechanisms such as penalties or arbitration that might destabilise a service. The LHBs could not switch providers to buy activity elsewhere. Nor was the LHB usually in a position to use the carrot of extra money for extra work to incentivize the local trust.

For example, a number of commissioners recounted their experiences in relation to small block contracts with distant providers. Typically, the value of these contracts had been set following the resource allocation exercise that determined the monies allocated to LHBs when they were established.<sup>54</sup> But some LHBs had reviewed these contracts and determined that they were paying an excessive premium for a service at the distant provider, when compared with the cost of treatment by a local provider. Thus they embarked on a drive to reduce the cost of the contract by moving the contract to cost per case. However the WAG was unwilling to back the LHBs in forcing the providers to change and the block contracts remained.

Rather than being a contract emerging primarily from bilateral negotiations between the purchaser and provider, the LTA was shaped by an overarching AOF that was essentially a planning document. The AOF was used by the centre to define targets and set the general 'direction of travel' for the Welsh NHS. It was shortly before Christmas, and in the rounds observed specified approximately 20 targets, each of which was broken down into a cluster of sub-targets.

The national AOF set the context for contract negotiations, which defined targets, processes and timetables. LHB and trust managers produced local AOFs concurrently for their respective organisations. These would include details of Local Delivery Plans specifying how organisations would achieve national and local AOF targets. In 2007/08, the AOF was produced as a joint document by each 'health community' (the groupings of LHBs and trusts



identified in the 2007 commissioning guidance). From 2008/09 individual NHS organisations were required to agree AOFs with their regional offices, 'ensur[ing] that they take account of the aggregated health needs of their health community to ensure that there are no gaps in provision'.<sup>55 (p. 26)</sup>

The LHB and trust Finance Directors interviewed for this study all agreed that the LTA formed a natural extension of the AOF. That in colloquial terms the LTA 'fell out' of AOF negotiations. Indeed, the national AOF document talks of the LTA as the 'contractual element to deliver the AOF',<sup>55 (p.27)</sup> indicating its close functional connection to the AOF. The national AOF document provided a timetable of dates for the submission of draft local AOFs, submission of final versions, regional offices' approval of local AOFs, and the production of LTAs.

Clearly, the centre exercised significant control over LHBs and trusts via the specification of targets and the associated performance management system, and decision space at local level was further constrained through the use of a template LTA. The contract template was first introduced in 2007/08,<sup>51</sup> and was initially presented as a model that could be adapted to suit local requirements. In the first year LHBs and trusts were required merely to include 'all the elements set out in the national model LTA'.<sup>51 (para. 3.2)</sup> In following year, the template became a mandatory all-Wales LTA,<sup>52</sup> although as we shall see below, theory did not accord fully with practice. The stated objective of the template contract was to address the 'variable quality' of existing contracts and improve the effectiveness of commissioning by clarifying the responsibilities of organisations and thus reducing the number of 'protracted disputes over 'agreed' activity levels, payments for activity variations, and where the responsibility lies for standards and targets that have not been achieved'.<sup>55 (para. 2.4)</sup>

Generally, the template LTA was well received by the Chief Executives and Finance Directors interviewed. In the first year there was considerable scope to vary the basic contract form:

*Yes, it was helpful but slightly theoretical and it was... what happened is that I think it was quite focused on a change of emphasis towards funding flows. And of course that hasn't happened so there's been...but most of the stuff in terms of accountability the agreement of activity levels, finances. Yeah, at least it's well documented (...) And I think at least there is flexibility, we have amended it, we have played with bits of it so it's not as if you've been held to account that you used a template exactly which is what some of the concerns were. But no I think it's worked okay.*

(DoF, LHB case study D, round 1)

We found more critical responses from LHB Finance Directors engaged in cross-boundary commissioning of services from England. While the WAG initially favoured the use of the Welsh LTA as a contract with foundation trusts in England. foundation trusts faced a statutory requirement to enter into legally binding contracts and considered that the LTA template document was not enforceable at law. In order to come to a working arrangement, the LHBs in the case study D regional grouping constructed a 'letter of agreement' for purchasing English services, containing activity and cost schedules and some simple clauses.

*It's not the LTA. Some of them will accept that as a schedule of money and activity, but some of them won't, they won't sign it and send it back.*

(CE, LHB case study D, round 2)

This ad hoc working arrangement was still in place in late summer 2009 when fieldwork ended

One might hypothesize that the Welsh planned economy approach would lead to a more prescriptive approach, compared to England, after use of the 'all-Wales LTA' became mandatory in 2008/09. This was not supported by our data. Several commissioners made minor adjustments to the template and one trust Finance Director explained that the model contract had simply not been followed in LTAs with the main provider, mainly on the basis of unsuitability in the local context:

*It was an absolutely awful document and locally we said immediately - people in the LHB and ourselves - you know, where is the nearest shredder? We'll do a proper one. We did our own one which was based very much around concentrating on what we had to... what we were doing together how we were working together and just recognising that there needed to be sensible dialogue and sensible cut off points in the year that we could use to measure how we were doing against the contract. But we had to allow some flexibility in it on both sides.*

(DoF, trust DT3, round 2).

Thus the LHB's contracts included some but not all of the national template headings. One of the main perceived disadvantages in this instance was that LHB and trust were already using three-year contracts and considered that going back to the one year contracts recommended by the guidance would be a retrograde step.

Overall, whatever space existed for decentralised autonomy by purchasers and providers was by way of what was agreed in the LTA. Block contracts placed most of the risks associated with service provision with the provider, who would then face the challenge of aligning activity with funding and the achievement of relevant performance targets. But to the extent that purchasers and providers met the WAG requirement in 2007-08 to shift to costs and volume contracts, there was some discretion to reallocate more or less risk to the purchaser. For example, there might be provisions relating to over-performance, particularly in support of targets, that required extra payments, which were usually at agreed marginal rates.

#### **4.4.3 Local prices**

Over-performance and marginal pricing had a different significance in the Welsh system, compared to England, because of the different contract currencies utilised. The official position in England was that activity covered by PbR would be reimbursed according to PbR tariffs (based on HRGs), so that the issue of marginal pricing did not arise for this activity (though as Chapter 3 shows the informal practice was sometimes different). In Wales, the main secondary care contracts in the case studies categorised activity in terms of in-patients, day cases, new out-patients, follow-up out-patients, and outpatient attendances, typically grouped by specialty. These currencies were triggered by deaths and discharges, or less commonly by

finished consultant episodes (FCEs). Many commissioners had encountered problems with the official information system utilised in contracting, the Patient Episode Database for Wales, which although generally reliable, tended to provide information up to a year after the activity had occurred. Therefore, commissioners tended in practice to use national datasets published by Health Services Wales to calculate activity. Most LHBs and trusts in the case studies calculated costs using TFR2 (or average speciality or sub-speciality costs), and applied a marginal rate of 25% of full-costs prices for allowable over-performance.

A plan by the WAG to introduce a new contract currency for inpatient stays based on hospital spells by HRG from 2009 was not implemented because of the NHS restructuring proposals. In England, as mentioned above, activity was reimbursed according to PbR tariffs based on HRGs. The non-use in Wales of HRGs, PbR and national tariffs meant that Welsh purchasers and providers continued to negotiate local prices on a contract-by-contract basis, and also had freedom to agree how marginal rates should be applied, for example, when a specified activity threshold was exceeded.

In the 1990s the management of over and under-performance had been a major focus of contract monitoring meetings, so that it was common, for example, to offset an undershoot in activity in one specialty against an overshoot in another.<sup>56</sup> However, by the mid-2000s parties seemed to have moved to a more approximate, global contract settlement, based on the overall quantum of costs which paid less attention to precisely-calculated trade-offs of that kind.

*R: When you're discussing money between trusts and local health board, a lot of other things get chucked into the pot as well, so things like, what they call the LDP, the Local Delivery Plan - that's the extra activity that you are going to have to do, next year to hit waiting time targets (...) and another one would be the extra activity you need to do, or investment you need to do to hit cancer standards. And what you tend to find is, and it gets very complicated, but finance directors throw all these things into the pot and very often what they end up doing is shaking hands on a deal that says, as I said earlier, you give me 350 million pound and I will consume my own smoke in relation to A B and C, but that also means by the way that if I happen to underperform on something you can't come to me for any money. Now that's very familiar to those people who remember the NHS back in the 80s and the early 90s, that's, the NHS financial regime of 20 years ago.*

*I: It sounds like [now] it's done in a much more global way, one thing that I remember [from a past study] is sort of discussion about trading off underperformance in one area against over-performance in another.*

*R: [I] think the system is, as I say, it is regressing, and I think one of the reasons it might be, well I think partly it is regressing because, partly it is regressing because in Wales this notion of a purchaser/provider split seems to be going out of fashion, so that's one reason. I think the other thing is that, if you take [case study C], the health system is bankrupt in the sense of (...) the LHB has a big debt and so on. And I think once you get to a certain level of financial problem, the traditional or the normal ways of dealing with contracts start to break down. But I think over, as I say, what you were describing was the way it was done in the late 90s probably was the way it was done up until about 2004, 2005, something like that.*

(Director of Planning, trust CT, round 1)

Over- and under-performance surfaced as issues at various points during the in-year management of a contract, but ultimately would be submerged

in the overall deal by which the business of the contracting round was concluded.

## 4.5 Transaction costs

Arguably the transaction costs of contracting in Wales became so great as to provide commissioners and providers with disincentives to use contracts as a governance tool. The question of transaction costs can be approached in terms of (a) the absence of levers available to commissioners in Wales, (b) the development of regional contracting and (c) the development of service specifications for use in contracts.

The first of these concerns the suggestion that the WAG incurred the costs of setting up an internal market but then did not allow the market and the contracting process to work so as to deliver the expected benefits. Several respondents complained that LHBs were in practice stopped from using contractual levers to change provider behaviour, or at least lost out in terms of time and trouble if they pressed ahead. We saw one example earlier in the chapter when a Finance Director who had identified potential savings if excessively-priced activity in small block contracts with distant trusts was 'repatriated' to local hospitals was pressured to abandon this idea. In terms of the local health system, several LHB respondents described situations where they were stopped from withholding payments from main provider trusts:

*...about two or three years ago when A&E was abysmal, we wanted to withhold money and say to the trust well you are not delivering on the contract so we are going to withhold money. [CE of NHS trust] goes running down to [Director of the local regional office] and well you can't do that, you can't do that because you know the trust is going to become unviable. How can a £400m organisation become unviable because you withhold £5m? It is nonsense isn't it? But there never seemed that political will in Wales to enforce some of that performance framework. So here you have got a contract that says one thing, you have got a performance management framework that says in essence some of the same things but none of it enforceable, and when you try and enforce it...*

(CE, LHB D, round 1)

Without the ability to apply market levers via contracting there was little reason for maintaining the organisational infrastructure of an internal market.

Finally, rigorous contract monitoring was difficult in the absence of a reliable information base. Commissioners had to rely on the trusts to provide contract minimum data sets and update databases, with the result that, although they were using the same systems, the commissioner and provider might calculate different final figures. To remedy this, as mentioned earlier, some LHBs used published national data rather than PEDW data. Nevertheless, the information that LHBs use to monitor activity and performance against the contract were sometimes regarded with suspicion.

Part of the rationale for setting up the Regional Commissioning Support Units was that they would 'enable LHBs to build up capacity and expertise, and to reduce the number of individual agreements and level of transaction

costs'.<sup>45</sup> (para. 10) It was hoped that RCSUs would achieve this by making more effective use of the skills and resources found in LHBs, by sharing knowledge and information, and improving contract handling.<sup>45</sup> (Para. 10) In the short period between the establishment of RCSUs and the publication of the consultation document on restructuring the NHS in Wales, these units had managed to achieve some efficiencies and reductions in transaction costs. Thus through information sharing, one RCSU facilitated the development of Individual Patient Commissioning policies across the region (tackling issues of a postcode lottery in provision of high-cost treatments). Respondents suggested better co-operation at regional level had helped synchronise the introduction of new treatments in areas like Lucentis (for age-related macular degeneration) and the latest dermatology treatments. Information sharing had been especially important in case study D where the RCSU had successfully negotiated much of the content of a shared LTA, which stayed even though the individual LTAs eventually decided to add their own separate cost schedules and sign their own LTAs:

*We tried to rationalise the [contracting] process to some extent and I think it worked, it was working reasonably well. But it was still very early days because, to a large extent you are talking about changing behaviours, cultures, ways of working and what I think was quite a finance driven approach to contracting, I wouldn't even call it commissioning. So that is quite a larger tanker if you like in terms of the approach that you are trying to turn around. So we did have as you know a regional group set up, consisting of LHBs- DoF representation. [The CE of an LHB] chaired it as chief exec. We did have a Director of Public Health and other representation on there but I think because we only had the one year cycle to test that approach, on brief reflection, my view is it was good. It was a good starter for 10. We were setting the mechanism and the culture. Some of the clinicians were starting to challenge some of the approach and want much more of an evidence-based service specification-driven approach. But when push came to shove it was still fairly financially-driven, because needs must.*

(Manager RCSU, case study D, round 2)

Alongside the processes of contract negotiation and monitoring, work on contract specifications was carried out by commissioners and by clinical networks. Clauses in contracts specifying details of minimum standards and service specifications had been highlighted in guidance as a tool for leveraging change. However, in practice, quality assurance was primarily managed through the AOF, since this was the key document in which nationally-agreed standards were communicated. Individual LTAs generally lacked this kind of detail. Asked whether quality standards were set out in the LTA one respondent said:

*Not as vigorously I suppose that is the word, not explicitly and rigorously put in if you like to measure performance as such. Although there is blanket phrases like 'expect you to comply with all the...' which I suppose really is just a hand down from WAG to us to providers but they expect to be accountable to the Assembly anyway. So I suppose the fact that we are public organisations there is that degree of expectation. If they are not public then you know it is a bit more explicit. So if you looked at some of our SLAs with maybe some of the voluntary sector you would see the service specifications would be more robust in terms of detail. But I think that is a sort of symptom of our long term agreements is they are financially and activity driven, because if you try to put a service spec for every service that a trust would provide us, like X\_\_\_\_\_ Trust would provide us, well as you can imagine the service directory would be about 3 inches thick and then you bolt that onto a set of service specs you know it starts*

*getting a bit unwieldy and unrealistic. However, I bet if we'd had that we would be much more efficient and effective.*

(DOF, LHB case study C, round 2,)

In effect, the contract was not as important as the alternative mechanisms of performance management and clinical governance. Indeed, Chief Executives tended to be more aware of performance issues than contractual issues:

*It's not very important. I think it is much more about, 'Is this service we are providing safe?' and, 'How safe is it?' and, 'How do you measure that safety?' The contract as I said is deaths and discharges, so I can be very efficient in this trust, I'll just kill everyone. I will hit the contract easily and reduce my costs tremendously. I'm not sure that will be acceptable in terms of governance. I'm much more aware of whether average length of stay is too high or whether our day-case rates are low or whether we've had more complaints in the area of service than I would be about where are we on the contract and how many widgets have gone through the hospital. That is an issue but it is not an issue compared to those other things.*

(CE, trust DT3, round 1)

#### **4.6 Clinical involvement and networks**

Clinical networks were introduced in Wales in 2001, following the publication of *Improving Health in Wales*.<sup>2</sup> Initially, two networks were set up, one on cancer and a second on coronary heart disease. These were then followed by networks focusing on for example, renal services, critical care, health promotion, sexual health, nutrition, and services for older people. In 2005, WAG issued guidance outlining its vision on how networks would develop, distinguishing between commissioner and provider networks.<sup>57</sup> Both commissioner and provider networks were, over time, to take full control of the relevant (commissioner or provider) budgets in relation to the clinical area, and thereby to gain the power to bring about radical change in an entire service. Commissioner networks were to both manage the network, and implement its decision, and the network was to develop quality standards and would accredit providers. Provider networks were to develop from a network focused on tactical decisions to a network that delivered change using an agreed long-term plan. The separation of commissioner and provider networks presented the networks involved in the study with problems, and so all three networks studied moved towards a more hybrid form which bridged the divide.

The 2007 Commissioning Guidance identified a role for the 'Managed Clinical Networks' to provide specialist advice on existing services and clinical support for the commissioning process. Senior network staff were expected to 'be a resource for the RCU to use as part of the commissioning team for that service'.<sup>45</sup> (para. 2.20) It was envisaged that the networks might align commissioning more closely with standardised patient pathways, and encourage more attention to quality and clinical effectiveness. The 2007 guidance stated that commissioners would need to identify the contract currencies and information necessary to support these changes.

The effectiveness of the clinical networks was related to the wider governance arrangements. The network manager of one provider network

reported how the shift to regional contracting provided a way of focusing the work of the network as the associated Board could be used to steer the involvement of commissioners, and to seek consent for change from the necessary commissioning bodies. Prior to the institutionalisation of regional contracting, this network was unable to effect change as it did not have a budget. Linking the network to regional commissioning seemed to have the potential to increase its influence.

The clinical networks did much work in developing clinical standards and service specifications, which were reflected in HCW contracts . However, our fieldwork observations suggested that the clinical networks only had a limited influence on RCSU and LHB secondary care contracting during the study period. There were indications that clinical issues were becoming more central in the contracting process, but in the examples from our interviews this was driven by staff in the LHB/RCSU teams rather than the networks.

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## 5 Comparing contracting regimes: tracers in England

### 5.1 Introduction

Having provided a general overview of contracting approaches in the two countries, we now narrow our focus to consider a number of key areas which shed further light on differences and similarities. We discuss 'tracer' issues relating to quality, incentives, risk allocation, demand management, targets and penalties, and dispute settlement.

### 5.2 Quality

The new standard contract includes a variety of clauses aiming at achieving specified quality standards and improvements. Quality standards are a mixture of national targets, regionally-agreed targets (usually facilitated by the SHA), and more localised arrangements agreed between commissioners and their providers. Schedule 3, Part 4A of the contract contains a number of Clinical Quality Performance Indicators (CQPIs), which are monitored via the process of 'clinical quality review', as described in Clause 33 of the contract. Clinical Quality Review includes the requirement for commissioners and providers to hold monthly Clinical Quality Review (CQR) meetings, for providers to submit monthly Clinical Quality Performance Reports to commissioners, and provisions for Joint Clinical Investigations (JCIs) if providers breach any of the agreed target thresholds.

Examples of quality indicators contained in Schedule 3 are: the mandatory national targets on MRSA and Clostridium difficile (C.difficile) infection rates, and a number of locally agreed indicators (e.g. 'emergency readmissions following discharge'). In relation to the locally-agreed quality targets, the contract guidance specifies that they need to be 'clinical indicators not process ones' and explains that the indicators need to be defined clearly, to be measurable and the consequences for their breach clearly stated.

The quality indicators are discussed and agreed in regular Clinical Quality Review meetings. Briefly, the process for agreeing the quality targets was described to us as follows: The PCTs drew up a list of proposals containing possible quality indicators as a way of initiating discussions, on which the trusts were asked to comment. A period of negotiating the indicators followed, until agreement was reached.

In 2009-10 when the CQUIN framework was introduced (see below), SHAs were tasked with ensuring that the CQUIN indicators chosen by the contracting parties were measurable and achievable, before signing them off. In case study B, this three-way process of negotiation created some



delays and perhaps a mild irritation, but participants on the whole welcomed the SHA's advice. According to one interviewee:

*So I think from our perspective it could have gone smoother but I don't think that's a reflection on the PCTs at all, I think that they were, to a degree, they were trying to agree things with us but then they were also having to agree them with the SHA so they were a little bit caught in the middle of a sandwich really... So for instance the PCTs came up with a schedule for the five CQUIN indicators and in fairness there was a lot of metrics in each indicator. But when the PCTs submitted that to the SHA, the SHA in this respect quite helpfully said, you've got far too many metrics in there, you need to simplify it and they did, so they got it down to literally sort of one or two metrics in each indicator, which we were quite happy with, but then they went to someone else in the SHA who said well actually you need a few more in, so it was you know... it was the first year and I thought I'm sure everyone's learnt from it.*

(BT3, Director of Clinical Governance)

Participants confirmed in interviews that in 2009-10, the quality indicators were much more clinically focused than in the previous year.

Quality indicators can be about patient safety (e.g. reducing hospital mortality rates, reducing MRSA infection rates), effectiveness (clinical and patient reported outcomes, revision of care pathways), patient experience (e.g. supply of prompt and effective discharge letters, increasing cervical cancer screening), and innovation (e.g. upgrading data and IT systems).

As part of the Clinical Quality Review process, PCTs monitor, via information submitted regularly to them by providers, the degree to which providers comply with meeting national guidelines and targets, such as NICE guidelines, Standards for Better Health, 18 week target etc. As we saw in Chapter 3, performance in achieving quality standards is also monitored by CQC which receives similar data on quality performance by providers.

In one of our case studies, an acute trust felt that the PCT was not clear in implementing some of the quality guidelines.

