

ALLIANCE CONTRACTING

Building New Collaborations
to Deliver Better Healthcare

February 2015

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The NHS needs to work more closely with the third sector. This is not just about more care in the community; it is about making sure people get quality care however complex their situation. Only by integrating services and coordinating them around the needs of service users will we be able to achieve a person-centred health and care system.

But everywhere we look there are barriers; between primary and secondary care; between physical and mental health; between health and social care. We need to break down these barriers to deliver improved outcomes.

The third sector can often provide expertise in innovative and collaborative approaches, as individual specialist organisations or as consortia - groups of third sector organisations with a shared interest in competing for and delivering services.

The NHS Five Year Forward View commits the health and care system to prevention and better local partnerships with the third sector. We need to give commissioners the tools they need to work with voluntary organisations and social enterprises, so that they can achieve the quality outcomes for the populations they serve.

Alliance contracting is one of those tools. Providers who deliver services within an alliance share the risk and reward associated with all elements of a contract. This could provide a meaningful new way of providing health and care services, as it guarantees the joined up working that will bring about joined up care.

ACEVO has dedicated this report to alliance contracting because, like the development of consortia, it can deliver many advantages for the third sector. For example, smaller charities that do not have the capacity to deliver a contract single-handedly can join a wider alliance as an equal partner.

Alliance contracting can work because it reflects the fact that whole person care is complex. If we are to provide for the diverse needs of people, and, in particular, reduce demand on acute emergency treatment, we need complex groups of people to deliver services together. Alliance contracting is not just another commercial vehicle; it is a genuine mechanism for delivering the change in service delivery that the NHS needs.



Stephen Bubb

Sir Stephen Bubb, Chief Executive of ACEVO

THIS REPORT

The purpose of this report is to define and explore alliance contracting. It will consider practical examples of its implementation and a study of what is driving its growth. In particular, it explores the role of alliance contracting in facilitating third sector organisations in the delivery of public services.

The report has been produced by Association of Chief Executives of Voluntary Organisations (ACEVO). As the Charity Leaders Network, ACEVO is the leading voice of the UK's charity and social enterprise sector. It provides support and representation for members, ranging from leaders of small community based organisations to those of the nation's best known charity brands. ACEVO supports leaders of voluntary sector organisations through activities that connect, develop, support and represent them. ACEVO's mission is to develop a modern, enterprising voluntary and social enterprise sector and a key aspect of this is ACEVO's championing of the role that the VCS can play in public service delivery.

This report has been written by members of ACEVO's Policy Team (Kate Brittain, Asheem Singh, Mark Winter) with background research carried out by Neil Coulson, who has been working as an independent consultant on partnering and collaboration within the voluntary and community sector for the past 15 years.

This report was designed by Nanako Aramaki.

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Disclaimer

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The health and social care system is facing serious challenges. Budget cuts, rising life expectancy and the increased prevalence of long-term and age-related conditions have exposed weaknesses and placed it under serious strain.

In tackling these challenges, ACEVO has been a leading proponent of 'prevention' and patient care in the community. But the barriers between different elements of the NHS, be it primary and secondary care, or physical and mental health, prevent the system from improving care. Breaking down these barriers, and building better health outcomes could deliver us the holy grail of a community and person-centred health and care system.

The NHS' Five Year Forward View attempts to provide the answers; it set out a strong agenda for integrating services and making out-of-hospital care a much larger part of what the NHS delivers.

The third sector is a pioneer in collaborative working. The number of third sector consortia has increased rapidly in the last two decades. It is time the health and social care system fully acknowledges this potential, introduces effective commissioning tools and allows the sector to realise its full potential within health and care.

Alliance contracting may be a large part of the answer. It is, in short, a contractual arrangement that relies on all parties having an equal decision-making role in the delivery of services. It is a mechanism for delivering joined up care.

Alliance contracting can enable the NHS to work better with the third sector and get better at providing care in the community. Its pathway of action is 'horizontal,' which is different to the 'vertical' contracting structures that are characteristic of a prime contractor sub-contracting out to smaller bodies.

But alliance contracting requires proactive commissioning and a more thoughtful approach to procurement. So that commissioners and providers may have the knowledge and resource they need to effectively deploy alliance contracting, it is clear that collaborative commissioning techniques should be explicitly supported by the next government. Alongside national guidelines, however, third sector bodies need to be proactive in encouraging the sector to recognise the benefits of alliancing, and how to be a truly valuable part of integrated care in the NHS.

