Contracting for collaboration and efficiency

Published 24 February 2017

Collaboration means many different things to different people in the NHS. In our view, the importance of defining your collaboration goes to the heart of its success. Agreeing your aims, knowing what is expected of you and those that you are collaborating with to achieve those aims, is a pre-requisite to achieving your goals.

There are two main themes of collaboration that are being considered in the NHS at present - Shared Services "Carter" Collaborations and New Models of Care. It is vital that these collaborations are not considered in isolation, as they are often intrinsically linked.

1. Shared services "Carter" collaborations

The Carter Review: "*Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*" recommended that there are efficiencies to be gained by NHS organisations collaborating to provide back office services, procurement, estates and facilities management support, etc.

There are many different models available to NHS organisations looking at such collaborations, each of which have advantages and disadvantages.

#	Points to consider: Carter Collaboration
1	Who is in the collaboration and what is the scope and objective?
2	What are each of the members of the collaboration contributing (in terms of resources)?
3	What legal form is most appropriate to meet our objectives (e.g. contractual joint venture, or corporate joint venture)? What are the procurement and competition law implications of the legal form?
4	What restrictions are there on members with regard to membership of corporate joint ventures / which member will be the legal host under a contractual joint venture (as relevant)?
5	How will decisions be made amongst the members, and what oversight will constituent organisations have of the work of the collaboration?
6	How can members exit and new members join the arrangements?
7	What will the workforce model be, and how does this change from the current arrangements?
8	What are the tax implications of the arrangement?
9	How will savings and losses be shared amongst the members?
10	Will this be considered a "novel contract" and therefore subject to the Integrated Support and Assurance Process? If so, how will this impact upon the timetable, and what needs to be demonstrated?

2. New Models of Care collaborations

Increasingly, providers of NHS funded services are considering how to collaborate in order to create Accountable Care Organisations (ACOs). *The NHS Five Year Forward View* sets out different models for collaboration (including multi-speciality community providers and primary and acute care systems).

Notwithstanding the differing terminology, the most obvious similarity is that the collaborations will lead to a more integrated provision of services based on the patient's needs. It will also involve (in its purest form) a transference of the risk of overrun of activity from the commissioners to the providers, and it is therefore important that providers consider how they can share risk under an ACO model.

#	Points to consider: New Models of Care

1	Does the scope of services for the new model require commissioners to collaborate (e.g. are primary care and social care included)?
2	Is the opportunity subject to a formal competition? Have the commissioners considered their obligations under the Public Contract Regulations 2015 and the NHS Choice Regulations 2013?
3	What legal form is most appropriate for collaborating providers to utilise (e.g. contractual joint venture, or corporate joint venture)? What are the tax implications of the different forms? Are there any issues relating to the powers of NHS organisations in being a member of such joint ventures that need consideration?
4	Will the commissioner share certain risks with the providers (e.g. where there are events that affect the population and that are outside of the control of the providers)? What are the outcomes that the providers must achieve and how will this be incentivised over the contract term?
5	How will decisions be made amongst the members, and what oversight will constituent organisations have of the work of the collaboration? What data will be shared and what arrangements are in place to ensure the legal sharing of the same across organisational boundaries?
6	If primary care is included, are GPs willing to give up primary care contracts to adopt a population based model? If not, how will primary care interface with the ACO?
7	What will the workforce model be, and how does this change from the current arrangements?
8	Will CQC registration be required / any amendments be required to existing CQC registrations? What indemnity arrangements are in place?
9	How will savings and losses be shared amongst the members, or will they be used for pre-determined projects?
10	Where new models of care are being implemented, the contracts involved are likely to be considered “novel contracts” and therefore subject to the Integrated Support and Assurance Process. Consider how this will impact upon the timetable, and what needs to be demonstrated as a result.

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