*I don't find the PCT entirely helpful because, you know, saying, we want that data as it's written down in the contract. Yes, okay, that's absolutely fine but, what does that actually mean, and what do you actually want? You know, as we had them saying 'what it says in the contract'. Okay, well take another maternity example, the NICE antenatal guidelines. It's 126 guidelines. What do you want in relation to those 126 guidelines?*

(AT2, Deputy Director of Operations)

As discussed in Chapter 3, clinical involvement in the main contract negotiations was indirect and limited. However, clinicians from both the acute and the primary care sectors were expected to be involved in agreeing the Quality sections of the contract. The CQUIN guidance (see next section) makes clear that clinical involvement is essential both in negotiating and monitoring the quality indicators and metrics. CQUIN schemes, according to the guidance, 'will allow PCTs to demonstrate their World Class Commissioning competencies, for example involving primary and secondary care clinicians...will help commissioners demonstrate competency four – clinical engagement'.<sup>17</sup>

On the side of the acute care providers, the Medical Director (or another designated clinician), the Director of Nursing and/or the Director of Clinical Governance would normally attend the Clinical Quality Review (CQR)

meetings. In addition, depending on the topics on the agenda, clinicians from relevant specialties would be called to attend these meetings. On the commissioner side, CQR meetings were chaired by a Director of Quality (normally of nursing background) or a designated GP from the Professional Executive Committee (PEC) and personnel with responsibilities related to Quality would also attend the meetings.

In case study B, the Quality Schedule (i.e. Schedule 3) and the CQUINs were monitored in the CQR meetings, but if a breach of targets was drawn to the PCT's attention, it was passed on to the Performance Review team who would then take responsibility for issuing breach notices to the providers and taking any other steps deemed appropriate (e.g. asking providers to prepare an action plan). In addition to this type of monitoring, PCTs in this case study introduced in 2009-10 a limited number of themed visits to their providers, some of them unannounced. These visits were conducted by the PCT's Directors of Quality, the Medical Directors and, depending on the theme, other members of staff with a clinical background. One participant emphasised the strong clinical involvement:

*When we do the Stroke one in the summer, we'll be very much led by a consultant who is part of the Cardiac Network, who is a specialist in that area and we haven't yet 'diaried in' the other reviewers, but we definitely will have a very strong clinical presence. And we're being supported as well by an SHA Peer Review Programme, who've chosen a number of areas where they will be doing peer review visits which will be really helpful and will supplement our own announced and unannounced visits.*

(PCT B1, Director of Quality and Safety)

As the above quotation shows, monitoring of quality was strongly facilitated by the SHA, which took the lead in organising peer review networks or programmes, focusing on quality-related issues in specified specialties (e.g. critical care). This involved a team of specialty experts visiting trusts within the SHA and assessing their performance against a list of national indicators related to specialties included in the programme.

Participants also referred to the existence of a number of clinical networks (e.g. Cardiac Network, Critical Care Network) which are involved in monitoring quality, either by providing the appropriate expertise to commissioners or by notifying commissioners of problem areas which happen to come to their attention.

Finally, there exists a patient quality focused network in the whole SHA, which meets monthly in order to exchange ideas and experiences. This was described as follows:

*We have one [network] that runs across the SHA. Started off as a Standards for Better Health Network, and has moved into a Patient Safety and Quality. It's a fantastic group. We share ideas. We also share information, in terms of if we've picked up something that somebody else hasn't. We will do collective responses, whether that's to a health authority or whatever. We have... always have, people from the Care Quality Commission and Patient Safety team there. And we're trying to now get the SHA to regularly turn up as well...So it is a good meeting, and it's a good support meeting as well.*

(PCT B2, Head of Clinical Quality).

In case study A, participants told us of plans to introduce a series of visits to providers as an additional way of monitoring quality. To our knowledge, in this case study, professional networks (e.g. Directors of Nursing), or SHA-wide networks (e.g. for HCAs) did exist, with variable success in terms of their effectiveness. In general, however, our impression was that the networking activity in this area, both at the local and regional level, was more limited compared to case study B. There was, for instance, no similar regional network for Patient Quality and Safety or Peer Review network.

Another potential area of clinician involvement, especially GP involvement, arose from the link between PCT commissioning and Practice Based Commissioning (PBC). This link was still in its early stages and needed to be strengthened. From interviews, we understand that efforts were being made by PCTs to involve GPs as much as possible. Asked about the input by practice-based commissioners in relation to quality issues, one participant said:

*Tiny, tiny. Since I've held the Executive Lead for this post I've been taking regular papers to our Professional Executive Committee on this topic, because the practice-based commissioners join us at the PEC, and I have tried over time to stimulate their interest and get their input...And I share with them on a regular basis the quality dashboards that come out of the quality review meetings, and we rate them as to whether the trust has achieved them or not... And also invite any feedback because as a group of GPs they will often come across patients who have experienced things or experienced difficulties themselves with the trust and occasionally have had bits of information sent to me...but we're just about to formalise that and I've just got a dedicated email address, which we will send out to all independent contractors.*

(PCT B1, Director of Quality and Safety)

As well as the plan to stimulate GP involvement by an e-mail forum for raising concerns about quality in acute care, this PCT had also established an internet discussion forum for the contracting professions (GPs, optometrists, dentists, pharmacists). Overall though, efforts to engage community-based professionals appeared disappointing. Another interview respondent told us that the number of PBC leads attending the PEC meetings (described in the above quotation) had fallen from eight to three over the course of the year.

To sum up, achieving quality improvements in the NHS has become a central government priority in recent years. A number of national and local targets have been introduced and there are a variety of mechanisms by which quality improvements are monitored at the national (e.g. CQC, Monitor) and local level (SHAs, commissioners). Contractual governance, performance management and clinical governance may all be utilised to bring about quality improvements.

### **5.3 Incentives**

As we have seen, the 'Commissioning for Quality and Innovation' (CQUIN) framework, introduced in 2009/10 became part of contracting negotiations and monitoring. CQUIN was only one part of the government's drive to achieve quality improvements in health care. Specifically, 'the CQUIN

framework is intended to support and reinforce other elements of the approach on quality and existing work in the NHS by embedding the focus on improved quality of care in commissioning and contract discussions'.<sup>17</sup> (p. 5)

As in Schedule 3, the emphasis here is on defining and achieving measurable quality indicators. CQUIN may be based in part in the Patient Reported Outcome Measures (PROMs), which acute trusts are required to provide nationally under the terms of the 2009/10 contract. Examples of CQUIN indicators from our case studies include: provision to patients of expected discharge date within two days of hospital admission, provision of single-sex accommodation, reduction to delays in patient discharges, reduction of time-to-surgery for elective and emergency admissions, reporting on patient surveys, and changes in a care pathway involving the acute trusts, community and mental health services.

The difference between Schedule 3 and CQUIN was that, while the CQUIN framework aims at achieving improvements in care quality by providing financial incentives, no such incentives are attached to Schedule 3. DH guidance on the contract, however, mentions that, in addition to CQUIN, contracting parties can agree to include further incentives for quality improvements. Specifically, Schedule 18, Part 1 of the contract, shows that currently there are no nationally mandated incentive schemes. Schedule 18, Part 2 includes the CQUIN indicators, while Schedule 18, Part 3 is reserved for any additional locally-agreed quality targets. In practice there is little difference between the type of indicators and metrics included in Schedule 3 and CQUIN.

For 2009-10, government guidelines allowed for up to 0.5% of the total contract value to be attached to achieving the CQUIN targets. The government announced plans to strengthen the CQUIN framework in 2010-11 and subsequent years by increasing the potential income to providers for meeting CQUIN targets to 1.5% of the total contract value. Along with the financial increase, however, some mandatory elements will be included in CQUINs, for example the requirement to include a patient experience element (which was previously optional).

Another novelty in 2009-10 was the introduction of a requirement for providers to compile and publish Quality Accounts, a process intended to parallel the production of Financial Accounts. CQUIN schemes and achievement against them, were intended to be part of the Quality Accounts.

There were doubts in some quarters about whether, in the first year of their introduction, CQUINs schemes were sufficiently challenging for providers and therefore deserving of the financial payments attached to them. One participant said:

*In fact a number of people on our Board were very unhappy about the CQUIN arrangements because when they looked at what they were they said, well they're just good quality and they should be delivering them anyway. So why should we give them more money. And you know as part of... as tariff you assume that they're delivering a certain quality of service.*

(PCT B1, Director of Quality and Safety).

At the same time many opined that CQUIN targets will become progressively more challenging in future years.

Central guidance makes clear that the CQUIN schemes, and by implication any other local quality targets, should be achievable and measurable, and therefore should be carefully selected and specified by the contracting parties. In case study A, however, some acute trust participants felt that the targets formulated were not always achievable, since meeting some of the targets (e.g. reduction of excess bed days) would depend on the PCT co-operating to provide facilities in the community. Asked about how the local quality indicators were chosen, one participant said:

*I think that we had a minimal say in choosing them. I think they were largely imposed. But I think within the imposition, there was the opportunity for negotiation within that... I'll give you an example, for bed occupancy. You know, I said, really what you're asking us to achieve is not achievable; which was 88% in medical patients ... in medical beds. And we're at over 100%. I mean, there were a number of things, and there's a number of things subsequently, that we've said that we can't deliver on. And I think Stroke's another example... And whilst I absolutely accept that we're not doing everything that we should do in regard to Stroke Services and the quality of the Stroke Services, there's a number of issues that we've said all along we can't deliver on, because actually you don't commission any neuro-rehab beds. You've got no step-down facilities for us for stroke patients, there's no community provision, etc, etc. Yeah, and as I say, we're not doing what we should be doing. But some of that also impacts... needs their co-operation because actually, yeah, we've got a Stroke Unit that's full of patients we can't move on because there's no facilities to move on.*

(AT2, Deputy Director of Operations)

In case study B, the PCTs reported a different approach to similar issues. Referring to discussions of the CQUIN schemes, one participant said:

*I mean it did take a lot of negotiation and a lot of discussion with the individuals, particularly around the CQUINs because of course there's a financial incentive to implement them, so they wanted to be very clear that they weren't signing up to something that was impossible. So there was a lot of negotiation around those but we did agree them in the end.*

(PCT B1, Director of Quality and Safety)

One CQUIN-related issue which gave rise to intense discussions was the PCT's insistence that acute trusts should provide timely discharge letters. GPs had been complaining that often they still had not received a discharge letter for their patients three or four weeks after they left hospital. The PCT wanted to reduce the period for sending discharge letters from 21 days (the trust's practice at the time) to 5 days. The trust agreed that the turnaround time for sending discharge letters needed to be reduced significantly, but argued that this was something that could not be achieved overnight. The PCT accepted that a gradualist approach would be more realistic, subject to the proviso that the five day target was achieved by the final quarter of the contracting year. This is an example of compromise achieved through negotiation and mutual understanding between the contracting parties. From our observations of CQR meetings, we know that similar compromises over timing occurred in case study A.

Another example of negotiating the quality indicators in case study B relates to issues of delayed discharges. At that time there was no national standard aimed at reducing delayed discharges but there was a requirement to monitor the number of delayed discharges. One participant described the PCT's acceptance that this was a problem that needed to be resolved through co-operation and better integration of health and social care.

*And there's been a lot of blaming across the health economy: well you know we would like this patient to go but it's the Local Authority's fault or it's Community Services' fault because they haven't got a bed in the community hospital or whatever, but we've very much taken the view that this is something we all need to work together on and it's not about blaming it's about looking at systems and making sure they are as streamlined as possible and us all being committed to do that but we're not there yet.*

(PCT B1, Dir of Quality and Safety)

The CQUIN framework was, in general, welcomed by participants. It was seen as a way of involving clinicians in contracting by engaging them in issues that interested them, such as clinical quality improvements. However, as our study was conducted during the first year of CQUIN's implementation, it is too early to be able to assess its effectiveness. Participants acknowledged that not all processes worked smoothly. Some of the metrics included in the CQUIN schemes, for example, were either too simplistic or not feasible within the existing resources. The expectation was that the CQUIN schemes would become progressively more challenging in the future.

## **5.4 Allocating risk**

One of the primary functions of a contract is to allocate risk between the contracting parties. A contract may set out the arrangements that will apply in the event that certain contingencies arise. The parties may agree in advance certain procedures for detecting risks and their consequences, and determining who will bear the costs.

Examples of areas that may give rise to risk relate to the volume of referrals to hospitals and capacity provision. According to DH guidance, 'managing the demand for secondary care services is a shared responsibility between PCTs and Providers'.<sup>42 (para. 6.1)</sup> PCTs are responsible for managing the volume of new referrals made to providers, that is, for managing external demand for acute services. According to the application of Payment by Results (PbR) rules, providers will be paid for any additional activity that results from an increase in referrals. Although managing the volume of external referrals requires co-operation across the system (e.g. liaising with GPs, re-configuring patient pathways), ultimately it is the commissioners who carry the financial risk for failure to keep demand under control and therefore it is in their immediate interest to get this right. The contract can therefore be regarded as a mechanism for managing undesirable effects of PbR on PCT finances.

According to the standard contract, providers are responsible for managing demand within the hospitals in order to achieve national and local targets agreed with the commissioners, and consequently they are responsible for

adjusting capacity to respond to changes in demand. Providers, therefore, face a risk from a substantial and sudden increase in external referrals, since they may need to increase capacity at short notice in order to meet the corresponding increase in demand without breaching targets. But, as one respondent told us, there is also a knock-on cost risk to the PCT:

*We are expected to be able to turn on capacity to meet their demand, so, the risk on failing to achieve 18 weeks, because you get too much work, to a greater extent sits with us [the providers]. However, the risk of the cost of that extra work, under payment by results, sits with the PCT. Likewise, if the PCT take work off us, that then sits with us, because we lose an element of income and you can't forecast out that quickly.*

(BT2, Director of Finance)

Since a substantial or unforeseen increase in demand poses a potential risk to both commissioners and providers, actual demand or activity is monitored monthly against forecast levels of activity contained in the Activity Plan (Schedule 3, Part 1), which has to be agreed at the start of each contracting year. Activity monitoring is based on a monthly activity report submitted by the providers to their co-ordinating commissioners and containing details of actual activity such as, GP, consultant-to-consultant and other referrals, conversion rates, average length of patient stay, patient waiting against the Activity Plan, and levels of admission and discharge.

Referring to activity monitoring and the risk of increases in demand, one hospital participant explained:

*The monitoring is quite slick now, arguably, it's too bureaucratic but, I mean, you know, to be honest I know on a daily basis, whether we're going to over-perform or not, because we get daily activity numbers that come through on a daily basis, which we share with them. So, I mean, you know that it's going to have an impact. If you're over-performing, well, clearly we'll get paid more, but it depends. For us the big issue is making sure we've got the right capacity to deliver the work. And, if it does change significantly, it takes us time to react. You can't just turn it on and turn it off.*

(BT2, Director of Finance)

Apart from the forecast levels of activity, the Activity Plan contains 'forecast thresholds' for each specialty which are intended to function as 'early warnings', in cases where actual activity exceeds the forecast thresholds. According to Schedule 3, Part 1, Clause 5 of the contract, if a provider breaches any of the forecast thresholds of the Activity Plan, 'the Provider shall notify the Co-ordinating Commissioner of such breach, and the Co-ordinating Commissioner and the Provider shall agree an Activity Management Plan' containing an analysis of issues such as referrals, conversion rates, activity levels, unit costs, the thresholds that have been breached and proposals to remedy the breaches, and any local targets and timescales within which they are expected to be achieved. The purpose of the Activity Management Plan is to explain the reasons for the over-performance and put in place appropriate remedies for it. The contract also states that if a provider is not able to increase its capacity in order to meet the 18 week target, the provider will have to notify the co-ordinating commissioner in writing, asking for a Capacity Review for the additional activity, in order to avoid incurring a financial adjustment (or penalty) for

failing to meet the 18 week target (NHS contract, Schedule 3, Part 1, Clauses 7 and 8).

Being aware of the degree of over-performance, and notifying commissioners in time when the thresholds are exceeded, are essential parts of contract implementation. In case study A, because of serious weaknesses in the acute trust's data quality and monitoring capacity, the trust appeared to be failing to meet its contractual obligations to the PCT in relation to threshold breaches. One PCT participant explained:

*We'd write to them saying, we want an answer to this Activity Management Plan. We were over-performing in certain specialties last year and in the contract it says, if you over-perform by two percent or more, then you must put on an Activity Management Plan in place as a trust... it's not so much the fact that they were over-performing in activity terms, it was a case of the contract does quite clearly say that the trust will monitor activity just coming through, and obviously plan ahead and if it looks like they're overheating they should be in touch with the PCT. They shouldn't, six months down the line, eight months down the line, get a letter from the PCT saying, what's going on here guys?... it got to the fourth stage where we asked for an Activity Management Plan, and it says quite clearly in the contract that if the trust goes over activity, and can't explain why, and that it doesn't agree with the PCT, why, then it doesn't get paid... They hadn't put the systems in place though which is bog-standard basic requirement for contract management.*

(PCT A, Assistant Director of Commissioning Acute Performance).

Of course, even in the presence of good data and when the reasons for over-performance are known, it may not be clear exactly what the parties can do:

*Well, there are trigger mechanisms within the contract that say if things exceed by 2% whatever, you escalate and try and work out what's going on. I mean, last year it was just the over-performance was too great...But, it was very difficult to see what they [the PCT] could do. What we would have to try and agree with them this year, if they were heading for significant over-performance or whatever is, you know, how do they want to manage it? Do they want us to miss 18 weeks? Do they want us to stop doing something? Or GPs stop referring patients or what, I don't know. I mean, those are the sort of discussions you'd have to have, but it is difficult. On both sides, you know.*

(BT2, Director of Finance)

PbR was introduced by the government as a way of improving efficiency in acute care provision. Put simply, the fact that tariff payments translate into average costs of services means that providers have an incentive to try to reduce the cost of their service provision (e.g. by reducing the length of stay in various specialties) to below the average cost. And since providers get paid for all the activity they deliver, they also have an incentive to increase their activity while at the same time reducing the costs of provision. It seems therefore that efficient providers are the real winners in this system. The incentive created by PbR for providers to increase their activity (provided of course they have the corresponding capacity), is one of the reasons that the contract acts as a counterbalance to PbR via its detailed clauses related to managing referrals and activity in general.

If external referrals increased to a volume which could not be accommodated within existing capacity, providers would not reap the full benefits of PbR since they would have to invest to create additional



capacity. But where such investments were made to cope with rising demand, providers ran the risk of being paid effectively at marginal rates for the extra activity since the income will needed to be traded off against the extra costs (which might be high when temporary capacity is created). There were particular risks to providers in conditions where demand levels fluctuated significantly over short periods, as the resulting uncertainty made it difficult to plan future capacity effectively.

The need to expand capacity in order to accommodate increases in demand was compounded by the need to meet national targets, such as achieving treatment of patients within 18 weeks from the time of referral. Asked how over-performance related to meeting targets such as 18 weeks, one participant explained:

*Well, it does because it means that we have to identify more capacity. We have to put that capacity in place; there're extra costs of doing that and we have clearly incurred extra costs. So while we received more income last year, we also increased our expenditure last year as a result of that... We make the decision as a producer, if you like, whether to invest in that additional capacity or not. That's a risk that we take.*

(BT1, Director of Finance)

The description above suggests that good data quality is an essential prerequisite both for accurate activity forecasting and monitoring activity against the Activity Plan. In case study A, the acute trust's poor quality of data resulted in difficulties with the monthly activity monitoring and failure to reach agreement on an Activity Plan before the beginning of the 09-10 contracting year, which ended with the parties being unable to agree a 'cost and volume' contract. Signing a 'block contract' meant losing the advantages of the new contract and changing the balance of risk allocation. For the PCT, the cost of the contract was higher than planned but the advantage was that their risk was capped. As one participant explained:

*It was more than we had planned...And, you know, the way we thought about it, at least we had certainty having the block contract, so there was no risk associated with that contract...it was affordable and it capped our risk, so we decided, you know, perhaps in the circumstances it was a price worth paying, if you like.*

(PCT A, Director of Finance)

By signing a block contract, the trust, on the one hand, received a guaranteed income that was higher than the PCT's offer during the negotiation period and higher than would have been due in light of the PCT's data challenges. On the other hand, the trust opened itself to an increased risk of losing money if demand rose substantially, since a block contract removed the incentive for the PCT to implement demand management schemes. One participant captured the perspectives of both sides:

*Given where we were in the year, if we, from a trust perspective, if we didn't do a block contract, then we had financial risk around data challenges. But there would also be financial, major financial risk for the PCT in terms of their performance, because even though they were going to do demand management, we know that they never do it. So from their point of view, they wanted to mitigate their risk. But I guess the PCT was less happy than we were because what they felt was that, potentially, if their challenges were successful, they could claw back a lot of money which they could use to do other programmes in primary care.*

*So by committing to it, they've lost the opportunity to get any residual funding. Clearly, it's a risk for the trust as well because the outcome of such a thing would be that the PCT wouldn't be motivated to do its demand management programme, because they know that we will have to do it anyway. So that remains a risk.*

(AT2, Head of Contracting)

In case study B we found another example where the contracting partners were willing to move away from paying on tariff, in this instance because of the financial difficulties of one of the two PCTs, PbR rules for over-performance were relaxed, with the agreement of one of its providers, as a way of helping the PCT. The trust agreed to be paid effectively at marginal rates rather than the full tariff-based payments due. Respondents suggested that this was because of the perceived importance of maintaining a good relationship with their commissioner, which was also in the trust's long-term interest:

*I mean, we've always tried to adopt, I hope, the principle that we want to work with them and not against them. I don't like confrontation. There is absolutely no advantage for this hospital, for them to be in financial difficult. So, we want to work with them. We don't want to bankrupt them.*

(BT2, Director of Finance)

To conclude, despite the presence of provisions in the contract to minimise or share risk (e.g. monitoring monthly referral and activity, putting in place demand management, prior approval and utility management schemes, performing capacity reviews), the risks of agreeing a 'cost and volume' contract, to both commissioners and providers alike, remain. As, according to participants, demand management schemes rarely work (see below), the financial risk to the PCTs is constantly present. Against this background, many see the informal understandings made possible by good relationships as a better way forward than strict allocation of risk according to the contract. In case study A, the formal contract provisions had to be temporarily suspended and a 'block contract' was signed as a way of helping the acute trust out of its financial difficulties. In case study B, the PbR rules were bent as a way of mitigating the financial problems of a PCT.