RECOMMENDATIONS

Policy Framework

1. A Collaborative Commissioning Unit should be established in the Cabinet Office's Government Innovation Group, to examine how collaboration and consortia building can transform public services. For example, it should stipulate how alliance contracting can be used in such a way that it develops existing engagement with collaborative working amongst third sector consortia. This could be a series of workshops run for key consortia and commissioners in the UK, delivered in association with third sector infrastructure bodies working alongside system partners.
2. The new EU public procurement regime allows for award criteria which balance best price with quality including social, environmental and innovative characteristics. It is clear that these criteria are very relevant for alliance contracting and this should be recognised when aligning the New Regulations with health and care services.
3. NHS England and Monitor must try to ensure that other health sector-specific legislation supports sustainable alliance contracting.
4. NHS England should consider how alliance contracting can be embedded into initiatives targeted at better integration of health and social care, such as taking on a specific role in the Integration Pioneer programme.

Alliance Contracting on the Ground

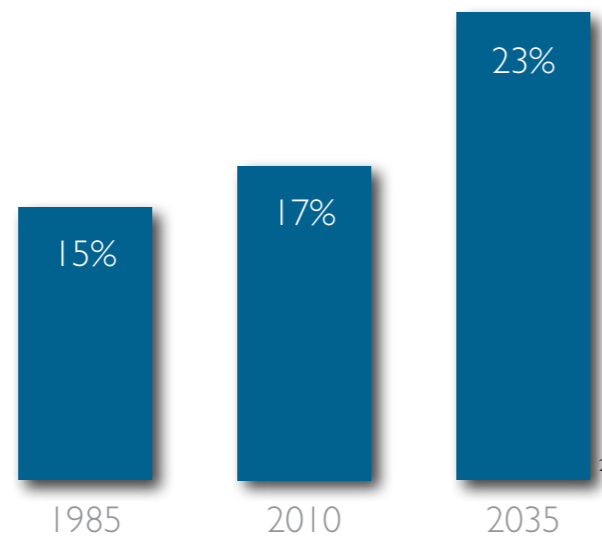
5. The Commissioning Academy should develop a special stream in partnership with LGA, NHS England and DCLG to ensure that commissioners can be appropriately trained in alliance contracting in the health and care system.
6. Targeted work should be undertaken with local commissioners to disseminate the potential of alliance contracting and to influence its adoption.
7. Support materials for good practice in alliance contracting should be made available on key websites such as Commissioning Assembly and Funding Central.

This could be made accessible via the ACEVO website and would contain the latest case studies, alongside good practice tools and techniques. To aid this, a link could be forged with LH Alliances, who have already started to develop web-based resources of this nature.

8. Existing third sector funding programmes, such as the Lottery Fulfilling Lives programme, should be made available to alliance contracting initiatives.

The health and social care system is facing serious challenges. Budget cuts, rising life expectancy and the increased prevalence of long-term and age-related conditions have exposed its weaknesses and placed it under serious strain. There has been a 37% increase in emergency admissions over the last decade. 65% of people admitted to hospital are over 65 years old.¹

Percentage of population aged over 65



In tackling these challenges, ACEVO has been a leading proponent of 'prevention' and patient care in the community. *The Prevention Revolution: Transforming Health and Social Care* is the 2013 report of the ACEVO Taskforce on Prevention in Health. It argues that addressing the wider determinants of ill-health and providing support in community settings will enable the NHS to overcome many of the challenges it faces, such as demand on acute treatments and the increasing prevalence of long term conditions.

Prevention: The Community Context

'The health service is largely structured to suit the treatment of episodic disease and injury rather than provide long-term, often complex, care in partnership with other agencies. We are not yet providing enough care outside hospitals, closer to home; care is too often not joined up, personalised or planned in the context of people's lives and circumstances; we are not doing enough to ensure the NHS plays its role alongside its partners in prevention, health promotion and early intervention to achieve long-term improvements in community health and wellbeing.'

The 2015 Challenge Declaration, NHS Confederation, 2014

¹ Royal College of Physicians (2012), *Hospitals on the edge: A time for action*, pp. 2 Available at: <https://www.rcplondon.ac.uk/sites/default/files/documents/hospitals-on-the-edge-report.pdf> [Accessed 25/11/14]

² Office for National Statistics (2012), *Population Ageing in the United Kingdom, its Constituent Countries and the European Union*, pp. 3

There is political consensus about the benefits of a preventative and integrated health and care system. But the barriers between different elements of the NHS, be it primary and secondary care, or physical and mental health, prevent the system from improving care and patient satisfaction. Breaking down these barriers, and building better health outcomes could deliver us the holy grail of a community and person-centred health and care system.

Politicians understand the issues, but do not necessarily have the answers. In his 2014 party conference speech Health Secretary Jeremy Hunt said:

"For me the point of the NHS is to make sure everyone gets truly personal care from people who know about them...As a first step that needs the integration of the health and social care systems."³

Andy Burnham MP, Shadow Health Secretary:

"...A vision for a 21st century NHS there when you need it, personal to you and your family, with time to care. A national health and care service based on people before profits."⁴

The NHS' *Five Year Forward View* attempts to provide the answers; it sets out a strong agenda for integrating services and making out-of-hospital care a much larger part of what the NHS delivers. Crucially, it emphasises the role of the third sector in delivering joined up, community-based care and acknowledges that 'voluntary organisations often have an impact well beyond what statutory services alone can achieve.'⁵

CONSORTIUM WORKING IN THE VOLUNTARY SECTOR

'The third sector is not just an alternative, competitive provider – it has strengths that often complement the work of the NHS. The third sector brings its particular expertise in community engagement, responding to the needs of service-users and using volunteers and peers to deliver services.'⁶

The third sector is a pioneer in collaborative working. For example, working as part of a consortium is established practice for many voluntary organisations.⁷ These are groups of organisations that come together with a particular strategic purpose in mind, such as advancing their missions or generating income. Some are relatively informal arrangements; whereas others may be more formalised and have their own legal identity.

Reasons for forming a consortium are varied, but are often motivated by organisations looking to bid for and deliver larger contracts, combine existing contracts, and form partnerships in expectation of new opportunities to deliver public service contracts.

There is abundant good practice within the third sector. It is time the health and social care system

³ The Rt. Hon Jeremy Hunt MP (2014) Speech to Conservative Party Conference Available at: <http://press.conservatives.com/post/98811391555/jeremy-hunt-speech-to-conservative-party> [Accessed 24/02/15]

⁴ The Rt. Hon Andy Burnham MP (2014) Speech to Labour Party Conference Available at: <http://press.labour.org.uk/post/98299443959/speech-by-andy-burnham-mp-to-labours-annual> [Accessed 24/02/15]

⁵ NHS (2014), *Five Year Forward View* Available at: <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [Accessed on 24/11/14]

⁶ NHS (2014), *Five Year Forward View* Available at: <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [Accessed on 24/11/14]

⁷ Gillespie, J., Knowles, L. (2014) *Real Local Change ACEVO and LGA*. Available at: <https://www.acevo.org.uk/sites/default/files/documents/ACEVO%20and%20LGA%20-%20Real%20Local%20Change.pdf> [Accessed 25/02/15]

fully acknowledges this potential, introduces effective commissioning tools and allows the sector to realise its full potential within health and care.

ALLIANCE CONTRACTING

Alliance contracting may be a large part of the answer; a synthesis of the political vision and on the ground action. Alliance contracting is, in short, a contractual arrangement that relies on all parties having an equal decision-making role in the delivery of services.

The simple premise is that an alliance of providers can deliver the many services a person with a long term condition needs. These services range from primary care to community support and the members of the alliance are able to work together more effectively by sharing information and so preventing the duplication of services. Alliance contracting is a mechanism for delivering joined up care.

Alliance contracting can enable the NHS to work better with the third sector and get better at providing care in the community while still only having a single contract. Its pathway of action is 'horizontal,' which is different to the 'vertical' contracting structures that are characteristic of a prime contractor sub-contracting out to smaller bodies. This means that a more equitable relationship between providers is enabled and decisions are taken with the whole person in mind.

The creation of Foundation Trusts and Independent Sector Treatment Centres, the growing emphasis on patient choice and the placing of tenders for some community services are all examples from the evolving environment in which commissioners must act. Of a £106 billion budget in 2011/12, the NHS' expenditure on non-NHS providers delivering NHS-funded care in England rose from £5.6 billion (11/12 prices) in 2006 to £8.7 billion.⁸

There is a significant potential for this market to grow. Much will depend on how Clinical Commissioning Groups (CCGs) choose to behave and how Monitor – the economic regulator – interprets its complex remit⁹. This involves tackling anti-competitive behaviour whilst promoting the integration of services, all of which is better for patients.

We believe we have no choice but to embrace innovation in the way we commission services, given the changing needs of society. For example, those with more than one long-term condition have the greatest needs, and the number of people with three or more long-term conditions has been predicted to rise from 1.9 million in 2008 to 2.9 million in 2018¹⁰. Patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year¹¹.

The finances may compel politicians to act but it is our view that from the perspective of social justice and better care, the alliance model is one of the most compelling approaches yet seen.