PbR, in particular, poses significant risks to PCT finances, a fact which is compounded in the light of the recent economic crisis and the need to curb public expenditure. This is reflected in the changes to the PbR system announced in the Operating Framework for 2010-11.<sup>58</sup> From 1st April 2010, there will be a ceiling on the amount of emergency activity which will be paid at full tariff rates. Any emergency activity which is above the contracted baseline will be paid only at thirty per cent of the emergency tariff. There is also mention of a move towards negotiated prices between commissioners and providers in future years, where the national tariffs will only represent maximum prices. As one participant correctly predicted:

*I mean, I think, given the economic downturn, I think payment by results is going to be scrapped, because it isn't going to work. So, you are going to have to have a more risk based, risk-sharing approach where, you know,... it goes back to more marginal rates and stuff. I just can't see how you can do it otherwise.*

(BT2, Director of Finance)

## 5.5 Demand management

Putting in place demand management schemes is one way in which PCTs can minimise their financial risk under the PbR rules. Demand management schemes are presented as a mechanism for achieving efficiency and also as being better for patients since they often involve providing care in the community or closer to home.

The study was undertaken against the background of a gathering storm in public finances and likely spending cuts, and trusts and PCTs were under constant pressure to identify areas for efficiency savings, which would help them avoid deficits. One PCT participant talked of possible options for efficiency savings:

*Efficiency, changing care pathways, you know, working closer with GPs and patients to give them alternatives, taking beds out if they're just not needed: so, lots and lots of different options... We're not expecting to commission new services, and in fact we'll be talking about where we decommission services, or if we do commission new services, you know, it'll be replacement cheaper services, not additional services.*

(PCT A, Director of Finance)

Since GPs were to a large extent responsible for referrals to acute trusts, demand management schemes could not be implemented successfully without their co-operation. Commissioners were therefore looking to strengthen their links with Practice Based Commissioning (PBC) as a way of strengthening demand management schemes. One participant described some attempts at such collaboration:

*Demand management is, I mean it's a term that's been around for quite a while now, hasn't it, and I guess that, some people might say that PCTs have failed entirely given if you look at the level of spend in the acute sector goes up and up regardless. I mean locally the mechanisms we've started to use are around practice-based commissioning largely. We're talking to our practice-based commissioners about schemes that we can use. For example we've set up triage mechanisms for musculoskeletal patients...If they haven't had all their tests, for example, they're sent back to have their tests done before they're referred into the hospital.. We're also trying to put other schemes in place around some of the gynaecology referrals, dermatology we're looking at, and ENT...and we have a number of community services that we've developed in the community provider, using GPs with a special interest. So again they're aimed at keeping people out of hospital.*

(PCT B2, Assistant Director of Contracting and Performance)

Other examples of demand management schemes include the re-design of care pathways (e.g. stroke, chronic conditions) by moving activities such as stroke rehabilitation into the community, or by managing people with long-term conditions in the community, thus minimising hospital admissions. While care in the community may help to reduce hospital admissions or hospital length of stay, it still required investment in terms of improving community facilities, such as additional community nurses, or building intermediate care hospitals. The problem with such schemes was that cost effectiveness remained to be established and evaluations were needed. Several respondents took the view that a shift of resources from hospital to community might not necessarily result in substantial savings for PCTs.

Another area where attempts were made to limit activity performed was in the area of so called 'low priority procedures'. In case study B, the PCTs, in consultation with clinicians, started compiling lists of procedures which trusts should not provide to patients except where certain criteria were met. One participant explained:

*It's been written with the Professional Executive Committee, so GPs from the PCT and we've spoken to Practice-based Commissioners as well about it. But in terms of its implementation, we'd like looking to do it two ways. One through practice-based commissioning, so the GPs not referring, there's a benefit to them obviously for you know savings back into their pots, but we'd also like to get it written into the acute contract, to say, if you do these procedures, you know, you won't get paid for them. So you know, you shouldn't be doing them.*

(PCT B2, Assistant Director of Contracting and Performance)

The trusts were in general agreement with the low priorities policy but were unhappy with aspects of its practical implementation. In particular they were concerned that the need to monitor and approve GP referrals might place an inappropriate administrative burden on the trusts:

*We haven't got a problem with the principle thing. What we tend to have a problem with is the mechanics of it, because what... the typical way of the PCT want to do this is, we don't commission any service, as long as...so if any of those get done, we just won't pay for them. And we said, well hang on, you know, these are your GP's sending the referrals in, there's got to be some joint ownership of this, and at the same time, let's not make it a bureaucratic process.*

(BT2, IT Manager)

Although PCTs in both case studies have implemented demand management schemes their benefit remained uncertain. Many participants were sceptical. Asked whether the PCT is successful in implementing demand management schemes, one respondent explained:

*I think it's very difficult for a PCT to control what their GPs do. At the end of the day a GP will decide what they do with a patient as they present; they can implement new pathways, that's possible. But, the problem with the health service is, if a new pathway means you get a GP to do it, rather than admit to hospital, it doesn't mean it will necessarily be any cheaper. It might be better quality, I don't know, it doesn't mean...because the GP contract means that GPs don't do anything for nothing anymore. So, I think they [PCTs] struggle with demand management.*

(BT2, Director of Finance)

In conclusion, although PCTs were constantly looking to minimise their risk by limiting demand for acute care services, in reality it was not in their power to do so. To begin with, it was difficult to stop patients from presenting at A&E departments and therefore difficult to keep emergency activity under control. Moving activity into the community required substantial new investment, with no guarantee that change would be cost-effective.

## **5.6 Targets and penalties**

As we saw, the NHS contract contained a number of national and locally negotiated targets. Of all the national targets, however, there are only two to which specific 'financial adjustments' (or penalties) were attached as a

matter of guidance, namely failing to achieve the 18 week and C.difficile targets. According to the contract, 'the co-ordinating commissioner may make financial adjustments to payments due to the Provider based on performance against the 18 weeks Referral-to-Treatment Target'. The contract specifies the precise percentage deductions corresponding to the percentage by which providers underachieve the 18 week and the C.difficile targets. Significantly it also provides that the commissioners have the discretion to reduce or waive the financial adjustments in both cases, if they consider that such adjustments are not 'appropriate in the context of the overall performance of the relevant health communities'. (See, NHS Standard Contract, Schedule 3, Part 1, Clauses 8 and 9).

The remaining targets (both national or local) did not have automatic financial penalties attached to them. However, commissioners had discretion to negotiate additional financial penalties for inclusion in the contract. One participant said:

*So far I'd have to say we haven't put penalties into the contract...so the consequences for poor performance we've got in there are largely around performance notices and agreeing action plans with them [the providers]. Having said that, we are planning this year to at least attempt to negotiate some financial penalties into the contracts for some of the key targets, and we've got examples of other PCTs who've done that.*

(PCT B2, Assistant Director of Contracting and Performance)

Apart from penalty clauses, there were other sanctions which PCTs could apply and which might have serious financial consequences for providers, such as transferring services to different providers if a trust breached national targets:

*Well there's not a financial penalty but Performance would issue a breach notice and if they [the provider] continue to do nothing about it and the standard continued to not improve, then we would look at commissioning that service from elsewhere... and we will remove services if we don't feel that they're being delivered appropriately.*

(PCT B1, Director of Quality and Safety)

Another sanction that providers incur for breaching quality targets is the lower rating they receive from CQC. In cases where trusts are applying for FT status, a low quality rating means that their application will be refused. This can also be seen as an incentive, in that trusts applying for FT status have a strong motivation to deliver on their targets and convince their commissioners that they are doing so, since they need the latter's support for a successful FT application.

Our study found no examples where financial penalties were applied by commissioners to providers for breaching either the national infection control target on C.difficile or the 18 week RTT target. None of the case-study providers were in danger of breaching the infection control targets (either MRSA and C.difficile). Regarding the 18 week target, if providers lacked the required capacity to achieve the target, an agreement was reached with commissioners to temporarily purchase additional activity elsewhere. In case study A, for example, the use of an Independent Sector Treatment Centre (ISTC) for orthopaedics eased capacity pressures on the acute trust. In case study B, one of the trusts notified its commissioners at

an early stage of capacity problems in some specialties, which resulted in a joint capacity review and appropriate action plans. Another trust in case study B also notified their commissioners that they were over-performing significantly in one specialty and asked for a capacity review, arguing that if they missed the 18 week target as a result, the PCT would not be entitled to 'fine' them. The PCT failed to undertake a capacity review, but in the event the trust achieved the 18 week target.

In general, the imposition of targets and penalties was seen by many participants as a necessary means by which urgent priorities within the NHS become the focus of improvement:

*I mean often, if we are being honest, if you attach a target to it then often that does improve, but that's only because you change your priority, you know you can't do everything, you can't be as good as you possibly can be at every single thing and inevitably when you attach a financial target to something or you know a financial benefit or you attach a target then trusts will inevitably have to prioritise those things above maybe some other things, but generally speaking trusts want to do everything well, it's just that they can't...I think sadly the major changes or major improvements in the way that we deliver care to patients have been driven by targets.*

(BT3, Director of Clinical Governance)

As already mentioned, meeting targets, such as 18 weeks referral to treatment, might conflict with pressures for providers to cope with increased demand. Hospitals were pressured to identify ways of becoming more efficient or increasing capacity, which might increase risk because it involved additional costs.

## **5.7 Dispute resolution**

The NHS contract described the process of formal dispute resolution which the contracting parties have to follow as a final resort. Dispute resolution might be sought either before or after the contract was agreed, though disputes over agreed terms are by definition disputes involving signed contracts. It could involve the three stages of negotiation, mediation and adjudication. The dispute resolution process differed slightly depending on whether providers were FTs or non-FTs, mainly in relation to the adjudication process.

The contract provide for a negotiation period lasting up to 15 operational days which represented the initial formal statement of the dispute between the parties, followed by a short window in which either party could make a written negotiation offer to the other. If the parties failed to reach agreement within the negotiation period, they had the option of seeking mediation.

In the case of non-FTs, the SHA acted as the mediator, while in the case of FTs, the SHA and Monitor would together mediate to resolve the dispute. In disputes involving FTs, the option existed to invite the Centre for Effective Dispute Resolution (CEDR) to be the mediator, in place of the SHA and Monitor, but this might be expensive as costs would be paid by the protagonists. Although the mediation process might be assisted by the SHA

and Monitor where necessary, the decision about the solution to the dispute would remain, at that stage, with the parties to the dispute.

Where no agreement was forthcoming at the mediation stage, the procedure provided for disputes to go to a final stage of adjudication. In the case of non-FTs, the SHA will adjudicate and its decision would be binding. In the case of FTs, however, adjudication took the form of what is called an 'independent binding pendulum adjudication', which involved the appointment of an independent panel for this purpose. Panel members were drawn from a group of experts and independent members identified by the 10 SHAs and Monitor. Pendulum arbitration involved finding in favour of one side or the other, with no compromise. The costs of the adjudication were borne by the unsuccessful party.

Although neither of our case studies went through a formal dispute resolution procedure, both, on occasions, came close to it, either before or after signing the contract. In the end, however, the parties agreed on compromise solutions.

In case study A, the closest the parties came to seeking formal dispute resolution was over the question of whether an expensive drug (Herceptin) was included in the 2008-09 tariff uplift. Unable to reach agreement during the contract negotiation period, and after having decided to seek dispute resolution, the parties agreed on a pragmatic financial settlement just before the due date for signing the contract.

In case study B, the PCTs came close to formal dispute resolution over the issue of late submission of data by the acute trust. On two consecutive months, data were submitted to the PCTs after the reconciliation point. An informant told us:

*We had issues where a fairish proportion of the data was received late, after the reconciliation point. Now my reading of the contract was that data, SUS data certainly, could not be amended or received after the reconciliation point. So, logically I believe that to mean that anything that isn't received by that point doesn't exist and you can't then accept. We had a lot of debate about that with the trust as you might imagine.*

(PCT B2, Assistant Director of Contracting and Performance)

There were arguments over whether the trust should be 'fined' a proportion of the activity value relating to the late data, or not paid for the activity at all, or should be paid in full on condition that data were submitted. When the parties failed to reach agreement, they began a process of 'local mediation':

*We just followed the process as set out by our SHA and the national contract process for agreeing and then going to local mediation involving the chief executives and the directors of finance. We still couldn't come to an agreement. We felt that, you know, that this was a bit over the top. You can't just send us data at any point, at any time in the future, and expect us to pay for it. There must be surely some kind of logical cut-off point at which you can say, no this is, you know, no, we're no longer paying for that.*

(PCT B2, Assistant Director of Contracting and Performance)

Since little progress was being made, the parties decided to initiate the process of SHA mediation as set out in the contract. They found, however,

that the SHA encouraged them to sort out their disagreement informally without going through the official dispute resolution process. This advice, coupled with the prospect of all-or-nothing pendulum arbitration based on uncertain criteria, was enough to get the parties to resume their bilateral negotiations:

*And we started the process to go to SHA mediation. I mean, and this is the interesting point for me, is that the process when you go to mediation is that, well first of all it's mediation and not arbitration, so you don't get this higher power coming in to tell you what the answer is. They will sit down and mediate a discussion between the two parties... But... and we were also told that if then, if nothing could be agreed at that point, then it would go to a pendulum arbitration. So the SHA would decide one way or the other, how they do that I don't know, but is a real disincentive to people to go through that process. And the clear message was, we want you to sort this out locally.*

(PCT B2, Assistant Director of Contracting and Performance)

Thus SHA mediation was aborted before a meeting could be held, with the contracting parties deciding to split the difference:

*And they set a date for us to come in and have a big meeting. The meeting was set up but we didn't actually go to the meeting. So before the meeting happened it was sorted out via the directors of finance, locally, there was a pragmatic you know, well I don't know how they came to their agreement, but a pragmatic financial agreement to avoid having to go through that process.*

(PCT B2, Assistant Director of Contracting and Performance)

An SHA respondent confirmed that contracting parties were generally discouraged from seeking formal dispute resolution:

*Our message into the system is, we expect you to resolve these things yourselves (...) But we're clear that we don't expect people to be squabbling; we expect them to be behaving professionally in resolving these disputes. (...) If you look at the contract, the contract is clear that whenever there is a shortcoming in quality or performance that the answer is to work jointly to remedy it and to seek improvement.*

(SHA, Director of Commissioning)

To sum up, despite threatening to use the process of formal dispute resolution at various stages of the contracting round, the contracting parties in our case studies always stopped short of formal arbitration. A number of factors – such as uncertainty about the outcome, a dissatisfaction with the past outcomes of SHA mediation, fears that being party to a formal dispute resolution procedure might delay the granting of FT status, and, in the case of FT adjudication, fear of the possibility of incurring the cost of losing the dispute – acted as effective disincentives to use of formal dispute resolution. The parties in the end saw that they had more to gain by seeking a pragmatic, compromise solution.



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## 6 Comparing contracting regimes: the tracers in Wales

### 6.1 Introduction

Having considered our tracer issues in relation to England, we now discuss comparative data for Wales. Again we consider the areas of quality, incentives, risk allocation, demand management, targets and penalties, and dispute settlement.

### 6.2 Quality

*Designed for Life*, the Welsh Assembly Government's 10-year strategy for the NHS,<sup>10</sup> placed special emphasis on developing quality improvements in healthcare in the period from 2008-2011. But in Wales compared to England more emphasis was placed on the use of clinical governance and performance management to take forward the quality agenda, as opposed to the use of contractual levers.

One senior trust executive highlighted how, in contractual terms, infection episodes were more significant for their impact on activity than as breaches of a specific target: 'having an outbreak is costly. It takes out capacity and you are stuffed' (Dof, trust DT, round 1). Another felt that the evidence base for clinical governance remained embryonic in Wales, and argued that clinical governance was driven by a 'cultural rather than contractual imperative' (Assistant CE, trust DT3, round 1).

Although respondents said there were close working relationships between trusts and LHBs on clinical governance and quality, this was somewhat detached from the work of agreeing the AOF and the LTA. If we take the example of infection control, the contractual process imposes certain requirements on providers, but does not constitute the main mechanism for specifying targets or sanctioning trusts which fail to meet them:

*Interviewer: How does it form part of the contractual agreement?*

*Respondent: It is part of the clinical governance as I said you know we are – [trusts] have a responsibility to inform us if they are not going to meet their targets because - I don't know - 6 wards have been closed this week because of I don't know some diarrhoea vomiting bug or whatever and they have a responsibility to tell us that they are not going to hit their targets etc but that is clearly built into the LTA and as I said their infection control annual reports come to us - so it is through that route. But you can guarantee that if there was a major outbreak the trust would be on the phone straight away telling us that there is something going on*

*Interviewer: Why would they do that?*

*Respondent: One because they have to - that is part of the reporting mechanisms for incidents, they have to report into us and then we report them to the regional office. But also because of the targets around waiting times, etcetera. If they felt that they weren't going to hit those targets they would want commissioner support in dealing with the Assembly, etcetera, so they would tell us things like that straight away.*

(Director of Clinical Development, LHB case study D, round 2 )

Wales has approached the problem of HCAs within a clinical governance framework overseen by the NPHS, and resting mainly on a system of audit and mandatory surveillance rather than targets enforced in contracts. Welsh NHS trusts must comply with the various surveillance programmes and report the data to the Welsh Healthcare Associated Infection Programme (WHAIP). The programme does not focus exclusively on MRSA and C.difficile but monitors a hierarchy of organisms that have become resistant and a cause for concern.<sup>59,60</sup> Trusts are required to set local annual disease reduction targets based on local risk assessments, and must report performance against these targets to the regional offices. Although in practice LHBs are usually involved in the reporting chain, they do not performance manage trusts in respect to HCAs.

While contracts were used to identify the quality standards that providers were expected to achieve, there was an absence of defined quality measures and no system for monitoring such indicators within the LTA:

*What we have got is an LTA that does include quality elements and they are more around expectations, statutory requirements, compliance with targets, things like that and you will have a copy of the LTA to take away with you today, the one anyway. Where if you like I think it is a bit weak is we have got a lot of information around activity, we have got a lot of information around finance, we have got a lot of information around performance (...) because it is countable to a large degree, you know measurable. I think with hindsight I would say we were fairly weak on the quality stuff however that is more around if you like the fact that as statutory organisations. We are all responsible for example, for complying with NICE. AWMSG, healthcare standards – big one - a big driver as you probably appreciate, clinical governance. So for example, to summarise, our contracts will say we will expect you to comply with all these things, plus we will expect you to achieve all the national AOF standards which includes more things around quality, like I am trying to think cleanliness and things like that you know...and complaints handling. So whilst it is...I don't think it is actually explicit enough in terms of this is what we want to measure in terms of quality this is how it will be monitored and this is what we will do if it goes awry. Now there are implicit systems in place for that, but in terms of contracting as such it wasn't explicit*

(DoF, LHB D, round 2)

There was no equivalent in Wales to the financial penalty imposed for breaching the C.difficile target.