⁸ Nuffield Trust (2013) Public Payment and Private Provision: The Changing Landscape of Health Care in the 2000s Available at: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130522_public-payment-and-private-provision.pdf [Accessed 25/11/14]

⁹ Institute for Government (2012), Choice and competition in public services: learning from history Available at: http://www.instituteforgovernment.org.uk/sites/default/files/publications/Choice%20and%20competition%20in%20public%20services_0.pdf [Accessed on 25/11/14]

¹⁰ Department for Health (2012) Long Term Conditions: Compendium of Information Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf [Accessed 25/11/14]

¹¹ NHS England (2013), The NHS Belongs to the People: A Call to Action Available at: http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf [Accessed 25/11/14]

THE CONCEPT: DEFINING AN ALLIANCE CONTRACT

Alliance contracting is increasingly being spoken about within the NHS. This is because there is growing acceptance that existing NHS contracts are not going to deliver the level of cross-sector integration it desperately needs to deliver better patient care. An alliance contract offers a very different model to what has come before.

An alliance contract is a contractual arrangement between the commissioner(s) and an alliance of parties who deliver a service. They share risk, collectively own opportunities and are all responsible for the delivery of a contract. Unlike a contract coordinated by a prime contractor, there are no sub-contractual arrangements. All organisations within the alliance are equal partners and organise their own internal governance to manage the delivery of care.

There are different ways of creating an alliance contract. It would typically tie commissioners and providers together to share the risk and reward of a particular project but an alliance of providers may come together without involving commissioners directly. This would be a looser consortium model, and may involve one organisation taking on the role of 'lead' provider when contracting with commissioners, but as long as risk and reward are shared equally by all providers 'alliances' present an opportunity to pursue radically different packages of care.

Traditional Contracting	Alliance Contracting
<ul style="list-style-type: none"> • Commissioner is separate from delivery process • Based on risk transference • Exculpatory approach within risk management framework • Responsibility for outcome delivery is apportioned across separate providers • Encourages decision making founded on 'best for self' • Closed book accounting 	<ul style="list-style-type: none"> • Commissioner closely linked to the delivery team • Based on risk sharing • 'No blame' culture • Everyone works towards whole system outcomes • Encourages decision making founded on 'best for project' • Open book accounting

Alliance contracting is new to the NHS, and relatively new to public services overall. It has its origins in the heavy engineering and oil industries of the 1990's. It was introduced by British Petroleum (BP) in North Sea oil platforms as a response to a range of problems with traditionally contracted service delivery, such as escalating costs, completion delays and litigation. Initial efforts to engineer a cheaper project by deploying new technology did not produce sufficient cost savings so BP deployed a new approach to contracting – alliancing – and selected a notoriously problematic oil reserve, Andrew Field, to showcase it:

'An even more radical formula was called for; a complete departure from the usual style of oil contracting, one which required a step change in behaviour. The adversarial relationships between oil companies, contractors and suppliers had to be confined to the history books... To this end, behaviour was identified as the essential partner for technology; the twin building blocks which if brought together could be capable of producing extraordinary results.'¹²

Modern public services face similar challenges. Services are more complex, demand is high, and the expectation to achieve savings is increasing. Authorities in Australia have expanded alliance contracting as a key method for procurement. National, state and territorial governments have deployed alliance contracts to deliver a range of infrastructure projects. A 2009 study stated that:

¹² Knott, T. (1996) No Business as Usual, British Petroleum Co.

'The total value of alliance projects in the road, rail and water sectors in New South Wales, Victoria, Queensland and Western Australia, over the period 2004 to 2009 was \$32 billion.'¹³

In July 2011 the Australian Government's Department of Infrastructure and Transport established national principles for Alliance Contracting to consolidate positive outcomes and ensure its use is applied appropriately across public services. These mandate public officials to ensure that public accountability, value for money and effective market engagement underpins all Alliance Contracting processes.¹⁴

Alliance contracting has been a central part of health partnerships developed in New Zealand. In trying to reduce the high levels of fragmentation in the health system, New Zealand's Government has increasingly moved towards:

'New models of care which see the patient rather than the institution as the centre of service delivery and which aim to promote a more seamless patient journey across community, primary and hospital sectors, greater use of primary and community care, and the shifting of care closer to home.'¹⁵

In 2009 the Government invited expressions of interest to deliver new models of care. Nine 'Alliances,' covering over 60% of the country, were selected to implement new models of service delivery. Strategies for improving the coordination of care have included the devolution of funding and services to the community, increased coordination of services between primary care providers and hospitals and the development of 'clusters' of providers to deliver integrated services.