In Wales, clinical governance was managed through a number of avenues. At the all-Wales level, the National Public Health Service assisted in developing three year rolling clinical governance plans<sup>61</sup> which were performance managed through the regional office.<sup>62</sup> But NPHS focused its work on servicing the development of national policy, and was less involved in the development of service specifications that might have informed contractual governance:

*But not a very sophisticated level of engagement [with the Health Service] in terms of development of service specifications, or in terms of it being based on population epidemiology. So the input that public health has had into the development of the health service particularly around contracts has been very limited. So we have had that group of staff (...) twenty-two public health directors in the local health boards and we have retained in the sort of more organisationally central location at the NPHS a small number of staff who work on health services issues. But in the main we service the Welsh Assembly Government and work with*

*policy leads there to develop policy and guidance work. We have worked with the networks...Cardiac Network, Cancer Networks, again on all-Wales standards, all-Wales issues and we have worked with Health Commission Wales. But...I suppose our level of involvement really mirrors the development of sophistication in my view of the contract in Wales, that they have never really been...had a very hard edge to them. They have never been predominantly based around any epidemiologically-based estimation of population need and they have never been based on development of sound service specifications. And because of there being twenty-two local health boards trying to engage with a very much smaller number of far more powerful trusts, there has been an imbalance of power and its just not an area that we've found it very fruitful to engage in.*

(Senior NPHS executive, round 2)

Aside from the work carried out by NPHS, the Welsh Assembly Government introduced the *Healthcare Standards for Wales* as a framework that would provide 'a solid base on which healthcare organisations can build and achieve the new and more challenging expectations for patient care set out in the Welsh Assembly Government's 10-year strategy, *Designed for Life*'.<sup>63</sup> (p.2) NHS organisations were expected to use Healthcare Standards for Wales as a self-assessment tool, with Health Inspectorate Wales providing assurance with regard to the veracity of these declarations.<sup>64</sup> (p. 2)

Alongside the *Healthcare Standards for Wales*, the *Healthcare Quality Improvement Plan* set out the Welsh Assembly Government's plan for realising the commitment in *Designed for Life* of improving healthcare standards,<sup>65</sup> by setting out a number of system level indicators on quality, and introduced the idea of 're-aligning' the focus of health care managers towards quality issues. This latter point was to be achieved by increasing the focus of trust and LHB boards on quality by issuing a 'requirement that Boards receive a monthly report on performance against the 5 information domains - i.e. efficiency, timeliness, safety, patient experience, effectiveness; the content should be nationally specified',<sup>65</sup> (p.15) by 'linking commissioning to explicit evidence-based pathways of care',<sup>65</sup> (p. 15) and requiring commissioners 'to commission services on the basis of pathways that incorporate evidence-based cross-agency interventions relevant to achieving the Healthcare Standards' .<sup>65</sup> (p. 16)

The upshot was the Healthcare Standards Improvement Plan which (along with the Balanced Scorecard, see below) was to form a central performance management mechanism 'used by the Welsh Assembly Government to monitor and manage the performance of local health boards and NHS trusts in Wales during 2007/2008' .<sup>66</sup> (p. 2) In addition, the 2007/08 AOF required that a number of Healthcare Standards for Wales and Health Quality Improvement Plan targets be realised. Most notably, organisations were required to self assess performance against the Healthcare Standards for Wales. In essence, quality was managed by the formulation of national standards, which were overseen by HIW (partly via self assessment) and performance managed through the regional office against the AOF.

While the performance management structure was being strengthened, there was an absence of clarity as to who carried out the performance management of clinical governance. As we saw above, the Healthcare Standards Improvement Plan mapped out areas where the centre, through

the regional office, would performance manage LHBs and trusts. But the template LTA document also included clauses which implied LHBs would performance manage trusts on clinical governance. The stipulation was that NHS trusts were to ensure that they made provision within the resources they received from commissioners to provide healthcare that met standards set out in government policy. Thus the trust was to comply with its clinical governance, healthcare standards and quality assurance obligations. The LTA set out how these obligations were to be met in an appendix which provided 'guidance to the trust on the core information requirements needed to assure the quality and clinical governance of health care commissioned through the LTA'.<sup>52 (p. 25)</sup> In effect, the trust was to assure the commissioner that it was meeting its clinical governance obligations by providing information in a timely fashion and as requested by the LHB or HCW. This also meant that the commissioner was made responsible for performance managing clinical governance through the LTA. But in practice, this led to a confusion regarding the performance management of clinical governance, since it was then the responsibility of both the regional office and the LHB to carry out this monitoring role:

*There are AOF targets for infection control at the moment. We just monitor on that basis. This is where as commissioners we've been undermined by the role of the Assembly and regional office dipping their finger in and making the trusts account to them rather than to us for everything. We keep an eye on it. I suppose where we get involved is if there's an outbreak of something and it has an effect on the harder targets like waiting times and activity. That's when it's at a point where it really becomes an issue for us in terms of a LTA. In terms of clinical governance the chances are that we would intervene earlier rather than at that point.*

(DoF, LHB case study D, round 1)

A number of respondents suggested that LHBs were undermined in their capacity to manage performance vis-a-vis clinical governance by the existence of the performance management arm of the centre.

Details of quality standards, service specifications, and quality improvements were constructed by a number of organisations. The NPHS was involved in the development of clinical standards and service specifications, usually in co-operation with the Clinical Networks. As a senior informant told us, this fed into contracting but generally in an indirect way:

*So you know presumably [the standards] form the basis of contracts, but it's at that sort of arms length level, and the same with the Cardiac Networks'.*

(Senior executive, NPHS. round 2).

### **6.3 Incentives**

Wales has no direct equivalent of the CQUIN schemes implemented in England. However, an *All Wales Sanctions and Incentives Framework*<sup>60</sup> was introduced in order to address the lack of a performance management framework identified in the *Wanless Review*.<sup>49</sup> In line with Wanless's recommendations, the strategy document *Designed for Life* sketched out plans for a performance management system which included 'a sharpened incentives and sanctions regime'<sup>10(p. 30)</sup>.

In essence the *All Wales Sanctions and Incentives Framework* set out arrangements for rewards and sanctions based on compliance with specified targets and requirements from the AOF. Initially these were divided between core targets (part A) and ministerial priorities (part B), though this arrangement changed in subsequent year. The framework stipulated that NHS organisations:

*... must achieve the Part A targets which represent the core minimum performance standard for 2007/2008. Any organisation that does not achieve all of the Part A targets will automatically face a range of sanctions, which are set out later in this circular. Any organisation that does not achieve all the Part A targets will not be eligible for any form of reward irrespective of their performance in any of the targets set out in Part B of the framework.*<sup>60</sup>

(p. 4)

Performance against targets was to be measured and rendered publicly transparent using an NHS scorecard. This was aggregated into a 'Balanced scorecard', and then later the 'National Reporting Framework', which rated performance according to four bands. In return for achieving the required performance, NHS organisations were eligible for the financial rewards in Table 2.

**Table 2. System of financial rewards, NHS Wales**

Performance band	Reward £ millions	
	Trust	Local Health Board
1	2	1
2	0.5	0.25

Source: *WHC, 2007 (069): 11.*

Those falling into performance band 3 were to receive help on their performance through the National Leadership and Innovation Agency for Health (NLIAH), and the Delivery and Support Unit (DSU). Those falling into performance band 4 were to be subject to special measures as determined by the Welsh Assembly Government.

However, the reward element of the scheme was withdrawn after one year of operation.

*The incentives were small amounts of non-recurrent money. I haven't seen a report on that, but that process has been withdrawn now anyway. It came in last year and it's now being withdrawn.*

(CE, LHB D, round 2)

The sanctions that the Welsh Assembly Government applied to under-performing organisations included a 'special measures' process. This process included: (1) the requirement that the organisation develop a recovery plan; (2) the provision of the necessary support to deliver the plan through the Delivery and Support Unit or the National Leadership and Innovation Agency for Health; (3) an increase in the performance

monitoring of the organisation by the Assembly Government; (4) the requirement that the Chairman report the organisation's progress to the Assembly Government; and (5) the Assembly may assign a Turnaround Director to an organisation if it considers that the 'organisation and/or health community performance is too poor to be improved by the measures outlined' .<sup>60</sup> (p. 13)

What attracted more interest among our interviewees were a small number of locally-negotiated incentive schemes planned to support demand management:

*Yes, and I think if you think broadly that we want all work as possible to go through a trust, whilst hitting waiting times targets. Bearing in mind that waiting times targets were coming in quite aggressively in terms of what we needed to achieve. Our view was that if you can push it out of the hospital to be treated in the community, or avoidance, that's what the care would be about. The system for putting incentives in or putting penalties in for doing more work, just sucks. So what we talked about was how can we set up a financial system that actually doesn't create that...in the end it's so simplistic, we agree a sum of money for what we think you need to do, if you can hit those targets by doing less, you'll save money and we'll have the benefit of less patients in the system.*

(DoF, LHB case study D, round 1)

The absence of a clear system of incentives and penalties was seen as a significant structural problem in the Welsh NHS by several respondents:

*...under the old system, you had the commissioner contracting with the trust, the trust, under the collegiate arrangements were working quite well in some cases, with commissioners. But there would generally come a point where the trust would kind of back off, would not bring the project through to its final conclusions. And what seems to have come up lately is that the reason is that it, the trust management, still don't want to actually, are not actually in a position to force the services to, you know, bring them on board in anyway. And actually...enough incentives, enough rewards, enough punishments to actually enforce change on the level of service.*

(Senior Officer, HIW, round 1)

## **6.4 Allocating risk**

As in the English contracting process, financial risk was an ever present concern in the AOF and LTA negotiations. The AOF negotiations provided organisations with an early opportunity to identify new risks associated with meeting ministerial targets and priorities, and to develop plans to deal with this. Following discussions about performance targets, the organisations sought to agree an LTA. Agreeing a level of funding for the quantum of contracted activity itself involved an implicit allocation of risks between commissioners and providers. Financial risks associated with the provision of high cost drugs were likely to fall primarily on the purchaser, which however would take steps to manage that risk. Additionally, risks were managed through the financial year via the contract monitoring process. Contract monitoring provided trusts and LHBs with the opportunity to identify areas of the LTA and AOF at risk of over- or under-performance, and the LTA included details of arrangements designed to manage such risks.

The work of producing a new AOF involved inter alia an assessment of the changing profile of risk from year to year. Organisations needed to reach as assessment of requirements and pressures in the forthcoming contracting cycle and produce a Local Delivery Plan in which risk was to be 'agreed in a professional and mature way'.<sup>55 (p. 8)</sup> The management of risk, in this process, involved using a 'traffic light' system, introduced as part of the overall performance management system in order to highlight those areas at risk.<sup>66 (p. 6-7)</sup> Green indicated performance on target, amber implied 'performance is below target but actions and resources are in place to ensure the target or measure will be achieved in the next period of performance review', and red signalled that 'performance is below target and an action plan / additional effort or resources are required to achieve the target or measure in the future'.<sup>66 (p. 7)</sup>

From our observations of the process of negotiating the 2009/10 AOF in case study D, this traffic light system was used to track progress toward an agreement on the risks involved in each target.

*DOF: I think if that's updated and its all green, and if I was a chief executive, and I am relying on colleagues to submit LDPs, the first thing I would want to know is have you got anything that resembles an LDP contents that we can revisit. We have got a month theoretically. So if I can get this over to you for Thursday morning and its all green then we are cooking on gas actually aren't we?*

(FEG, 27 January, round 2)

It remained for local teams to identify detailed ways of tackling those risks. For instance, one of the meetings observed dealt with the problem of how to address the Access 2009 waiting times targets within a reduced financial allocation. The managers in the meeting had to decide how they would achieve targets with less funding, in this instance a £5 million funding cut in one LHB area:

*Chair: ...we have still got then to come up with a cost improvement plan haven't we? (...) a couple of issues. One is the overall costs of the LDP and how we manage that. And I think there is a detailed process isn't there? Because my impression of well the discussion I had with James yesterday morning was about in essence sort of obviously trying to deliver the targets for £27m and then giving that if you want that issue almost devolving that down to the divisions isn't it and making the divisions responsible right? The thing that strikes me obviously they have got this fairly...well we've got this high impact stuff we have got the sort of (...) approach in departments which we know has produced productivity improvement which is part of the high impact stuff - actually it is like reducing queues and stuff like that - as a means of trying to pull those costs out, if you want or reduce the costs of implementation. But we have got...how we got to this conversation was about varicose veins wasn't it and I think (...) the demand management scheme is an important element and the other thing [trust finance director] told me yesterday was this...demand increases 5% in orthopaedics or whatever so they talked about demand management and so it is critical to this isn't it?*

(DIG, 17 April, round 2)

In effect, the production of an LDP involved engaging in discussions with managers and clinicians on how to produce the efficiency and productivity savings required.

Negotiations between trusts and LHBs to produce an LTA might include protracted discussions regarding who would bear financial risk:

*Largely they were what was being required of us to be done and the amount of money that was being made available for it being done. We happened to have local health boards that have no bloody money. The [city] local health board is in [financial] recovery, HCW have less than no money, they have millions of pounds less than no money. [Nearby LHB] is out of recovery but in a very tight financial position. So in effect they have been able to say that we won't fund your over-performance where other LHBs do. We can't stop emergencies coming through and we can't turn them away. So arguments around those sorts of things would have meant that we won't sign off the AOF until we're content with the level of risk that's involved. We won't agree that and that goes on and on and on, until you get down to fewer and fewer; the ones left, the most difficult ones. (...) Once you get down to that point, it's about single services with single amounts of money attached to it. And it could come down to an amount of under £100,000 for one service, but that's a lot of money when we're balancing our books on £47,000 slight surplus last year, so you lose £100,000 and you're in deficit.*

(CE, trust DT1, round 1)

In this example, the allocation of risk involves a progressive narrowing of the focus to specific services and relatively small amounts of money. Sometimes the LTA would include the main quantum of agreed services, but exclude those areas where agreement could not be reached. Usually such provision would be subject to ongoing negotiation and, where no agreement was reached, would be managed as non-contracted activity.

Although the LTA was itself a risk-sharing agreement, it was set inside a framework in which certain risks had already been distributed to commissioners and providers via hierarchical command. Specifically, WAG guidance laid responsibility for funding high-cost medical interventions with commissioners, a position that exposed LHBs to a significant financial risk, while trusts were not similarly burdened. Thus commissioners were expected to implement 'NICE appraisal guidance is required to be made within three months of issue and will apply to all technology appraisals issued by NICE'.<sup>67 (p. 3)</sup> They had also to take account of advice from the All-Wales Medicines Strategy Group (AWMSG). Moreover this responsibility was set inside the commissioners' duty to achieve financial balance. The upshot of this was that the LHBs introduced an individual patient commissioning process in which individual referrals were approved or rejected on a case-by-case basis. The risk of overspending was managed through the use of a cost-per-case mechanism for funding new drugs, while drugs already approved by NICE or AWMSG were purchased via the LTA. Nevertheless, fluctuations in the demand for these drugs had the potential to undermine an LHB's financial position.

As in England, one recurrent issue during a period of financial turbulence was whether to agree cost-and-volume or block contracts. In fact there has long been a degree of definitional ambiguity in Wales, where many contracts that are labelled as cost and volume contracts have a substantial block element.

*We've never moved away from proper block contracts, the bulk of it is on block and it's been around marginal performance. Actually, over the last couple of years we've actually gone through (...) the way that we attribute risk. We've actually shifted more of the delivery risk to the trust. So whereas before if there was an issue with the trust not being able to meet some of the waiting times targets and we would have to go and but some of the extra capacity from other trusts, we've actually said to trusts no you've got to sub-contract that, that is your responsibility. We've given you a sum of money, if you need to sub-contract, you need to pay*



*the consultants over-time to do it. But that's up to you. So in a way we've moved to passing some of that risk back to trusts, and saying here's a sum of money, deliver all our targets. We think that's a fair sum of money for the targets we are asking you to deliver. At the end of the year we've looked at respective financial positions and we've moved money around to try and make the whole system come back into financial balance, so it's not a method you would recognise in England*

(DoF, LHB case study D, round 1).

Block contracts burden providers with the risk insofar as the provider has to deliver a service and meet targets within a given financial envelope. However, as this informant testifies, the use of block contracts had also involved a negotiation with commissioners for additional monies to fund additional performance, which might transfer some risk back to the commissioner. Significantly, the above interviewee draws attention to how the commissioner would look at its end of year financial position to consider how to 'make the whole system come back into financial balance'. Overall, our study suggests that the imperative of whole system financial balance would potentially supersede the imperative that individual organisations should bear the costs of their exposure to risk as determined by the contract.

The aggregate end-of-year position became increasingly important as the details of the end of the internal market in Wales became known to participants. This was demonstrated in an observed meeting where directors of finance discussed which organisation should fund over-performance in several areas of the contract. The regional contracting partners were already aware that most would merge into a single unified health board later that year. In this meeting, two views were put forward. The first was that the marginal rates detailed in the contract ought to be applied, and the LHBs invoiced by the trust for the additional activity:

If we go back to purchaser and provider, there is a signed LTA with all of the words in there that says we...well actually we will bill you anywhere between £9 and £16 million [based on differing projections] is the number and we have run that figure from referrals, derived demand, what's in what's out, whichever way you want to take it, it is a big number. But its £2.7 million the actual cost so that gets billed. (Trust DoF, FEG March 10, round 2)

The opposing view was that it was better to concentrate the deficit in one organisation, a large trust. Applying the contract terms would mean that all the LHBs ended the year in deficit, while the trust would break even. Against this there was an advantage in having as many partners to the forthcoming merger as possible report a balance or surplus.

*Chair: There is no point in doing it if you are not getting some material gain out of it. It's difficult for me to...hammer this one isn't it? But...it's only bloody worth doing it if you are getting five out of six over the line. (...) Because like...four out of six are over the line already so...what is the bloody point? So the advantages would be just to recount, [LHB X with small deficit] balances, [LHB Y with large deficit]'s net position improves, you have got the deficit logged in one place, which may or may not have a political ramification. Dis-benefits, [names WAG performance manager] going into low earth orbit. But that might not be a dis-benefit because I would quite like to see that anyway! [Laughter]*

(FEG March 10)

Thus, the costs associated with the risk of over-performance were allocated to the single trust as a way of improving the overall position of partner organisations.

## **6.5 Demand management**

As already reported in respect of England, there was a tension in Wales between the pressure applied by commissioners on trusts to meet waiting times targets, and the LHB's own responsibility for overseeing demand management initiatives (including primary care schemes) that might reduce the flow of patients to trusts. Again this was partly about the allocation of risk between parties, and the 2008/09 model LTA specified the respective obligations of both LTA and trust. Overall the LTA would bear the major responsibility of managing demand to the levels assumed within the LTA, but the trust was required to implement certain internal trust schemes. Accordingly the contract provided that trust over-performance due to failure to achieve LHB-led (including primary care) demand management targets would be paid for by the LHB at specified marginal rates. Conversely over-performance due to failure to meet trust-based demand management plans would not be reimbursed.

The issue of demand management in Wales needs to be understood against the background of the unfavourable comparisons drawn between Welsh and English waiting times in the early 2000s,<sup>68-70</sup> and the high political priority given to this issue. The *Second Offer* scheme, introduced in 2004 to give long waiters the option of treatment at an alternative hospital, was primarily about managing waiting lists rather than patient choice, and was supported by a range of additional measures to tackle this problem. During the research period Wales was moving towards the final stages of implementing an Access 2009 policy which aimed to progressively narrow the waiting times gap with England. The target to be achieved by 2009 was a referral to treatment (RTT) target of 26 weeks (the '2009 access target'), as compared with the English 18-week RTT target. This was supported by various specific measures, both on the LHB/primary care side and within the trusts.

As in England, these measures included triage by GPs with special interests or hospital-based referral management in specialties such as orthopaedics and ENT, as well as the development of alternative (non-surgical) services and pathways, flexible patient booking systems, and pooled waiting lists.<sup>71</sup> Additional schemes included use of photographs with referrals to reduce outpatient visits ('Cameras in Primary Care'), referral newsletters for GPs, and a Demand Management Webpage in a LHB adjacent to our case studies. In the two case studies, the triage arrangements took an ad hoc, even experimental form, and varied greatly between specialties. For example, in 2007/08 in case study C orthopaedic referrals to the main trust were subject to different triage processes (to determine whether surgery or alternatives such as management by rheumatologists or physiotherapy might be appropriate) depending on the purchasing LHB involved. The main

case study LHB agreed to use of the main trust's in-house musculoskeletal triage service, while a neighbouring LHB also funding referrals to this trust preferred to utilise triage via GPs with special interests. As described by one informant:

*[In LHB C, the scheme] was based around GPs with a special interest in orthopaedics being referred cases from other GPs. They would access patients and only refer onto orthopaedic consultants cases they thought needed their specialist intervention. It was only ever a pilot. Only a minority of practices were in the pilot to send their patients to these GPs. The initial assessment was that GPs liked it but the numbers ending up on consultant orthopaedic waiting list was unchanged because the conversion rate to surgery was very high of those patients who were seen by the GPs and then referred on. High conversion rate is what you would expect, as the unsuitable cases have been screened out. However, there is some debate if the pilot was an effective demand management tool. As there has been an assessment made of this it should be clear. Most people think it did work. However (tellingly) the pilot ended and it has yet to recommence. A major reason for this is that the LHB had to pay the specialist GPs to provide the service and they are in great financial difficulties. You may ask – well aren't they benefitting from the results? In financial terms the answer is 'not really' because (a) they signed a block contract with the trust so they end up paying what they paid last year plus the additional money to the GPs and (b) the whole system has to treat (and somehow pay for) more patients to meet the reduced waiting time targets. In other words the system is not stable. The above screening process might have reduced cost if waiting times remained unchanged but they have to drop. So the pilot may be helping this but financially you still end up paying out money the LHB believes it hasn't got. [With patients from the adjoining LHB] GPs were encouraged to refer to the musculoskeletal team headed by rheumatologists first rather than direct to orthopaedic surgeons. The rheumatologists would sift out cases where patient management did not require orthopaedic input, especially surgery. This meant that orthopods should see fewer outpatients and would waste less time seeing inappropriate cases. The consensus was this worked. However, although the waiting list for orthopaedic outpatients dropped, the rheumatologists waiting list started to climb. However, it was stopped – by [the commissioner] – for reasons that have not made clear to me. I suspect part of the reason was opposition from orthopaedic surgeons who disliked the role rheumatologists and physiotherapists were taking. As of today it has not restarted.*

(e-mail from Director of Planning, trust CT, round 1)

Midway through fieldwork the trust pressed to use its own in-house system for patients from both LHBs, before then suspending both mechanisms, and then finally at the end of the period reviving the in-house system.