The Alliances were mandated to establish a single governance group and integrated operational management structure and to use alliance contracting to advance their proposals.¹⁶

Canterbury District Health Board (DHB) in New Zealand is a part of the South Island Health Alliance. Its Community Rehabilitation Enablement and Support Service (CREST) is a community-based support team to facilitate the earlier discharge from hospital of elderly people to home-based rehabilitation services. Launched in 2011, it has since been extended to accept referrals directly from general practice, allowing people to be rehabilitated in their own homes by avoiding hospital admission altogether. The support extends to assisting patients in being able to shop again, reconnect with friends and rebuild social networks.

13 Department of Treasury and Finance (2009) In Pursuit of Additional Value: a benchmarking study into alliancing in the Australian Public Sector Available at: <file:///C:/Users/brittainK/Downloads/In-Pursuit-Additional-Value.pdf> [Accessed 24/02/15]

14 Australian Government Department of Infrastructure and Transport (2011) National Alliance Contracting Policy Principles Available at: http://www.infrastructure.gov.au/infrastructure/nacg/files/National_Alliance_Contracting_WEB.pdf [Accessed 25/11/14]

15 Ministerial Review Group (2009) Meeting the challenge: enhancing sustainability and the patient and consumer experience within the current legislative framework for health and disability services in New Zealand: report of the ministerial review group Available at: <http://www.beehive.govt.nz/sites/all/files/MRG%20Report%20Meeting%20the%20Challenge.pdf> [Accessed on 26/11/14]

16 Cumming J, (2011) Integrated Care in New Zealand, International Journal of Integrated Care Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3226018/> [Accessed 25/11/14]

CREST uses a funding model based on an alliance agreement between care providers and the funder. Contractors agree margins and funds in partnership, and their performance is visible to other partners in the alliance. Profits re-enter the system to improve profits according to an agreement made by all providers.¹⁷

As the King's Fund has recently stated, the intention of the alliance contracting approach is that:

'integration and collaboration are formalised through the contract, as commissioners and providers within the alliance are legally bound together to deliver the specific contracted service.'¹⁸

These precedents demonstrate that alliance contracting can be a useful mechanism for integrating work in unpredictable and challenging environments. The NHS is one such environment. Integrated care is needed if the NHS is to move away from an over reliance on acute treatment and genuinely provide a range of services in primary and community care, including prevention and self-care. National Voices has stated that:

'achieving integrated care would be the biggest contribution the health and care services could make to improving quality and safety.'¹⁹

Integrated care is best understood as a strategy for improving patient care.²⁰ Finding the best ways of bringing it about is a pressing policy concern. As a mechanism for bringing about integration, alliance contracting could be a large part of how the NHS puts integrated care into action and achieves better quality care for its service users.

17 Timmins, N and Ham, C. (2013) The Quest for Integrated Health and Social Care: A Case Study in Canterbury, New Zealand Kings Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf [Accessed 25/02/15]

18 Addicott, R. (2014) Commissioning and contracting for integrated care Kings Fund. Available at: <http://www.kingsfund.org.uk/sites/files/kf/kings-fund-commissioning-contracting-integrated-care-nov14.pdf> [Accessed 24/02/15]

19 National Voices (2011) Principles for Integrated Care Available at: http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/principles_for_integrated_care_final_20111021.pdf [Accessed 24/02/15]

20 Shaw, S, Rosen, R, Rumbold, B. (2011) An overview of integrated care in the NHS: What is integrated care? Nuffield Trust. Available at: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/what_is_integrated_care_research_report_june11_0.pdf [Accessed 24/02/15]

5 STEPS TO DELIVERING AN ALLIANCE CONTRACT

Alliance contracting is not only a relatively new concept in public services; its specific purpose is to enable complex and diverse delivery. This does present challenges in setting up an alliance contract, but as this chapter outlines, once alliance contracting has been identified as the preferable commissioning model, providers and commissioners need simply to work flexibly to agree terms and outline service delivery.

Step 1: Identify the Right Situation

Given its history, it is clear that alliance contracting will be most suitable to scenarios that are dynamic and possibly unpredictable:

- Numerous complex and/or unpredictable risks
- Complex interfaces
- Difficult stakeholder issues
- Complex external threats
- Very tight timeframes
- High likelihood of scope changes (such as technological changes or political influence)
- A need for owner (commissioner) interference or significant value-adding during delivery
- Threats and/or opportunities that can only be managed collectively²¹

Step 2: Meet Key Success Factors

Just as there will be contracts particularly appropriate to alliancing contracting, it is important that the providers are able to come together in a way that promotes partnerships.