While waiting times targets were enforced primarily through performance management rather than the contract, waiting times and the associated demand management schemes were a constant concern in contract negotiation and monitoring. In some instances, for example, LHBs were willing to relax their requirements on contracted activity levels providing that waiting times targets were met:

*What we said was that if they over-performed, if they were being inefficient or we weren't managing our demand properly, that was their problem, but we tried to give them assurances that we had demand management in place. If you under-perform, you keep it [the money]. It sounds very simplistic and it does sound that all we're doing is giving a sum of money and saying go and manage it. But there is a bit more logic behind that. It was like yes we are giving you a sum of money, get on and manage it because we're pretty sure we know what you need to do for electives this year and we want to try and pull the rest of it back. Essentially in terms of contract monitoring, each month we'd have a couple sheets of A4 which showed the target activity, the actual activity, you've seen them. It would come to a sum at the*

*bottom right hand corner but then we would never take that money off them. The agreement was that we would leave that money with them.*

(DoF, LHB D, round 1 )

Towards the end of fieldwork when managers were planning for future cost reductions in light of the looming crisis in public finances, demand management was often discussed as part of overall plans to cut costs.

*Chair: A couple of issues. One is the overall costs of the LDP and how we manage that and I think there is a detailed process isn't there? Because my impression of well the discussion I had with George yesterday morning was about in essence sort of obviously trying to deliver the target for £27m [in cost savings] and then (...) almost devolving that down to the divisions isn't it and making the divisions responsible, right? The thing that strikes me (...) well we've got this high impact stuff we have got the sort of (...) approach in departments which we know has produced productivity improvement, which is part of the high impact stuff. Actually it is like reducing queues and stuff like that as a means of trying to pull those costs out if you want or reduce the costs of implementation. (...) How we got to this conversation was about varicose veins wasn't it? And I think they are. The demand management scheme is an important element and (...) the other thing [trust finance director] told me yesterday was this...demand increased 5% in orthopaedics or whatever so they talked about demand management and so it is critical to this isn't it?*

(DIG, 17 April, round 2)

However, many of our respondents were sceptical about the potential of existing schemes to deliver the anticipated cost savings: there was a widespread feeling that, against the background of a changing NHS, real gains would be limited.

## **6.6 Targets and penalties**

In Wales, targets were set by the Department of Health and Social Services, and issued to the NHS via the Annual Operating Framework. The AOF, which superseded the Service and Financial Framework (SaFF) in 2006, provides NHS organisations with information on Ministerial targets, and a framework for agreeing how to deliver these targets. The SaFF document issued for the 2006/07 period identified targets in accordance with strategic themes, which were then broken down into deliverable activity related targets. The AOF for 2007/08 presented targets as 'requirements' NHS organisations were expected to deliver, but continued to use the SaFF as the template that organisations used to demonstrate how they would deliver these targets. The 2008/09 AOF again set out targets, requirements and efficiency and productivity gains, but here the SaFF was replaced with Local Delivery Plans. Thus, in the study period the SaFF was replaced by the AOF and associated LDPs.

As the form of the documents changed, so too did the wider policy context. The SaFF for 2006/07 was issued as part of *Designed for Life* policy, such that all of the 2006/07 targets formed the first steps in the 10-year strategy. However, by the end of fieldwork the influence of the 10-year strategy appeared to be waning,<sup>72</sup> and had been overshadowed by the Government's plans for the restructuring of the NHS in Wales.

The 2006/07 SaFF and the 2007/08 AOF were constructed in light of the 2005-08 targets set out in *Designed for Life*. The document outlined an improved planning framework, whereby a series of three-year strategic frameworks (with associated targets), were operationalised through annual targets in the SaFF. The initial 3-year targets were about preventing ill health, improving access to care, and designing better services in certain key areas.. Interestingly, *Designed for Life* included 54 targets for the NHS in Wales to achieve by March 2006, the 2006/07 SaFF included 25 targets, the 2007/08 AOF included 22 targets, the 2008/09 AOF included 20 targets and the 2009/10 AOF included 26 targets. Overall there was a move to reduce the numbers of targets but specify them in greater detail.

The process of agreeing how to implement targets was an important part of negotiations between commissioners and providers, but was only partly specified in the Welsh LTAs. It was driven by the higher-level planning agreements – the SaFF and later the LDP. The process governing these negotiations also changed over time, so that the 2006/07 SaFF and the 2007/08 AOF were local health community documents, while the LDPs were produced by individual organisations. The situation changed again with the 2009/10 AOF when, in light of the impending transition to an integrated system, the groups of NHS bodies who would form the new health boards were required to work together to produce LDPs.

Although there were a large number of targets, some had a higher priority than others:

*The targets...well there are targets and there are targets, although they've reduced over the years. Because I think the first SaFF came out with 128 targets, I think they're down to about 20 now although there are sub-sections. But we all know that there are a number of those targets that are the do-or-die ones. There are a number that you have to meet them, but you won't get sacked if you don't. The crucial ones are A&E, the outpatients and treatments, finance, probably detox, and cancer and the waiting times. Those are the five that you're going to be up before the minister on. The rest of them, everyone is working really hard on, but they never feel as important. If you look at what goes to [CE NHS Wales]'s management team in terms of performance, it's those five things. So there are targets and there are targets. We all know the ones we've absolutely got to deliver. (...) So everybody knows that they are the key targets that you have to deliver, and that's where the focus goes on delivering those. Apart from A&E, as a community, we've been very successful on delivering those things. In terms of some of the other targets, that's not where the investment's gone. The money has gone into the big ones.*

(CE, LHB case study D, round 1)

The LTAs reflected, rather than set, the targets arising from the wider planning process. The model LTA included a general reference to the AOF targets, but did not contain the detailed clauses found in the English contract. Thus the 2008-09 template contract contains a clause stating that the trust shall, 'Provide access to elective capacity that is commissioned to meet and not exceed the national and local outpatient, and inpatient/day case, waiting lists and maximum waiting times standards on a commissioner basis (Schedule 6). The schedule then makes reference to certain key targets, such as, 'The LHB/HCW requires the trust to ensure Management of Waiting Times Targets and Waiting Lists is detailed in WHC(2007)086.'

Generally the AOF targets were enforced through performance management and line-of-command sanctions rather than via contractual levers. As the waiting times targets associated with Access 2009 became a major service priority, there was a feeling in some quarters that the management imperative to meet this target outweighed anything written in the LTA, for example, in respect of funded activity levels:

*Researcher: Some people have been saying that the RTT target has made the LTA meaningless or very, very difficult...it just doesn't have the same kind of meaning as before the RTT came in.*

*Trust CE 3: That's probably true because if you have a target time for a RTT, does it matter how many of those patients you've dealt with as long as you've dealt with them. There is an argument, there has been an argument and for some providers and commissioners there has been an agreement that it doesn't matter how much activity you've done. Have you met RTT targets, waiting times targets, access targets? If you did it doesn't matter whether it was through a thousand patients or ten. It depends on what you consider to be the measure of your agreement. One of the issues is that if you can achieve a waiting time target with less activity, should you do that or should you just exceed the waiting times target, so you make waiting even less. If the target is twenty-six weeks, but in gynaecology, because of the referrals or whatever, we can get that waiting time down to ten weeks through normal activity, should we do that, or should we say to our gynaecology colleagues instead of having an operating theatre every week, you're going to have one every fortnight?*

(CE. trust DT2, round 1)

The centrally-determined target was seen as more important than the locally-agreed LTA, and therefore there was less pressure to achieve the activity schedules associated with the LTA than to achieve the required waiting times.

The 2008 all-Wales LTA contained no mandatory penalties, but did make provision for LHBs/HCW to include in Appendix 7 a penalty schedule for non-disclosure or lateness of data. The model LTA from the previous year had contained a schedule making provision for financial penalties in relation to non-provision of information, and breaches of elective, diagnostic, and therapies' waiting times targets, but it left it to commissioners decide whether to apply this and to specify cash values. It would thus have been possible for contracts to support the national targets by imposing financial penalties (or payment adjustments) with similar effect to those imposed in England. However, in practice this did not happen. In fact, none of the case study LHBs or LHBs in the regional groups studied included such penalties in LTAs. As our interviews showed, senior NHS management felt that the use of contractual penalties has 'withered away' in Wales. Use of local penalties in LTAs had not in practice been encouraged by the centre:

*The only areas with penalties (..) the only one that was protected was provision of information. [There were] potential penalties...I'm struggling to remember what they were, but basically we were told anecdotally don't implement them, you won't be supported.*

(DoF. LHB C, round 2).

The model LTA and the all-Wales LTA both included clauses specifying marginal payment rates that could be applied to over-performance relative to trust-based demand management plans, which were included in most operative LTAs. In theory reducing marginal payment rates constituted a

form of penalty for the provider, but this was rendered almost irrelevant by the tendency to reach an overall financial settlement at year end that rolled outstanding issues into an overall compromise settlement.

## **6.7 Dispute resolution**

The dispute settlement process in Wales was complicated by the simultaneous operation of two mechanisms: the arrangements pertaining to NHS contract disputes and a separate Debtors Arbitration process.

By 2008, the NHS dispute settlement arrangements associated with the early days of the internal market<sup>31</sup> had gone through several modifications, and now centred on a process outlined in the template LTA guidance.<sup>51</sup> (Annex A),<sup>52</sup> (p.23) This outlines three levels for dispute settlement: first negotiation between named contracts staff, second negotiation between chief executives, and third in the case of unresolved disputes, binding external arbitration via the Regional Director (in respect of LHB issues), and the Director of Service Delivery and Performance Management (in respect of HCW issues), and, ultimately, the Director NHS Wales. General contract disputes were dealt with by carrying out discussions with the parties, gathering evidence, and '[throwing] it back at them and [saying] well if you don't want to make a decision, then we will' (RO2, round 1). The Regional Directors interviewed reported that in the rare cases that went to arbitration, compromise settlements were likely

In the early 2000s, as discussed in Chapter 4, there had been a proliferation in arbitration cases in Wales. One response was to exert increased management pressure to discourage recourse to formal arbitration, but the Welsh Assembly Government introduced a Debtors Arbitration process in 2007, which was intended to facilitate the handling of minor disputes.<sup>53</sup> Neither of our main case study LHAs was involved in a case that went all the way to formal arbitration over an NHS contract in the study period, though – as mentioned in Chapter 3 - one dispute progressed some way through the process before a change of personnel in the LHB led to a compromise outcome (case study C). Both LHAs were involved in a small number of disputes over invoices under the Debtors Arbitration process in the study period, but no cases progressed to a formal arbitration by the regional office.

Debtors Arbitration was concerned primarily with disputes over unpaid invoices. The focus on invoices was designed to place responsibility with the executive officers of NHS organisations, to dissuade organisations from raising 'speculative invoices' and promote the speedy settlement of valid invoices. This reflected the Assembly's view that disputed invoices indicated 'a breakdown in communication between organisations' and that arbitration was indicative of 'a failure of Accountable Officers to deal with the matter locally in a prompt and professional manner'.<sup>53</sup> (p. 3) Importantly, in contrast to the main NHS contracts dispute resolution process, Debtors Arbitration did 'not result in the apportionment of liability', but relied on the exercise of pendulum arbitration, either requiring payment in full or voiding the invoice

concerned.<sup>53 (p. 4)</sup> Interestingly, in this respect the new process resembled the early 1990s internal market arbitration scheme in Wales, in which the pendulum decision proved to be such a deterrent to use of the official process that it was largely displaced by alternative informal arrangements.<sup>31</sup>

The Debtors Arbitration process overlaid a formalised process onto the informal mediation role played by the regional offices of NHS Wales. Thus, a dispute that remained unresolved after negotiations between first, Directors of Finance and second, Chief Executives, would then go to the regional office for Arbitration. Where disputes were between organisations within a region, the matter would be referred to the local regional office, while disputes between organisations in different regions would go to the third (neutral) regional office. As stated earlier, apportionment of an invoice was not permitted: 'The invoice (or disputed portion of the invoice) will either have to be paid in full or have a credit note issued against it in order to cancel the debt'.<sup>53 (p. 9)</sup> The arbitrator was not 'required to justify the decision taken in any way';<sup>53 (p. 9)</sup> nor was there an appeals process.

The main interest of the new arrangement in this context is that many contractual disputes might be channelled either through the main NHS dispute settlement process or the Debtors Arbitration process, providing that they could be reduced to a demand for payment of an invoice. Respondents suggested that, in practice, there was an incentive for both sides to define disputes as disputes over invoices rather than disputes over contracts:

*There was an arbitration process, which was in place before, which was external arbitration. To be honest I can't recall how that works. There is a push from the [trust] Finance Director to use the invoice method as much as possible because it pushes people into agreeing really. The risk of not winning is worse then taking the risk of 50% for example, if you can agree that locally.*

(DoF, LHB D, round 1)

Another informant opined that 'perversely [pendulum arbitration] has made the LHBs and the trust work a bit closer together. But we still get the niggly bits at year end when we are trying to agree finances because there is not enough to go around' (DoF, LHB case study D, round 1). In essence, the use of pendulum arbitration forced a de-politicisation of issues on which the health service felt they needed political steering. The upshot was the attitude that, through arbitration, 'nobody wins because when I have seen an arbitration I can't recall one that's gone anything other than 50: 50. So you may as well decide...50:50' (DoF, trust DT2, round 1), and that pendulum arbitration in effect forced compromise agreements.

However, one informant suggested that gaming might sometimes undermine the mutual push for compromise, since organisations might invoice for more than the value of the issue, 'because you know you're going to get it slashed':

*You know you are going to go to an arbitration process, but with any form of negotiations you know you are going to have to start high to be whittled down. It's about that process in negotiation of where do we get to, to become higher or lower, I can't remember the technical description, but everybody is trying to work out what everybody's mid-point is. It encourages*



*people to go in high or low and if you know the outcome of the arbitration might be fifty-fifty, it's in your interests to keep the number high. The chances are you may get more than you wanted in the first place. I'm not saying that always happens, but there is an awful lot of that that goes into the process.*

(CE, LHB D, round 1)

The interviews brought to light the frustration felt by many senior managers with both traditional NHS arbitration and the newer Debtors Arbitration process. There was a view that because decisions did not need to be explained, the rules governing disputes remained obscure. For instance, one interviewee recounted how he had sought to change a small contract with a distant provider from a block to a cost-per-case contract, but found this resisted by the trust which then threatened to go to arbitration. His view was that the LHB's real priority was 'to make savings and be commissioners. [But] if you do it you've got to have arbitration, and you'll lose.' (DoF, LHB case study D, round 1). Others were concerned that arbitration had little to do with the specifics of the issue involved:

*There are a number of issues around arbitration; one is that often the people who are arbitrating don't understand the complexities of the issue. It often relies upon who got their story in first. It often relies upon what is the general view. Is this a good trust or a good LHB? To me it's a very...it's not an objective view at all, it's much more about – I think this.*

(CE, trust CT, round 1)

Another interviewee similarly complained that arbitration was a 'mechanical' process because the arbitrators frequently, were unaware of the histories behind the issue. Thus they mechanically applied the contract terms to the issue at hand (CE, trust DT2, round 1).

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## 7 Conclusions

### 7.1 Introduction

Our study of contracting practices in the NHS in England and Wales has found much common ground, alongside significant differences. In this final chapter we discuss areas of convergence and divergence, the tension between centralism and decentralisation, the importance of 'relationality' in contracting, and lessons for policy makers

### 7.2 Convergence and divergence

One of our main findings is that, despite headline policy differences, there were broad similarities of approach in many areas of contracting practice in the two countries. In both systems the outline of the contracting cycle and many operative procedures were prescribed in guidance from the central departments. This led to a common approach on many issues, but also sometimes imposed different requirements arising from national policy differences.

Both systems 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. England's 'standard contract' and Wales' 'model LTA' both combined mandatory elements with clauses subject to local negotiation and agreement. After 2008/09 when WAG made it compulsory for LHBs to use the template, the model LTA effectively became a standard contract (the 'all-Wales LTA'). Paradoxically, a Welsh system emphasising planning appeared from our case studies to allow rather more local variation from the template than an English system emphasising markets. We saw in Chapter 4 how one LHB had effectively abandoned parts of the 2008/09 all-Wales LTA with the tacit agreement of the regional office. However, in both countries the provisions of standard contract templates established certain parameters which PCTs/LHBs and trusts had to take into account when they designed local agreements, especially in areas such as dispute resolution, incentives and penalties.

Dispute resolution is a particularly interesting area for comparison because markets and bureaucracies generally settle disputes in different ways. Early policy statements about the legally-binding nature of the contracts between PCTs and FTs, led many commentators to suppose that these contracts would take a similar form to PCT contracts with private providers which could be litigated in the courts. In fact, the English guidance has established a common dispute settlement process for FTs and NHS trusts, which continues to provide for internal NHS arbitration. Wales introduced rather more complex NHS arbitration arrangements than England, with the dual tracks of the NHS contracts disputes settlement process and the Debtors

Arbitration process, but overall the Welsh and English systems operated in broadly similar ways. While, at face value, the English FT dispute-settlement process involved pendulum arbitration and the main Welsh process did not, the de facto shift to use pendulum-based Debtors Arbitration for contract disputes in Wales created a similar disincentive to frivolous disputes. In both systems, the overseeing organisations – the SHAs and regional offices – appear to have been applying strong pressure to discourage arbitration and encourage local compromise settlements. This empirical result bears out the theoretical point made in Chapter 1 that here, as in other instances of the ‘new public contracting’, the criterion of legal enforceability is not definitive of contractual relationships, and has no necessary implications (positive or negative) for relationality in the commissioning process.

With regard to technical aspects of the contracts, there were both commonalities and differences. The predominant contract currencies utilised were hospital provider spells (HPS) and HRGs in England, and average specialty prices combined with deaths and discharges in Wales. There is some overlap in that spells and FCEs featured in some contracts in both countries, though the Welsh deaths and discharges currency has never been implemented in England. At face value, English commissioners purchased mainly on PbR tariffs and Welsh LHBs continued to negotiate local prices, and this was reflected in the latter’s greater use of clauses dealing with marginal pricing in contracts. This, of course, was similar to the pre-PbR English approach and one interesting finding of the study was that English commissioners had not entirely abandoned the old ways. Local prices based on negotiation continued to apply to treatments not covered by PbR, but we also found an example where a system similar to marginal pricing was applied informally by a trust to ease the plight of a partner LHB that was in financial difficulties. The 2010-11 Operating Framework in England allows a return to marginal pricing in the area of A&E work, and several respondents expressed the view that there might be a further shift away from tariffs in other areas. Wales had considered a move to tariffs in the study period and completed an exercise to map PbR (tariff) pricing onto currently-purchased activity, partly because of concerns about cross boundary commissioning, but did not adopt the system.

There were also similarities in the approaches to risk management that we observed. In our English fieldwork, perceived risk centred mainly on issues concerning capacity, over- or under-performance, and the achievement of relevant targets (especially on waiting times). There was more of a preoccupation in our English (as compared with Welsh) interviews with the risks associated with building additional capacity for what might turn out to be short-term demand pressures, which was probably a reflection of local conditions. Respondents in both English case studies reported that they considered good relationships to be a more satisfactory way of managing risk than watertight contract clauses. Indeed the perception that partners might help manage problems that arose as a result of uncontrolled risks seems to have been borne out by events. As mentioned, a trust assisted a PCT in financial difficulties by allowing over-performance to be reimbursed

at less than PbR tariffs, and a PCT agreed to a generously-priced block contract to limit a trust's deficit.

Similar concerns with keeping performance in line with contracted levels and achieving targets were apparent in Wales. Risk was addressed in the Welsh planning process by a traffic-lights system which required a formal assessment of risk profiles - as green, orange or red - at the start of the annual cycle. In the early phase of the study we observed several contracting meetings where the allocation of risk between purchaser and provider was a contentious issue, but as time went on, and with integrated health boards soon to be formed, LHBs and trusts moved towards block contracts and a pragmatic allocation of deficits. From the interviews, the Welsh DHSS took a rather more prescriptive approach to the allocation of risk than was the case with the DH in England, something which was evident in areas such as high-cost interventions. High-cost drugs surfaced as a particular concern for many Welsh respondents, perhaps reflecting a number of interventions on this issue by the Health Minister during the study period.

The two countries utilised surprisingly similar demand management policies centring on such mechanisms as new non-hospital care pathways, referral triage centres and triage by GPSIs. The English purchasers made considerable efforts to involve PBC leads in this area, which of course was an element in the situation not present in Wales. Respondents in both countries expressed a degree of scepticism about the potential of demand management schemes to realise the anticipated savings. This is a key area for evaluation and improvement since demand management will clearly be critical to systems facing increasing funding pressures in the near future.

Both systems had experimented with financial incentives, but while this approach was gaining momentum in England, the reverse was happening in Wales. The English CQUIN schemes looks set to grow in importance as part of a system of harder-edged contractual rewards and sanctions, but the more limited All Wales Sanctions and Incentives Framework had all but withered away by the time the internal market was abolished.

The differences were even sharper in the area of financial penalties. In England these were one of the main mechanisms for enforcing key service targets, again reflecting the greater weight placed on contractual governance. In Wales, the first model contract had made provision for optional local penalties in areas such as target breaching, and also a standard penalty clause on late information for LHBs who wished to include it. However, the revised all-Wales LTA of the following year retained only the optional information penalties. In fact, in practice the WAG DHSS appears to have applied informal pressure to discourage inclusion of contractual penalties. None of the Welsh case study LTAs utilised them. The closest thing to a financial penalty in Wales was the use of clauses allowing a reduction in the marginal prices to be paid for activity in agreed circumstances, something that was less significant in England with less non-PbR activity. Even here the impact was limited because of the tendency of

Welsh LHBs and trusts to arrive at an aggregate, compromise financial settlement that would wrap up outstanding problems.

This pattern of divergent headline policies but similar micro-level practices, is in line with the findings of other intra-UK comparative studies of policy in the areas of health inequalities<sup>50</sup> and patient choice.<sup>71</sup> Alongside forces promoting divergence, there may be a counter trend towards 'policy drag', whereby much of the technical development work done in the larger English system influences what goes on in the smaller countries.<sup>73</sup> Blackman and associates<sup>50</sup> highlight the example of performance management and the tools developed to monitor health inequalities. A similar argument could be made out with respect to the accounting techniques, standard contract clauses, contract currencies, and data systems used in the NHS contracting process. These contracting technologies had a significant development cost, and the tendency in the devolved administrations is to utilise or adapt existing instruments rather than develop new ones.

Beyond these technical 'spill-over' effects, there were similarities in service cultures and the informal adjustments made by staff in both countries to keep their systems working. The NHS internal market as it has evolved has clearly not been a self-organising system. The need for constant adjustments and steering has generated a range of coping techniques and practices that keep market-like arrangements in place, even under non-market conditions. While English management regime of 'targets and terror' of the early 2000s may have been harsher than that in Wales,<sup>48</sup> policy implementation in both systems nevertheless relied on a certain amount of local interpretation and even rule bending to make contracting work, which was widely copied within NHS management networks in both countries.

While these technical and cultural aspects of contracting tend to promote convergence, the divergent aspects of contracting that we observed appear to derive more directly from macro-level policy differences. Our study suggests that the main areas of divergence arise from the English NHS's attempt to put more weight on contractual governance as opposed to hierarchical command, which in turn follows from the greater emphasis on markets as against planning, compared with Wales. This led to a drive to give a harder edge to contracts via use of penalties and incentives, and to tailor PCT contracts to accommodate provider plurality (a common template for all provider types). The technical, cultural and political influences discussed impact differentially on different aspects of contracting work, and may help to explain the mixture of divergent and convergent elements observed.

### ***7.3 The dance of centralism and decentralization***

The ongoing tension between centralising and decentralising forces is a prominent feature of the NHS in both England and Wales. In each country the bilateral service contracts had to be considered alongside vertical performance requirements, which however differed significantly in form.

Vincent-Jones<sup>26</sup> has argued that recent public service reforms combine increased central control of policy and strategy with decentralisation of operational management. 'Centralised decentralisation' involves a grant of greater managerial autonomy in the operational sphere, allied to a strengthening of regulatory frameworks and their sanctioning capabilities. It encompasses a variety of arrangements involving different combinations of continued hierarchical control with elements of delegation and devolution.

Our study suggests that, though the English and Welsh NHS systems revolved around purchaser/provider contracting in local health economies, there were growing differences in the wider regulatory environments and the nature of the remaining hierarchical controls. Both systems relied on mixed regulatory controls, but with different mechanisms and mixes. The English arrangements combined elements of top-down DH or SHA oversight of commissioning, via the standard contract and the national Operating Framework, with a transfer of some regulatory functions to external institutions. Welsh policy makers had settled on a different mix of regulatory instruments that excluded tools associated with markets and competition. Instead Wales had given a fresh twist to command and control by promoting a model of small-country governance that emphasised better connections between the WAG and local organisations and communities.<sup>12,74</sup>

One obvious difference was the establishment of arms-length regulatory bodies in England – in the shape of CQC and Monitor – and the rejection of this approach in Wales. The WAG preferred direct command, combined with a traditional healthcare inspectorate located within a government department. The English route reflected interest in policy circles in concepts from economic regulation theory and the experience of the utilities sector and other healthcare systems, where independent regulation has been utilised.<sup>75,76</sup> As we saw in Chapter 3, Monitor had an important role in overseeing the financial health of FTs, and the CQC could use its extensive enforcement powers to ensure that trusts met standards relating to public involvement, patient experience, clinical quality and safety. Wales' conventional inspectorate – Healthcare Inspectorate Wales - monitored performance in achieving a similar set of standards, but had no comparable powers to sanction poor performance, and did not feature greatly in the management discourses we observed, except insofar as it provided ammunition to WAG and the regional offices which fed into performance management.

Another difference lay in the working of the Operating Frameworks utilised in the two systems. England PCTs and trusts prepared their plans and contracts within the parameters set annually by the NHS Operating Framework. Although this was a national document, more remote from individual commissioners and providers than the Welsh AOFs, it acted as a reference point for performance management of PCTs and trusts by SHAs, which also assessed PCT performance against the World Class Commissioning Competencies.<sup>41</sup> It is worth emphasising that the targets regime in England is still significantly tougher than that in Wales, so that meeting the requirements of, for example, the 18 week RTT target is an

extremely challenging task, whether enforced contractually or via the Operating Framework. By contrast, the national AOF produced in Wales provided a baseline for individual PCTs and trusts to prepare their own AOFs, describing how they would achieve targets and other service requirements within their annual financial allocation. The content of these might be amended in negotiations between the regional office and LHBs or trusts, before the parties signed off the agreements, leaving the individual organisations responsible for delivering their agreed parts of the AOF.

The Welsh AOFs resemble, on a smaller scale, the framework documents agreed between government departments and executive agencies under the Next Steps Initiative and the Public Service Agreements between the Treasury and spending departments linked to the Comprehensive Spending Review. Vincent-Jones<sup>26</sup> has used the term administrative contract to characterise public service agreements of this type, which are primarily concerned with improving bureaucratic performance via target-based management systems, and ensuring accountability of units holding decentralised budgets. These frameworks serve as reference points for processes of target setting and performance management, while allowing a greater measure of devolved managerial autonomy than would obtain under conventional command. They embed purchaser/provider contracts within an additional contract-like agreement, but one in which contractual norms seemed less-well developed. While the bilateral service contracts had a history going back to 1991 and were underpinned by shared understandings arising from many years of practice, the norms associated with the AOFs were more ambiguous and hard to separate from those of traditional command and control.

In Vincent-Jones terms, the purchaser/provider contracts potentially fall into a second public service contract category of economic contracts. They may be structured to help create competition or harness other market-type incentives within public sector environments. This was clearly the case in England where competition was part of the national policy discourse, and to a lesser degree in Wales where contractual incentives and sanctions had not entirely disappeared from the policy agenda. The AOFs were not intended to harness competition and market incentives, but were framework agreements linking superior and subordinate levels within a public service hierarchy. They had a hierarchical rather than a quasi-market character.

Overall there seemed to be more distance between English PCTs and trusts and the two main regulatory bodies than was the case in the smaller Welsh system. Wales is a country of only just over 3 million people, smaller than most of England's 10 SHAs, whose populations range from about 2.5 to 7.5 million. Thus much of the performance management in the Welsh system involved regional offices operating in relatively small health economies. Even where there was direct involvement by the Welsh DHSS or HIW, the distance between centre and periphery was no greater than that between an English PCT or trust and the SHA. Our impression from interviews was that Welsh regional offices and the WAG took a rather more hands-on stance in facilitating negotiations between commissioner and purchaser than

the English SHAs. The vertical relationships appeared less close in England than in Wales, which could put the onus of managing the contractual relationship more on the partners themselves.

## **7.4 Relationality**

Our study confirms earlier findings regarding the hybrid nature of contracts in the NHS, and highlights their strong relational component. In the NHS context contracts function partly as administrative planning instruments, securing accountability for the delivery of a public service, but are also designed (in England more than Wales) to incorporate economic incentives.<sup>37,77</sup> They are formal documents that are intended to be 'complete' in the sense of anticipating and providing for future contingencies. However, while completeness or 'presentation' is essential to effective planning, it is clear in the NHS as in other contexts that contracts are socially embedded in organisations that have ongoing relationships with each other. The discrete norms of planning, consent and choice exist in balance with more relational norms concerned with flexibility, reciprocity, solidarity, role integrity, power, proportionality and harmonisation.<sup>36</sup>

For relational contract theorists, the success of the contract as a governance mechanism depends crucially on 'relationality' as a facet of social exchange. The contractual partners must in other words observe the relational norms necessary to foster trust and co-operation, which in the longer term are likely to deliver mutual benefits for the parties.<sup>26,36</sup> The quality of the relationships with local partners was clearly a major preoccupation for commissioners and providers on both sides of the border. Respondents in all four case studies reported times when relationships became tense and adversarial but also provided examples of solidarity, reciprocity and mutual support.

As noted above, one English trust relaxed the requirement for PbR tariff-based payments to help a PCT in financial difficulties, while a PCT offered a struggling trust a block contract on favourable terms. In Wales, there was a general move towards block contracts with less strict enforcement of activity levels against contracted volume (though still concern with targets), and even agreement in one instance for a trust to hold a deficit so that the local health economy as a whole looked as healthy as possible ahead of the formation of a new unified Health Board.

Yet the events in Wales, in particular, highlight differences between the current NHS context and the contracting relationships discussed in the relational contracting literature. In the NHS we often find a type of forced relationality, which arises because parties are locked into local relationships with partners and have no possibility of 'exit'. The imposed nature of NHS contracts, the lack of choice of trading partners and the consequent appearance of a type of dispute that does not arise in the world of private sector contracting – the pre-contract dispute, over the terms of an agreement that the parties have no choice but to enter – were all highlighted in the early commentary on the NHS internal market.<sup>78</sup> This is,



of course, at odds with one of the discrete contract norms, the norm that the contract is a voluntary agreement which the parties freely consent to enter. As Macneil<sup>36</sup> suggests, the norm of consent is strongly associated with the existence of choice, or at least acquiescence in being bound. The risk is that the absence of consent will have negative implications for the effectiveness of the contract as a governance mechanism.

In Wales the period after publication of the 2007 commissioning guidance saw a concerted top-down drive from the DHSS to draw a line under a period of difficult relationships and over-use of arbitration so as to rebuild co-operation and trust. The problem was that instructions from the top did not translate immediately into cultural change in the service. From our case studies, it appeared that when relations did improve following the new policy direction, it was often because departures of senior managers allowed previous differences to be smoothed over. Much of the behavioural change that did occur, in terms of dispute settlement and better sharing of information, appeared to be motivated by fear of disapproval from regional office or the WAG. Tougher performance management did sometimes bring LHBs and trusts together to present a common front, as in the case of infection control reporting, where it was said that trusts would wish to have commissioner support when untoward events arose. The more co-operative tone observed in relations between Welsh LHBs and trusts towards the end of fieldwork coincided with greater lip-service to the relational norms underpinning co-operation and trust. But, as we saw in Chapter 4, this came against the background of the planned NHS restructuring and reflected the efforts of organisations and individuals to safeguard their positions in the face of impending change. Relationality did not so much grow organically as organisations gained greater knowledge of each other and built trust over time, but rather developed as a pragmatic response to uncertain conditions.

The co-operative behaviour observed among the English organizations took a different form than might be predicted by relational contracting theory or transactions-cost economics. Contractual requirements were varied in light of the identity of the partner concerned just as theory would indicate, but all the instances observed occurred either as the prevailing contracting team philosophies changed to encourage a general move towards more co-operative relations, or as a response to lack of resources. We observed no examples where commissioners sought to vary the nature of a contract or build trust according to the nature of the service or product involved, for instance, in areas that were hard to monitor or seen as prone to opportunism. It was not the indigent complexity of contracts that led parties to put their faith in relationships rather than ever-tighter contract clauses, but the more prosaic matter of stopping a local partner's downfall having negative consequences for cognate organisations. Overall, as in Wales, co-operation was largely about mutual protection for the partner organisations in the local health economy. In a context where deficits or disputes might be seen by the SHA or regulators as reflecting badly on all partners, there was mutual benefit in solving problems bilaterally. To the extent that harder-edged contracts and greater use of market incentives put English

PCTs and trusts at greater risk, we would expect this kind of local co-operation to be a common response. This underlines the fact that further movement towards market-like contracts in the English NHS will do nothing to lessen the importance of relationality.

## ***7.5 Lessons for policy makers***

Our study describes contracting practice in the two systems in a period that has already passed. England is continuing to build its supply-side market and looks set to make further radical changes (see below). Wales has abolished its internal market and is finalising arrangements for an integrated system that nevertheless remains responsive to citizen preferences. It may seem that the lessons of this study for the future are quite limited.

Yet we think that the spill-over influences from one system to the other, tensions between centralism and decentralization, and relationality will continue to be big issues on both sides of the border. Rather than involving linear travel on paths that take the systems ever further in opposite directions, we believe that there may be elements of backtracking and 'implementation lag' in both countries.

Whether English policy makers can take the supply-side market to a new level and realise their quest for a 'self-improving system' remains to be seen, but US experience of a regulated market with much greater purchaser and provider pluralism suggests a continued oscillation between regulatory and competitive solutions to cost containment.<sup>79-81</sup> We expect to see examples of such policy oscillation in the English context. The proposals unveiled by the Coalition Government involve further decentralisation, with a new independent NHS Commissioning Board, the abolition of the SHAs and PCTs, a transfer of commissioning responsibilities to GP consortia, greater pluralism on the purchaser side with some commissioning support from private firms, and a new division of labour between the arms-length regulators, with CQC dealing with quality and Monitor handling economic regulation.<sup>82-84</sup> However, history has shown that a good deal of central direction will be necessary to push such changes through.

Wales appears set to end the use of one variant of public sector contracting – economic contracts using market-like incentives – in the Welsh NHS. But a type of administrative contract – in the shape of the AOF – looks set to survive. A new Five-Year Service, Workforce and Financial Strategic Framework is being developed whose first steps are spelled out in the 2010-11 AOF.<sup>85</sup> Much as happened previously, the Health Boards will each be required to produce a local 'response to the AOF' which sets out their plans for service improvements and delivery of national requirements. The AOF will continue to function as a planning instrument mapping out targets and annual incremental changes under the umbrella of the 5 year strategy.

The operation of NHS Wales as an integrated system operating in the shadow of the larger English system raises fascinating issues for future research which we were unable to pursue in the present study. England and

Wales share a long border and traditionally have large cross-border flows of patients, making the Welsh situation rather different from that of Scotland which has also ended its NHS internal market. Towards the end of fieldwork several respondents told us that commissioning and contracting were terms that had now been largely excised from current Welsh policy documents, and raised doubts about the future policy relevance of our findings. Nevertheless the transition from the former LHBs and trusts to the seven new Health Boards does not mean that all the tasks previously carried out under the commissioning banner will disappear. Cross-border purchasing of services from English providers, purchasing of services from the independent sector (significant in areas such as cancer care with important providers such as Marie Curie and Macmillan) and joint purchasing with social services will all require contract-like documents, which may or may not be managed in the old ways. The new planning system will encompass issues of population-needs assessment, priority setting, and rationing of high-cost treatments that were important elements of the commissioning process, and may involve changing language more than practice. Transitional arrangements in some of the new Health Boards involve transfer payments between the former commissioning and provider divisions (still currently occupying the same sites with many of the old staff). One task for future research will be to investigate how far any internal financial transfers within Health Boards or financial allocations made from the centre to the Health Boards are linked to formal performance agreements (other than the AOF) and whether these have a near-contractual character.

At present an international observer regarding the NHS systems of England and Wales from afar is likely to discern more commonality than difference. In the wider scheme of things they remain publicly-funded, and predominantly publicly-delivered, Beveridge-type systems. It might be said that those who shout loudest about divergence are indulging in what Sigmund Freud called a 'narcissism of minor differences'.<sup>86</sup> As systems that share so much, they highlight small differences as a way of asserting their distinct identities and visions. Yet as systems develop and mutate, small differences can translate into species change. The differences in NHS commissioning practices that we have examined in this report are quite limited, and have not yet transformed the fundamental character of the English and Welsh NHS services. In future, and particularly if the English system moves down the path towards greater pluralism with major private sector involvement, policy divergence will have more substantial consequences.

Our experience confirms the findings of other recent SDO studies (such as 08/1618/125 (Exworthy) and 08/1718/147 (Peckham)) that the transaction costs of conducting NHS research are increasing and that NHS organisations are generally less willing to co-operate with research than in the past. The current research ethics framework makes demands that are out of proportion to the risks posed by studies that focus on managerial work. Trust policies on research governance approval remain diverse, and the 'research passport' system (at least at the time of fieldwork) was still not

operating as intended. Gaining ethical and research governance approval is a major resource consuming activity and a largely unfunded burden on many SDO projects. We suffered real setbacks when a PCT that had agreed in principle to co-operate withdrew consent, and another with whom we had negotiated for months finally refused access. We also found that many other organisations denied or curtailed access to meetings, which was different from our experience with similar organisations in the 1990s.

Our suggestions for policy makers are as follows:

1. Currently the English and Welsh NHS systems diverge only in quite limited ways, so that the two systems still share many common features. This should ensure the continuing feasibility of cross-border activity, at least in the short run, but cross-border work, the reimbursement mechanisms to be used, and the arrangements for ensuring quality and resolving disputes are key areas for monitoring and future policy development.

2. One of the lessons of relational contract theory is that behaviour comes before law. The contractual norms emerge from the practice of contracting rather than the law of contract. Changing the legal framework does not in itself change behaviour. Policy makers need to be aware that the cultural dimension of contracting has been crucially important, and of the likelihood of a degree of 'implementation lag' before new policies work in intended ways.

3. Relationships will remain important whether within a contractual or a planning framework.

- The challenge of moving in England towards greater purchaser and provider pluralism is that regulation is likely to become more complex and the transaction costs associated with co-ordination and disputes will rise, particular if litigation is allowed to increase. Continuing recourse to hierarchical command in the present governance arrangements has kept the potentially negative aspects of provider pluralism in check. However, the content of the recent Coalition Government White Paper<sup>83</sup>, especially regarding the changed responsibilities of the CQC and Monitor, suggests to us that policy makers will need to re-visit these issues. At a time when the role of non-governmental bodies is coming under some scrutiny, it will be important to analyse the components of successful regulated markets and the role of arms-length agencies, and ensure that the regulatory arrangements in England are fit for purpose.
- With regard to the integrated Welsh system, it is important to realise that relations between organisational divisions can be as difficult as those between separate organisations. Bilateral relations of a kind occur even within a planning framework. The integrated NHS system of the 1980s was not free of conflicts between, for example, District Health Authorities and the hospital units, or managers and professionals. Many of the specific lessons of relational contract theory also apply to the planned allocation of resources in a multi-divisional Welsh Health Board.

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 in services, and demand management, will remain central to the new planning regime. It is important not to forget the lessons of the contracting and commissioning era, and to bring the best practices into the new framework. One key issue will be how the system can preserve an element of internal scrutiny and challenge in the areas of financial management and resource allocation. It may be that policy makers need to consider returning to some of the intermediate new public management mechanisms such as internal transfer payments and divisional budgets, rather than seeing integration as a straightforward solution to the co-ordination problems of the internal market. This aspect of policy presently appears to be underdeveloped, so that the new Health Boards are experimenting with different local approaches.