Trust between Partners	Small number of Partners
Alliance contracting would be especially apt if delivery partners already had a track record of working together. A pre-existing foundation of mutual trust will exist, on which to build strong co-operative principles.	Alliance contracting is based on relationship management; the larger the team the more difficult this becomes.
Equality between Partners	Agreement between Partners
The presence of a large, dominant provider negates the principles of alliance contracting. Where there are partners of varying sizes and scope, it is critical that they all have a voice in delivering the contract.	Alliances based on clearly documented principles to which all members are completely agreed, and have had equal responsibility for shaping.

Step 3: Announce the Alliance Contract

Pre-procurement, commissioners should explore whether alliance contracting would be suitable to particular projects, by assessing the complexity of a project that may cut across multiple sectors, and determining a risk-reward ratio that does not deter potential new providers. If alliance

21 Ross J(2003), Introduction to Project Alliancing, pp 2 Available at: https://iccpm.com/sites/default/files/kcfinder/files/Alliancing_30Apr03_D_PCI.pdf [Accessed 26/11/14]

contracting is selected the resultant business case should include an appraisal of all other options and offer a clear explanation of the reasons to contract an alliance.

A key element of the selection criteria when procuring an alliance must be a demonstrable commitment on the part of providers to collaborate, as indicated by step 2. In order to compete for a contract, providers within an alliance will need to collaborate, and selection criteria will look for a commitment to this.

Step 4: Negotiate Key Terms

There are some key areas of negotiation that all providers will need to discuss in order to ensure that the alliance is fair and integrated.²²

Specification of services: All participants must take joint responsibility for overall service delivery.

Warranties and Indemnities: The system of risk and reward must be clearly articulated and agreed upon to ensure all providers are aware of the financial risks associated with poor performance.

Insurance and Liability: As responsibility for outcome delivery is shared, risk is also shared. There can be no resorting to traditional indemnities and protections between contracting parties.

Compensation and Payment Structure: The split of any financial risk and reward for under and over performance must be agreed upon before the contract commences. As well as agreeing target costs, each provider must know what share of the overall delivery they are expected to undertake and, therefore, what proportion of the overall funding they are on target to receive.

Variation: Variance in service delivery for activity and outcomes and the process for agreeing future variations to the contract need to be clearly established in advance, particularly in order to ensure compliance with relevant procurement legislation.

Step 5: Articulate Shared Risk and Reward

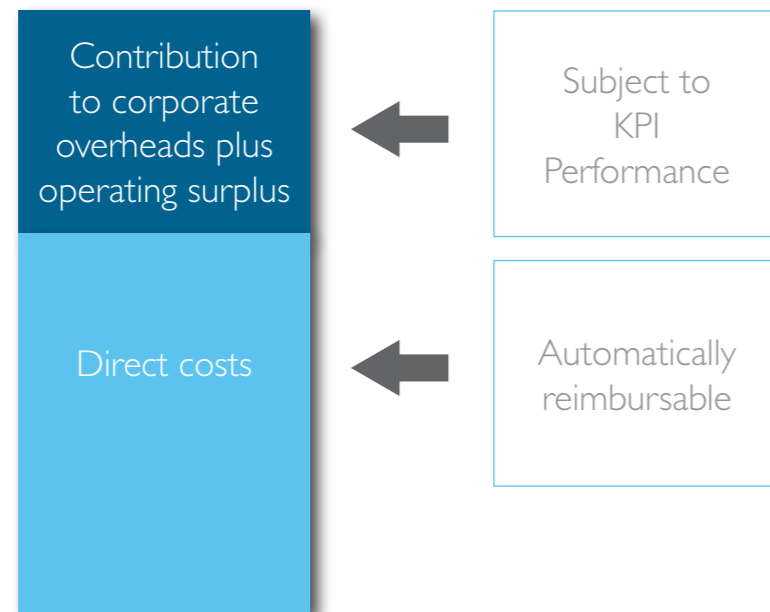
The shared ownership of risk and reward is the key feature of an alliance contract. It follows a 'gain-share, pain-share' model. The whole project team, including the commissioner, will set a target cost. Throughout the contract term, actual cost is compared to target cost and the cost under or over-runs are then shared by all participants. The team gains or loses as a group depending on project performance.

The comparison of target to actual cost is done through 'open book accounting.' Each provider should be prepared to show actual records of expenditure to other participants in the contract. The only exception to this approach would be where Competition Law applied, discussed elsewhere in this report.

As part of the initial target cost setting exercise, an Alliance Contract would include a pre-agreed definition of direct costs and contribution to corporate overheads. The commissioner would reimburse a proportion of costs that are directly incurred in delivering the project. Indirect costs, such as overheads, are subject to project performance – see figure 1.