5. English policy makers need to take account of the importance of relationships and informal, 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 as set out in the Health and Social Care Bill, PCT purchasing gives way to purchasing by GP consortia, or specialist external agencies sub-contracted to undertake this task.<sup>84</sup> Policy makers will need to ensure that, where new players enter the field, expertise regarding economic incentive structures and regulatory options, is accompanied by experience of real-world NHS contracting behaviour and the norms that applied in the past.

## **7.6 Lessons for NHS Managers**

When we embarked on the present study we did not anticipate the magnitude of the structural reforms ahead. Our dissemination plans assumed that the organisations and personnel, including the senior managers on whose co-operation the study had depended, would remain in place to receive feedback and that this might include suggestions for modest improvements to current arrangements. The mergers of LHBs and Trusts in Wales and the soon-to-occur reforms in England will result in a dramatic transformation of the management environment. Particularly in England the abolition of the PCTs and SHAs will involve the departure of many of the existing personnel and an influx of new players. As final revisions to this report are made, the best estimate is that perhaps sixty per cent of PCT and SHA staff may move across to GP consortia or the NHS Commissioning Board.<sup>84</sup> At the same time there are ongoing discussions concerning private sector support for the commissioning function, and the likelihood of a role for a new group of managers who have different backgrounds and skills.

It seems likely that increasing differences will emerge in the nature and focus of NHS management work in the English and Welsh systems. This will mean that managers on the two sides of the border are likely to face rather

different challenges, and will be bringing research evidence to bear on different problems.

The abolition of PCTs and SHAs in England has been justified in terms of the need to reduce bureaucracy, but also appears to be linked to a perception that the existing NHS organisations will not support the cultural change necessary if service reform is to succeed. NHS managers transferring across into the new commissioning bodies will find themselves on the horns of a dilemma. On the one hand, the NHS Commissioning Board and many GP consortia may look to experienced NHS managers to keep the ship steady and pass on expertise regarding many of the routine aspects of contracting and commissioning. On the other hand the new organisations may fear that re-hiring the old PCT staff will simply reproduce the undesirable 'bureaucratic' attitudes that were to be swept away, so that they will also listen to private sector experts with different ideas about the contracting process. Knowledge of, and evidence about, how NHS commissioning worked in the past will in our view still have relevance, but will also risk being dismissed as part of an old order shown to have failed. Even those managers based in NHS trusts are likely to find their assumptions and existing practices challenged by commissioners. In this environment, lessons based on the past that are proffered may not be readily accepted.

In Wales managers are likely to experience a more incremental adjustment from soft contracting to transactions between divisions in integrated organisations. Most will be unfamiliar with the planning processes and resource allocation mechanisms that operated before the internal market, and some may underestimate the potential for conflict over internal transfer payments<sup>87</sup> and the importance of relationality within as well as between organisations<sup>88</sup>. Managers will be able to apply much of the expertise developed in the commissioning era in these new circumstances, but will also have to work out new arrangements for overseeing resource allocation that involve challenge and accountability as well as co-operation.

Our recommendations to managers are:

1. Managers should not forget the importance of 'relationality', both in an environment where harder forms of contracting are gaining prominence and in the context of transfer payments within integrated health boards. The social relations in which contracting is embedded often have a smoothing effect when problems arise. There may be a turn towards technical aspects of contracting and formal economic modelling, but the lessons of socio-legal scholarship over more than two decades is that a balance must be maintained between the so-called discrete and relational contractual norms<sup>26</sup>, between holding a party to the letter of a written agreement and co-operative behaviour.
2. The NHS has suffered in the past from periods when overly adversarial relations caused problems in the contracting process. Staff in health authorities, and later the PCTs and LHBs, sometimes put too much reliance on the discrete norms, perhaps based on erroneous ideas about the reality of business contracts, and found themselves needing to

rebuild working relationships. It is especially important that managers in the new environment, particularly in England, do not repeat these mistakes and exaggerate the advantages of 'distance' and 'robust' dealings in negotiating and managing contracts.

3. NHS managers in both England and Wales should be modest and measured about the lessons of the past, but they should be clear that the experience of the internal market remains relevant in the new environment. Managers more than any other group of actors have detailed familiarity with the mechanics of commissioning large volumes of activity over a lengthy time period and, whatever the failings of the old purchaser/provider split, they will play a key role in ensuring that organisational memory regarding the practicalities of commissioning and contracting is not lost. They should be open to new ideas, but also make the case that experience is important.
4. Managers from the private sector now becoming involved in NHS commissioning are a potential source of new ideas and can bring expertise from other health care systems. However theory gained from a distance should not be seen as a substitute for firsthand experience. Contracting in the market-oriented United States system also depends on a mix of formality and relationality<sup>56</sup>. It will be important when seeking lessons from other systems to listen to experts familiar with complexity of real-world contractual negotiations.

## ***7. 7 Suggestions for further research***

Future studies are needed 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.

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## Appendix 1 The research team and advisory group

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\*\* Joined project 2007-09 but left team because access could not be agreed for a Leeds case study.

\*\*\* January to April 2007.

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## Appendix 2 The case studies

The characteristics of the case study areas are summarised below.

### ***England – case study A***

This case study comprised one PCT (APCT1) and its main acute care provider (AT2). They are situated in a mixed rural and urban area. One of its major towns (in which our acute Trust is situated) is ethnically diverse with a high concentration of Sikh, Muslim and Hindu communities relative to the rest of the country. The town has recently been experiencing high levels of immigration, mainly from former Eastern European countries, but also from Somalia, Pakistan and India. This has impacted on the provision of local public services including health, education, transport and housing. The town has pockets of deprivation, although its unemployment figures are not high relative to other parts of the country (65% of its residents are in employment according to the 2004 study by the Office for National Statistics). A projected high birth rate in two of the main towns in the area and a projected increase in the population aged 75+ are expected to put additional strain on health resources.

**The PCT (PCT A)** The PCT covers an area with five main towns falling within three unitary authorities. Pockets of deprivation exist in all three authorities. According to the ONS mid year estimates for 2008, the resident population in the area covered by the PCT was approximately 400,000. Modelling of the expected changes in age distribution, performed by the ONS, shows that in the next five to ten years around 26% of the population will be 65+, around 19% will be 75+, and around 10% will be under 14. These changes will have a major impact on planning services in the acute and the primary care sectors and are therefore a key factor in the contract negotiations between the PCT and its main acute care provider. The PCT anticipates that it will achieve its budgeted surplus of £1.26m (Finance Report 09-10), despite the significant challenges it faced during the financial year, not least because of its main provider's current financial difficulties which impacted on the contract negotiations as well as the PCT's finances. The PCT's total budget was approximately £510m in 08-09, and £537m in 09-10.

**Trust AT2** is a large District General Hospital, which became an FT three years ago. It provides health services for a population of around 500,000 people and employs close to 4,000 permanent staff. The value of the contract with its main PCT over the two years of our observation has been between £130m - £150m. It delivers acute services from two hospital sites, and manages outpatient and some diagnostic services at four additional sites. The Trust reported a £1.8m surplus in 08-09, which was significantly lower than its forecast of £5.5m. The lower than anticipated surplus, which was partially due to contract disputes and data quality challenges from the Trust's main commissioner, had the effect of reducing the Trust's financial

risk rating (FRR), which resulted in the Trust being placed under intense review by Monitor. In the 08-09 Care Quality Commission assessment, the Trust achieved 'fair' for quality of services and 'fair' for financial management.

## ***England – case study B***

This case study comprised two PCTs (BPCT1 and BPCT2) and three acute care Trusts (BT1, BT2, and BT3), covering a mix of rural and urban areas.

**PCT (PCT B1).** This was formed in 2006 by merging three smaller PCTs. The total population of the county for which the PCT provides health services is estimated to be approximately 530,000 and is expected to have increased by 12% by 2020. The county contains affluent suburban and rural areas especially in the south, but also industrial towns in the north with pockets of deprivation (six areas are within the 10% most deprived areas nationally). It has a slightly lower proportion of people aged under 34 than the national average and a slightly higher proportion of people aged 40 – 69. The relatively high number of people in or close to retirement will have an impact on future patterns of health care demand since the utilisation of health services by the elderly is significantly higher than the rest of the population. The PCT commissions acute care from three main providers (BT1, BT2 and BT3). In 09-10, the PCT's total budget was approximately £785m. The contract value in 09-10 for the three acute care providers was approximately £104m for B3, £88m for Bb, and £71m for B2. The PCT is currently in a difficult financial position which goes back to the substantial deficit it inherited after the merger in 2006. After repaying that deficit, it achieved a non-recurrent breakeven in 07-08 and 08-09. Continuing financial pressures, caused mainly by high acute hospital planned care demand and demand for continuing healthcare services, resulted in the PCT forecasting a potential recurrent financial shortfall at the start of 09-10 (approximately 3.2% of its allocation). The Board consequently approved a Financial Recovery Plan setting out a strategy to deliver a financial breakeven in 09-10, which the PCT predicts it is on course to deliver.

**Trust BT1.** This Trust is a single site hospital which provides a range of traditional district general hospital health services including medical, surgical and maternity care, and works closely with other hospitals for services like cancer, pathology and coronary heart disease. It serves a population of approximately 250,000 from the surrounding local area, which includes pockets of deprivation. It employs approximately 1,700 staff. The trust's main commissioner is BPCT1 which accounts for 76% of the Trust's income, and its third biggest commissioner is BPCT2 accounting for 6% of its income. The Trust's total income in 08-09 was approximately £100m. Although in 08-09 the Trust achieved a financial surplus for the third consecutive year, it presented a cumulative deficit of c. £3.5m, some of which dated back to 05-06. It is, however, on course to deliver the financial recovery plan drawn in 05-06 and expects to achieve breakeven by 2010-11. In the 08-09 Care Quality Commission assessment, the Trust achieved



'fair' for quality of services and 'good' for financial management. It is currently applying for FT status.

**Trust BT2.** This Trust provides services from two hospital sites and serves a population of approximately 270,000 residents. There are five towns in the surrounding area.

The Trust employs over 2200 staff. A wide range of traditional district general hospital services, such as day case, inpatient, outpatient and maternity services are provided. In 08-09, the Trust achieved a financial surplus of c. £7m, significantly above its initial forecast of £3m, which was mainly due to significant over-performance on all of its main contracts (arising from increased referrals). The Trust's total income in 08-09 was approximately £122m. For 09-10, the Trust is forecasting a surplus of c. £4m. In the 08-09 Care Quality Commission assessment, the Trust achieved 'good' for quality of services and 'good' for financial management. It was recently granted FT status.

**PCT (PCT B2).** This PCT was established in 2002 and serves the population of a major city (approximately 350,000 people). It employs over 1500 members of staff. The city includes areas of affluence but also high deprivation. It is considered a relatively deprived city overall ranking in the bottom 15% in England, a factor which is associated with poorer health and therefore high health care needs. The city's population is predominantly young with fewer people aged 65+ than nationally. It is expected to grow in the next twenty years due to more births than deaths and it is expected

To become more ethnically diverse. It commissions approximately 92% of its acute care activity from BT3 (the value of the contract for 08-09 was close to £190m), and the rest from BT1 and BT2 (the value of the contracts for 08-09 being £5.5m and £2.4m respectively). The PCT is in a healthy financial position, having achieved a surplus in the last two years and anticipating meeting its target of c. £4m surplus for 09-10. The PCT's total budget for 09-10 was approximately £555m.

**Trust BT3** is a big Teaching Hospital which provides acute and specialised care for a population of over 1,000,000 people. The Trust is currently applying for FT status. It was first established as a Trust in 1992 and offers services from two sites. It specialises in cardiology, neurosurgery, stroke, joint replacements, IVF, diabetes, cancer care and kidney transplants and employs approximately 6,400 staff. In the 08-09 Care Quality Commission assessment, it achieved 'good' for quality of services and 'good' for financial management. In 08-09 the Trust recorded a total income of approximately £427m, which represents an increase of close to £50m from its 07-08 income. The increase is due to factors such as inflation uplift, changes in the PbR tariff, and increased levels of clinical activity. The majority of its income (c. 80%) comes from PCTs. The Trust achieved c. £5m surplus in 08-09 and it aims to achieve a surplus of £3m in 09-10.

**Trust CT (A)** was one of the largest in the UK with 16,000 staff and an annual budget of £770 million. The Trust has four major hospitals, 14 community hospitals, clinics and treatment centres with in-patient beds,

and 46 community clinics and health centres, providing 2,800 beds. The Trust's catchment area is home to about 700,000 people. The organisation was created from the merger of two former Trusts just as our project started. At that time the management team changed and a new organisational structure was introduced. However, hospitals in the east of the Trust continued to be run separately from the hospitals in the west and the distribution of clinical activity across the area remained an issue in contract negotiations.

### ***Wales – case study C***

This is a predominantly urban area which has traditionally been associated with manufacturing and heavy industry. At the time of the study the single LHB (LHB C) purchased over 90% of its secondary care activity from a local Trust, and the bulk of the rest with a Trust in an adjacent town. After a provider merger in 2007/08, this LHB commissioned over 95% of secondary care services from the new amalgamated Trust, therefore operating under near-local monopoly conditions. As in many other Welsh localities, there is a significant flow of referrals (arranged via Health Commission Wales) to the main Welsh tertiary services hospital outside the area.

The **LHB (LHB C)** was established as a statutory body in April 2003 to serve a population of 228,000 people. From 2008 it became part of a partnership of seven LHBs forming the SW Regional Commissioning Group. Membership of this group was focused on coordinating planning and policy across the region. Thus, this LHB continued to negotiate its own contracts with its main provider Trust. We have not used codes for other organisations in the regional group whose staff were interviewed, identifying these only by the relevant case study.

### ***Wales – case study D***

This locality is a mixed industrial valley/ rural area which includes pockets of deprivation and has a declining and ageing population. The LHB has major contracts with three NHS Trusts in urban centres to the north and south. One of these southern centres is the location of Wales' main tertiary care hospital.

This **LHB (LHB D)** was established on the 1st April 2003, to provide services to a population of 170,000 people. From 2008 this LHB became part of the SE Regional Commissioning Group and sought to co-ordinate its purchasing with 9 neighbouring LHBs. We have not used codes for other organisations in the regional group whose staff were interviewed, identifying these only by the relevant case study. One of these LHBs acts as one of two Welsh lead purchasers for cross-boundary contracting between Welsh LHBs and English providers. Despite an aspiration to move to contracts arranged directly between the regional commissioning unit and providers, all these LHBs continued to sign off individual contracts during the study period (and until their eventual merger into new unified Health Boards in 2009).

**City NHS Trust** (DT1) is one of the largest NHS Trusts in the UK and includes eight constituent hospitals. The Trust provides local health services for a population of around 500,000, and is also the main tertiary referral centre for Wales. In 2006/2007 the Trust's total income was £610 million and it employed approximately 13,500 staff.

The **Urban NHS Trust** (DT2) comprised three acute hospitals in a city and two medium sized towns, supported by eighteen community hospitals, health centres and mental health and learning disabilities facilities. It catered for a population of about 600,000, and employed about 13,000 staff, with an annual income of over £500 million.

The **Rural NHS Trust** (DT3) to the north was created on the 1<sup>st</sup> April 2008 following the merger of two previously autonomous Trusts; it comprises ten hospitals, of which two are district general hospitals. The Trust is the fourth largest NHS Trust in Wales with an operating income of over £300 million, employing 7,600 staff in total. It delivers acute, intermediate, community and mental health services to a population of 330,000 residents in a mixed rural/industrial valleys area. Apart from the substantial volume of activity provided for the case study LHB, this trust works in close partnership with a neighbouring LHB.

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## Appendix 3 Observations and interviews completed

Because of the ongoing NHS changes occurring during the study period, the focus of our observations in the two countries differed. In England an important strand of NHS managers' work remained centred on contracting and commissioning right through the study period. The new standard contract functioned, among other things, as a mechanism for ensuring that central targets such as the 18 week pathway, the four hour A&E target and national targets on infection control were achieved. Negotiating and monitoring the contract were processes conducted by designated contracting teams with relevant specialised skills. Their meetings were occasions when purchaser and provider staff interacted and the nature of contractual processes and relationships could be examined. We focused our empirical research on observing three types of contracting fora, involving Directors' meetings. Technical meetings and Clinical Quality Review meetings. The Directors' meetings were the main site for contractual negotiations and the place where unresolved issues from the other meetings were discussed.

**Table 3. Meetings observed in the English case studies**

<b>Meeting</b>	<b>Case Study A</b>	<b>Case Study B</b>
Directors	17	10
Technical	5	
Clinical Quality Review	3	1

In Wales, the impending restructuring of the service led to the suspension of most regular contracting meetings and their replacement either by person-to-person meetings of senior managers or negotiation via correspondence, neither of which was directly accessible to us. We collected very little observational data from Wales on contract negotiations. Instead we directed our observations at more general meetings concerned with the management of the commissioning process and plans for its adaptation into the future, and put more emphasis on qualitative interviews to collect information on the core contracting tasks which were now no longer being carried out in meetings. Apart from a small number of internal LHB contracting team meetings, the team attended six Heads of Commissioning meetings and one Regional Executive Commissioning Board. These meetings were intended to allow LHBs to co-ordinate their activities on a regional basis. Aside from these broader commissioning meetings, we attended eleven meetings of an Individual Patient Commissioning Panel in which decisions regarding non-commissioned care were decided, and one meeting of the English Local Negotiating Team, responsible for cross boundary purchasing.. In addition, given the linkage between contracting

and the wider commissioning process, we also observed the proceedings of a number of clinical networks in Wales that had been established as part of the new commissioning arrangements introduced in 2007.

**Table 4. Meetings observed in the Welsh case studies**

<b>Commissioning and Contracting</b>	<b>Case Study C</b>	<b>Case Study D</b>	<b>Joint</b>	<b>Key</b>
Secondary care commissioning group		1		SCCG
Executive commissioning group		1		ECG
Internal Commissioning group		2		ICG
Heads of Commissioning	6			HOC
Regional Executive Commissioning Board	1	1		RCEB
Individual Patient Commissioning Panel	11			IPC
English Local Negotiating Team	1	1		E-LNT
<b>Planning and Performance Management</b>				
Delivery Implementation Group		10		DIG
Access 2009 Board		1		A2009
Unscheduled Care Board		3		UnCB
Finance and Efficiency Group		2		FEG
<b>Networks</b>				
Renal Network			1	-
Cancer Network Board		2		-
Cancer Commissioning Group		2		-
Critical Care Network Board		2		-

In England, with a more settled policy context, we completed fewer interviews at these higher levels and focused mainly on senior respondents from SHAs. SHAs are not involved directly in the contracting process, but

they have the important function of performance managing PCTs and non-FTs. They are required to sign off the CQUIN targets agreed between PCTs and Trusts, and are also involved in regional initiatives involving clinical pathways and service changes. External organisations such as Monitor, NICE, and CQC influence the contracting process in less direct ways. Monitor, the regulatory body for Foundation Trusts, has a remit to ensure that Trusts meet required financial (avoiding a deficit) and quality criteria (complying with national targets). CQC is the body responsible for ensuring that NHS Trusts (acute, primary care, FTs and non-FTs) comply with the requirements of the national quality framework. NICE is the body which approves which new drugs can be used by NHS Trusts. Since meeting quality targets is an important part of the contract and the new drugs which are approved by NICE may have a significant impact on the finances of Trusts and PCTs, these issues relate directly to contracting discussions. For the purposes of this project, the role of external organisations was pursued in our observations and in the interviews we conducted and are described in this report under the theme centralisation versus de-centralisation.

**Table 5. Interviews in England**

<b>Case study A</b>	<b>Case study B</b>
Head of Commercial Development (Trust)	Director of Quality and Safety (PCT)
Head of Contracting Year 1 (Trust)	Head of Clinical Quality (PCT)
Director of Finance (PCT)	Director Nursing and Operations (Trust)
Assistant Dir of Finance (PCT)	Director Clinical Governance (Trust)
Infection Control Clinician (Trust)	Director of Finance (Trust)
Director of Nursing (Trust)	ICT Manager (Trust)
Deputy Director of Operations (Trust)	Finance Manager (Trust)
Head of Contracting Year 2 (Trust)	Director of Finance and Performance (Trust)
Director of Finance (PCT)	Commercial Director (Trust)
Contracts Manager Consultant (PCT)	Director of Contracting and Performance (Trust)
SHA – Senior Officer	Assistant Director of Contracting (PCT)
	Performance Manager (PCT)
	SHA – Senior Officer

In Wales, with restructuring already proceeding, we supplemented our case study interviews with interviews at regional and national levels. This included key staff from NHS Regional Offices, and bodies such as Health Commission Wales and Health Inspectorate Wales that had a presence in the local health economies studied. At national level we interviewed key

informants in the Welsh Assembly, the Welsh Assembly Government and the Department of Health & Social Care.