22 McGough R., Dunbar Rees R. (2013) Team effort: Commissioning through alliance contracts. Health Service Journal Available at: <http://www.hsj.co.uk/home/commissioning/team-effort-commissioning-through-alliance-contracts/5065272.article#.VOygZ3ysVUs> [Accessed 24/02/15]

Figure 1: Alliance Contracting Target Cost Model



Factors such as quality, safety, service user experiences and agreed service outcomes are considered non-direct cost based on Key Performance Areas (KPIs). KPIs are weighted at the outset of a project and measured via pre-agreed Key Performance Indicators (KPIs). Successful achievement of KPIs ensures providers are reimbursed for their non-direct costs, including profit margin.

A risk and reward model should both reflect fair remuneration and encourage behaviours outlined by the commissioner. This commercial framework underpins the collaborative working of an alliance and must be openly negotiated and agreed upon by all parties.

Gain-share

If providers within an alliance contract under-run on their target cost and perform well on other non-cost based KPIs, they can increase their share of the financial gains beyond these reimbursements; they keep a portion of the under-run.

Pain-share

If the provider does not perform as well on non-cost based KPIs, they do not achieve any margin and cannot recover their overheads. Similarly, if they overrun on target costs but perform well on KPIs, it is likely that their margin would be eroded or eliminated by having to pay for the excess spend.

Truly integrated working is not without its challenges. It requires a business culture and collaborative skills that the NHS does not necessarily associate with the third sector. But alliance contracting provides an opportunity for the third sector to work with public bodies precisely because it has longstanding expertise in pioneering new ways of caring for people in their communities, including partnerships.

THE OPPORTUNITY: ALLIANCE-BUILDING BETWEEN THE THIRD SECTOR AND NHS

Third sector organisations are experts in preventative care and community support. They have a proven track record of empowering individuals to self-manage long-term conditions. Alliance contracting is new to the sector but there is a natural affinity between it and the sector's inclination to innovation.

As such, there is growing awareness of its benefits. For example, collaborative working was a key theme of NESTA's People Powered Health Programme. In 2011 Stockport was chosen as one of 6 UK localities to participate in the programme. Its goal was to transform mental health care commissioning in the region by forging collaborative commissioning vehicles – alliances of providers. This required Stockport Metropolitan Borough Council to demonstrate a flexible approach to improving outcomes for service users.

Within this programme, an alliance contract was developed between SPARC, a small community-based mental health provider and Stockport Mind. The service aims to support people on their own individual road to recovery after mental health illness.

COMMUNITY PRECEDENT: THIRD SECTOR CONSORTIA

Specific examples aside, there is much that the third sector does that reflects the spirit of collaboration. Consortium-based working has many affinities with working as an alliance, and it is now an established practice within the third sector. A predominant consortium model is that of the 'super provider,' whereby multiple frontline providers in the sector come together. There is no merger, but a new company structure is created in which each provider is a member.

Consortium development partners spend time defining and agreeing 'core operating values.' These are used to articulate 'the offer' to prospective members and eligibility criteria. Core operating values will typically include a commitment to:

Objectivity and impartiality

- Consortium members striving at all times to be open, honest and transparent in their involvement in consortium affairs
- Representatives of the consortium being required to work with integrity for the good of the whole consortium

Equality of membership

- All member organisations are expressly equal in status and there is an explicit commitment to avoiding any domination of the consortium by particular organisations or individuals

Inherent dynamism and responsiveness

- The partners are constantly open to welcoming new consortium members rather than operating as a closed circle of collaborators. This commitment to 'ensuring contestability' is designed to promote and safeguard vitality and dynamism within the provider network

Case Study: Sheffield Cubed

Sheffield Cubed is a formal consortium set up with a new legal entity to provide governance for the consortium members.

As a third sector membership organisation it seeks out bidding opportunities for contracts and funding to enable its members to meet the needs of local people.

Its collaborative approach enables single larger contracts to be secured centrally and delivered through member organisations. This achieves economies of scale while maintaining local third sector delivery and accountability to the communities they serve.

Sheffield Cubed has over 90 member organisations delivering a range of projects including a three year contract to establish a network of Health Champions.

The third sector is extremely well placed to develop this good practice into forming, or being part of, alliances. For example, individual organisations could become part of an alliance of others, or a voluntary sector consortium could join a large scale alliance alongside an NHS Foundation Trust. However, mainstreaming the alliance model relies just as much on commissioners as it does on providers. This requires the health and social care system to undergo a significant cultural change.