**Table 6. Interviews in Wales**

<b>Case study interviews</b>	<b>Case Study C</b>	<b>Case Study D</b>	<b>Nat</b>
Trust Director of Planning	1		
Trust Medical Director	1		
Trust Chief Executive	2	4	
Trust Director of Finance	1	1	
LHB Chief Executive	2	3	
LHB Director of Finance	2	6	
Health Commission Wales Chief Executive			1
Regional Office Chief Executive	2	1	
Regional Commissioning Managers	1	3	
Commissioning Manager (Trust and LHB)	3	1	
Individual Patient Commissioning Group Members	6		
Access 2009 Project Staff (Waiting times)		2	
Local Negotiating Team Member		1	
Managers of Clinical Networks		2	
Unified LHB Nursing Director	1		
Unified LHB Community and Mental Health Director		1	
Unified LHB Director of Finance	1		
LHB Lead, Non-NHS Service Level Agreements	1		
Local Authority Social Services Department interview		1	
<b>The Changing Welsh NHS</b>			
Special Advisors (WAG SA)			5
Members of the Welsh Assembly (AM)	3		
Non-executive members of NHS Trust and LHB boards	1	1	
Senior Civil Servants			3
Chief Executive Officers of Regulatory Bodies			3

Note: This includes a small number of repeat interviews with a single individual. For instance, one Trust Chief Executive was interviewed first in respect of his Trust role, and later as Chair of an observed board meeting.



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## Appendix 4 Change, organisational turbulence and research access

When this study was commissioned there was little to suggest that a further period of NHS system disturbance was imminent. However, as described in chapter 1, the 'McKinsey reviews' in England were taking place in 2006-07 just as we began access negotiations. These led to considerable movement of senior staff in England. It was not long before the shift to regional commissioning and news of the impending restructuring of the NHS in Wales affected research fieldwork there.

At the time of our project proposal in 2006 we had made preliminary approaches to two Welsh and three English PCTs and received encouragement that research access was likely to be forthcoming. Hughes had attended a single Welsh SCCG meeting in 2007, but had then decided to put fieldwork on hold until a start could be synchronised with the English fieldwork, where access had not yet been agreed.

The situation in England has become very uncertain, with the McKenzie Reviews underway and many PCTs led by acting chief executives who felt unable to approve research access until permanent appointments were made. After very protracted negotiations with one PCT and its main provider NHS Trusts we believed permission for a London case study had been agreed in late 2007. However a few months later the incoming permanent PCT Director of Commissioning flatly ruled out participation in the study. The need in a case study to recruit organisations in matched sets, which just one dissenting organisation could render unviable, was a major problem in a period when many senior office felt under pressure and apprehensive about opening their organisations to researchers.

Over this same period the London team carried on negotiations with two other PCTs, one located in a Home County and one in south central England. At this time we encountered a depressing picture of equivocation and delay. We had attempted to gain access to the south central PCT via senior contacts within public health medicine who had co-operated in previous research, but the new management team was again unwilling to participate. Eventually the London team obtained permission to proceed from the Home County PCT, but found itself with no immediate candidate for the second case study. It was to take almost another year before another PCT in south central England agreed to take part and its research governance requirements were met.

Meanwhile the Leeds team had approached two PCTs and received an encouraging indication of likely agreement from the acting chief executive in one. Three NHS trusts and a private sector provider also promised co-operation if we were able to get their PCT on board. Negotiations in the north continued for more than a year with no positive conclusion. Eventually a financial crisis led to the sacking of the old PCT management team. With

no prospect of early access agreement, the chief investigator took the decision to abandon the fifth case study.

Ethical approval for the study was gained on 10 May 2007. This too had been subject to delay because we had initially been advised by MREC insiders that we would need to specify fieldwork locations before an application was likely to be approved. Subsequently we learned from another SDO project team that certain RECs had been prepared to give ethical approval without full location details. We took our proposal to an MREC known to have followed that approach, but had to wait for a future meeting because of the large number of applications already in the queue. Subsequently we gained research governance approvals from the various purchaser and provider organisations in the study. The process with LHBs and PCTs was relatively straightforward, but there were delays with a number of NHS Trusts, either because Trust risk assessment committees requested further information about the study or technicalities concerning honorary contracts and medical examinations (which were required by some organisations even though the study required only interviews with managers). At the time of our fieldwork, the research passport system was not working effectively in either England or Wales.

Once access for the first English case study was agreed, the Welsh team went back to the two LHBs where research governance approval had already been gained to begin fieldwork, but discovered that the contracting landscape had changed. The SCCGs were about to be discontinued and we became aware that we would need to agree research governance with new groups of actors associated with the Regional Commissioning Support Units. Although we already had some additional research governance permissions from neighbouring LHBs that had been occasional attendees at the two SCCGs, this raised a thorny issue of needing additional permissions from the other LHBs supported by the RCSUs. We also needed to make additional approaches to the RCSU heads who were not based in our case study LHBs. All this led to further delays. Pending access to the RCSUs the Welsh team gained permission to attend internal contracting team meetings in LHB C and LHB D. We attended several meetings of both the LHB commissioning group and the (more strategic) LHB executive commissioning group in LHB C, but a few months after the publication of the Consultation document on NHS restructuring these forums were discontinued, so that most contract negotiations and monitoring took place in either one-to-one LHB/NHS trust finance director meetings or meetings linked to the RCSU. In LHB D internal contracting team meetings were suspended almost immediately. We were allowed to sit in on the meetings of an existing individual patient commissioning group (for high cost treatments) and a few *ad hoc* meetings, but were again left waiting for access to RCSU meetings.

After two months of further delay, qualified permission to observe some aspects of the RCSUs' work was granted in both areas. In case study C we were allowed to attend and audio record 10 successive meetings of a Heads of Commissioning group and a meeting of the RCSU executive group. However, this latter group advised us that they would not welcome our

attendance at further meetings. In case study D we were initially advised that we had permission to attend both the RCU executive meetings and some of the team meetings where contract negotiations would proceed. However, many several scheduled meetings were cancelled and our first attempt to attend a negotiation meeting led to the researcher being turned away. We were advised by the Chair of one of the groups that we could instead learn of the content of these meetings via interviews.

Later we widened the focus in Wales to examine not only the main case LHBs but other participants in the RCSUs. In England, our second case study turned out to involve two PCTs working closely together in lead and associate roles, that alternated for different local trust providers. Thus the study evolved to become more complicated than simple case studies of single NHS purchasers.

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## Appendix 5 REC approval

Multi-Centre Research  
Ethics Committee for  
Wales

Chairman/Cardeirydd :  
Dr Gordon Taylor

**MREC**  
*for*  
**WALES**

Pwyllgor  
Ymchwil Ethegau  
Aml-Ganolfan  
yng Nghymru

Administrator/Gweinyddes:  
Dr. Corinne Scott

Churchill House, Fourth Floor, 17 Churchill Way, Cardiff, CF10 2TW  
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MREC website: <http://www.nres.npsa.nhs.uk>  
e-mail: [mrec@bce.wales.nhs.uk](mailto:mrec@bce.wales.nhs.uk)

16 May 2007

Professor David Hughes  
Professor  
School of Health Science  
Swansea University  
Floor 2, Vivian Tower  
Singleton Park,  
Swansea SA2 8PP

Dear Professor Hughes

**Full title of study:** Studying health care organisations - Contractual governance in a system with mixed modes of regulation  
**REC reference number:** 07/MRE09/29

The Research Ethics Committee reviewed the above application at the meeting held on 10 May 2007. Thank you for attending to discuss the study.

#### Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

#### Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

#### Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

#### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Application	signed Dr Hughes	27 March 2007
Investigator CV	1	01 March 2007
Protocol	NHS Service Delivery and Organisation R&D Programme Application Form : Full	

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## Appendix 6 Information sheet (observations)



PRIFYSGOL CYMRU ABERTAW  
UNIVERSITY OF WALES SWANSEA



NHS Service Delivery and Organisation R&D Programme

### Information about the research

#### **Studying Health Care Organisations, NHS SDO R&D Programme**

You are being invited to take part in a research study. Before you decide whether to participate it is important for you to understand why the research is being done and what it will involve. Probably you will have heard about the research already via the presentation made to your organisation, but please take time to read the following information carefully. Please contact the researcher if there is anything that is not clear or if you would like more information.

#### **1. What is the purpose of the study?**

This study will investigate recent changes in the way that NHS service commissioning is regulated. It will examine the behaviour of managers and staff involved in commissioning in England and Wales, and compare the approaches taken. Along with other research findings from the wider SDO programme, the results should give a better understanding of the most effective approach to NHS commissioning and how the process can be adapted to best serve the public interest.

#### **2. Why have I been chosen?**

We have selected five local health economies in England and Wales as case studies to provide detailed information on commissioning arrangements. The Chief Executives of the main organisations involved have agreed in principle to take part, and we have also presented information on the project to the regular attendees at the purchasers' contracting group meetings. We are now approaching individual members of staff to see whether they are willing to participate. You have been contacted because you attend contracting team meetings that we would like to observe.

#### **3. Do I have to take part?**

Participation in the study is voluntary. If you agree to take part you will be asked to sign a consent form. Even if you give your agreement, you are still

free to withdraw at any time. All we ask is that you discuss your concerns with us, to see if there may be a way to complete observations of those members of the contracting group who have consented to take part. If you do participate, you may ask the researchers to disregard certain events in meetings or not to use certain data you have provided, and this information will then not be included in the analysis.

#### **4. What will happen to me if I take part?**

The research team is interested in the NHS commissioning process and how it overlaps with other governance mechanisms such as performance management and clinical governance. The observational part of the study involves nothing more than looking at what normally happens in commissioning meetings, and will not involve any extra work for you. The research team will tape record the meetings (with your permission). This will help avoid mistakes and allow a better analysis of what goes on. Observations will last for about 18 months from May 2007. We may approach some of you after that date to request an informal interview, but participation in that too is voluntary.

#### **5. What about confidentiality?**

The research team is fully aware that matters discussed in contracting meetings may be commercial in confidence or sensitive in nature, and should under no circumstances be disclosed to other organisations or the press. We give an absolute assurance that this will not happen and, if required to do so, will sign a formal agreement with your organisation to that effect. Confidentiality will be ensured in the following ways. All information will be fully anonymised so that no-one can identify you or other people who attended meetings. The tape recordings of meetings and any notes we make will be transcribed (without real names) and kept in locked filing cabinets at the University. Only members of the research team will have access to this information. Audio recordings will be saved on a secure University computer and will be destroyed 5 years following the completion of the study. We will adhere to the Data Protection Act 1998 at all times.

#### **6. What do I have to do?**

This phase of the research involves you allowing the researcher to observe aspects of your work that relate to regular contracting meetings. You are not required to spend any time on additional activities relating to the research, although in the future we may make a separate request for you to help us with an informal interview. If that happens, we will provide an additional information sheet and ask you to sign an additional consent sheet.

#### **7. Are there any risks?**

There are no physical risks in taking part in this research. We also give our firm assurance that you and your organisation will not be put at risk by any disclosure of confidential information to third parties. You can withdraw from the study if at any time you feel uncomfortable with any aspect of it.

## **8. What will happen to the results of the research study?**

In 2009 the results of the study will form a report which will be presented to the NHS Service Delivery and Organisation R&D Programme. We will also organise a dissemination event for organisations that have taken part. The results (which will protect your identity completely) will also be published in journals and presented at conferences. The project report will be published on the SDO website as one of the studies under the theme of 'Studying Health Care Organisations': <http://www.sdo.lshtm.ac.uk/sdo1272006.html>

## **9. Who is organising and funding the research?**

The study is led by the School of Health Science, Swansea University, working in partnership with the Health Services Research Unit at the London School of Hygiene and Tropical Medicine, and the Centre for Health & Social Care and School of Law at Leeds University. The project advisory group contains representatives from a range of NHS organisations as well as patient groups. The study is funded by the NHS Service Delivery and Organisation R&D Programme.

### **Contact for Further Information**

Further information about this study is available from: (insert relevant team)

Requests for study results should also be forwarded to the above addresses.

Thank you once again for taking the time to read this information sheet.

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## Appendix 7 Information sheet (interviews)



### Information about the research

#### **Studying Health Care Organisations, NHS SDO R&D Programme**

You are being invited to take part in a research study. Before you decide whether to participate it is important for you to understand why the research is being done and what it will involve. Probably you will have heard about the research already via the presentation made to your organisation, or because of your involvement in an earlier stage of the project, but please take time to read the following information carefully. Please contact the researcher if there is anything that is not clear or if you would like more information.

#### **1. What is the purpose of the study?**

This study is investigating recent changes in the way that NHS service commissioning is regulated. It is examining the behaviour of managers and staff involved in commissioning in England and Wales, to compare the approaches taken. Along with other research findings from the wider Service Delivery Organisation (SDO) programme, the results should give a better understanding of the most effective approach to NHS commissioning and how the process can be adapted to best serve the public interest.

#### **2. Why have I been chosen?**

We have selected five local health economies in England and Wales as case studies to provide detailed information on commissioning arrangements. The Chief Executives of the main organisations involved have agreed in principle to take part, and we have begun observation of regular contracting meetings. We are now approaching individual members of staff to see if they are willing to complete an informal interview. You have been contacted either because you are a regular participant in contracting meetings or because you have other involvement in the contracting process. Not all participants in meetings have been approached for interviews, but we have tried to include the main organisations and disciplines represented.

#### **3. Do I have to take part?**

Participation in the study is voluntary. Even if you took part in the observations, you may not wish to complete an interview. If you agree to take part you will be asked to sign a consent form. Even if you give your agreement, you are still free to withdraw at any time. If you do participate, you may at a later stage ask the researchers to disregard certain things that



you said in the interview, and this information will then not be included in the analysis.

#### **4. What will happen to me if I take part?**

The research team is interested in the NHS commissioning process and how it overlaps with other governance mechanisms such as performance management and clinical governance. We have started observing regular contracting meetings, but also want to collect information on the perspectives of the participants and others affected by the commissioning process. The informal interview will take about one hour. You will be asked about the commissioning process and aspects of it that lie within your area of expertise. Sometimes the researchers may want to ask about recent events, and the relationships between particular purchasers and providers. If you agree, the interview will be tape recorded. This will help avoid mistakes and allow a better analysis of the data. These informal interviews will be completed over about 18 months from May 2007 as part of our case studies of purchasers and providers in England and Wales.

#### **5. What about confidentiality?**

The research team is fully aware that some aspects of the contracting process are commercial in confidence or sensitive in nature, and should under no circumstances be disclosed to other organisations. We give an absolute assurance that this will not happen and, if required to do so, will sign a formal agreement with your organisation to that effect. Confidentiality will be ensured in the following ways. All information will be fully anonymised so that no-one can identify you from any extracts from the interview that we may use in reports. The tape recordings of interviews will be transcribed (without real names) and kept in locked filing cabinets at the University. Only members of the University research team will have access to this information. Audio recordings will be saved on a secure University computer and will be destroyed 5 years following the completion of the study. We will adhere to the Data Protection Act 1998 at all times.

#### **6. What do I have to do?**

This part of the research involves an interview lasting about one hour. It will therefore take some of your time, but we will endeavour to arrange a time and place suitable for you, and can change this if you find that other pressing engagements come up at short notice. Most respondents opt to be interviewed in their own office or another suitable meeting room in their organisation, and we travel to their site. However, if it is easier for you, we can arrange an alternative venue. If you agree to the interview, we will telephone nearer the time to check that it can still go ahead as arranged.

#### **7. Are there any risks?**

There are no physical risks in taking part in this research. We also give our firm assurance that you and your organisation will not be put at risk by any disclosure of confidential information to third parties. You can withdraw from the study if at any time you feel uncomfortable with any aspect of it.

## **8. What will happen to the results of the research study?**

In 2009 the results of the study will form a report which will be presented to the NHS Service Delivery and Organisation R&D Programme. We will also organise a dissemination event for organisations that have taken part. The results (which will protect your identity completely) will also be published in journals and presented at conferences. The project report will be published on the SDO website as one of the studies under the theme of 'Studying Health Care Organisations': <http://www.sdo.lshtm.ac.uk/sdo1272006.html>

## **9. Who is organising and funding the research?**

The study is led by the School of Health Science, Swansea University, working in partnership with the Health Services Research Unit at the London School of Hygiene and Tropical Medicine, and the Centre for Health & Social Care and School of Law at Leeds University. The project advisory group contains representatives from a range of NHS organisations as well as patient groups. The study is funded by the NHS Service Delivery and Organisation R&D Programme.

### **Contact for Further Information**

Further information about this study is available from (insert relevant team)

Requests for study results should also be forwarded to the above addresses.

Thank you once again for taking the time to read this information sheet.

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## Appendix 8 Consent form (observations)



## CONSENT FORM

**Title of Project:** Contractual governance in a system with mixed modes of regulation

Name of Researchers: David Hughes, Shane Doheny

Please initial box

1. I confirm that I have read and understand the information sheet dated March 2007 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that meetings I attend which are being observed by the researchers will be audio-taped and transcribed. I give my permission for this to take place.

3. I give my permission for the researchers to use suitably anonymised verbatim quotations from my contributions to the meetings being observed as part of the study.

4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

5. I agree to take part in the above study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

When completed, 1 for participant; 1 for researcher

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## Appendix 9 Consent form (interviews)



## CONSENT FORM

**Title of Project:** Contractual governance in a system with mixed modes of regulation

Name of Researchers: David Hughes, Shane Doheny

Please initial box

1. I confirm that I have read and understand the information sheet dated March 2007 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that the interview that I participate in will be audio-taped and transcribed.

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

4. I give my permission for the researchers to use suitably anonymised verbatim quotations from the interview in which I am taking part.

5. I agree to take part in the above study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

When completed, 1 for participant; 1 for researcher

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## Appendix 10 Dissemination

Two background papers prepared for the project have been published:

1. Hughes, D. and Vincent-Jones, P. Schisms in the church: NHS systems and institutional divergence in England and Wales, *Journal of Health & Social Behavior* Vol 49, 4 : 400-416, 2008.

2. Hughes, D., Mullen, C. and Vincent-Jones, P. Choice versus voice? PPI policies and the re-positioning of the state in England and Wales. *Health Expectations* 12(3): 237–250, 2009.

Presentations based on earlier drafts of 1 above include:

May 6, 2007. Hughes, D. and Vincent-Jones, P. Schisms in the church: institutional divergence in the NHS systems of England and Wales. REFGOV, SGI, Health Stream Workshop, Loránd Eötvös University of Liberal Arts and Sciences, Budapest.

October 19, 2007. Vincent-Jones, P. Hughes, D. Allen P. et al. The English and Welsh case studies, REFGOV, SGI, Third Common Workshop, Institut International de Paris La Défense, Paris.

March 6, 2008. Hughes, D. Divergence in UK health policy: the contrasting cases of England and Wales, Open Lecture, Department of Healthcare Management, Hacettepe University, Ankara, Turkey.

April 15, 2008. Hughes, D. Policy Divergence in the British NHS: the Contrasting Cases of England and Wales. Lezione Magistrale (Master Class) at Germaneto campus (Law and Economics Building), Magna Graecia University, Catanzaro, Italy.

August 21, 2008. Hughes, D. Divergence in UK health policy: the contrasting cases of England and Wales, Open Seminar, College of Public Health Sciences, Chulalongkorn University, Bangkok, Thailand.

December 11, 2008. Hughes, D. Economics, geography or institutions? Using neo-institutional theory to understand recent UK health policy. Invited presentation at: One day symposium: Making connections between medical sociology & organizational studies to explore the management of change in healthcare systems, National College for School Leadership (NCSL), Nottingham.

April 1 2010. Recent UK health reforms and policy divergence in England and Wales. Faculty of Public Health, Naresuan University, Phitsanulok, Thailand.

Presentations based on 2 included:

March 19-20, 2009. Hughes, D. Choice or voice? PPI and the re-positioning of the state in England and Wales. University of Edinburgh, SDO Workshop (organiser, S. Peckham) with invited external speakers.

September 26 2009. Vincent-Jones, P. Hughes, D. Health Case Study Report, REFGOV, SGI, Fourth Common Workshop, University Foundation, Brussels.

Other presentations:

September 5, 2007. Hughes, D. Contractual governance in a system with mixed modes of governance, SDO networks and governance research workshop, Brunei Gallery, SOAS, London.

June 3, 2009. Hughes D. NHS Contracts in England and Wales: the dance of centralism and decentralisation, Delivering Better Health Services, SDO/NHS Confederation Annual Conference, Birmingham.

September 2 2010. Hughes D. Deliberating Tarceva: a case study of how NHS managers decide whether to purchase a high-cost drug in the shadow of NICE guidance. BSA Medical Sociology Group Annual Conference, Durham University.



**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](mailto:sdo@southampton.ac.uk).