OUTCOMES BASED COMMISSIONING

The rise of outcomes based commissioning demonstrates that the NHS is acknowledging the changes needed to improve patient care. In 2010 the White Paper, *Liberating the NHS*, outlined the Coalition Government's intention to shift the NHS from a focus on processes to a focus on health outcomes:

'Success will be measured, not through bureaucratic process targets, but against results that really matter to patients – such as improving cancer and stroke survival rates.'²³

The NHS Outcomes Framework for 2014/15 demonstrates the continuing commitment of Government and NHS England to refining high-level national outcomes, such as 'enhancing quality of life for people with long-term conditions,' and to ensure that commissioning across the system is geared towards measuring success by patient-centred outcomes.²⁴

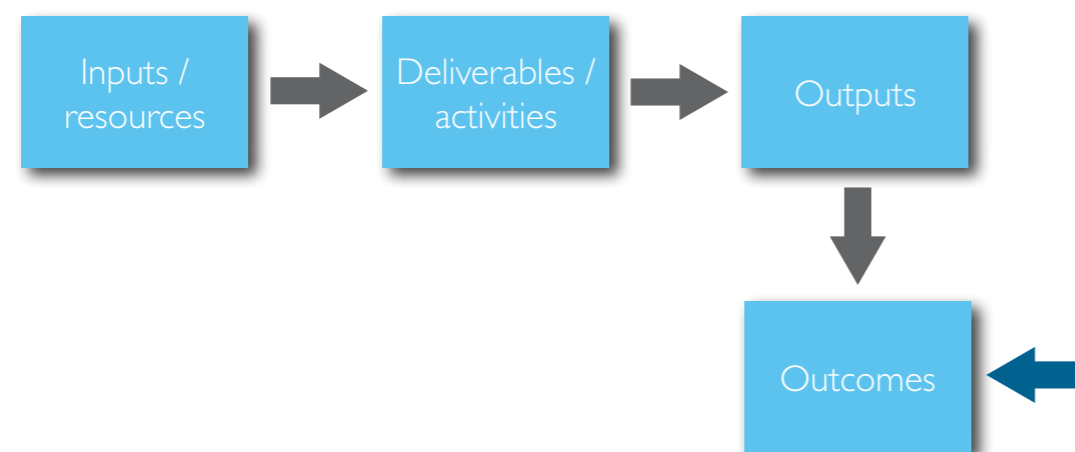
Outcomes based commissioning measures the success of service delivery by strategically set outcomes, rather than inputs and outputs during the process. For example, rather than assessing the number of clients signed to a drug treatment clinic (input), or how many hours of service

²³ Department of Health (2010) *Equity and Excellence: Liberating the NHS* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf [Accessed 26/11/14]

²⁴ Department of Health (2013) *The NHS Outcomes Framework 2014/15* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf [Accessed 26/11/14]

those patients receive (output), outcomes based commissioning looks to how many have stopped, or reduced, their drug use after a designated time. The focus is shifted from how a service operates to the benefits that the service achieves.

Figure 2: Shift to Commissioning Outcomes



CCGs across the country are adopting outcomes based commissioning. For example, in March 2012 Oxfordshire Clinical Commissioning Group (OCCG) introduced it into a number of service areas, one of which is the 'frail elderly'.

One of the rationales is that an outcomes-based commissioning contract provides a mechanism for integrating services and incentivising providers to make transformational changes.

Crucially, OCCG has recognised that alliancing enables waste, duplication, delay, misunderstanding, poor communication and other inefficiencies to be removed from services through a whole system integrated approach.²⁵

In Oxfordshire, 3 high level outcomes have been agreed:

1. That frail, elderly and vulnerable older people are enabled to be as healthy, active and independent as possible in their own home, with the support needed to do this.
2. In a care crisis or health emergency the person is supported as effectively as possible, and that there is efficient transfer of care between agencies with any necessary health and social care support to them and their carer.
3. That the treatment and care provided is right for the person's needs in the right setting and respects the person's individuality and dignity.²⁶

This shift towards better outcomes has provoked some NHS organisations to explore alliance contracting. If better care, or better outcomes, can be achieved through integration, then alliance contracting provides a mechanism for aligning with these new measures.

²⁵ Oxford Clinical Commissioning Group (2013), Outcomes Based Contracting Summary Report: Older People in Oxfordshire Available at: http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2013/11/13.59_c_Older_People_Summary_Report_19_11_131.pdf [Accessed 26/11/14]

²⁶ Oxford Clinical Commissioning Group (2012) Outcomes that Matter' Exploration Event Review, Developing the outcomes for better patient care and better value Available at: http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2013/04/OCCG_Outcomes-that-Matter_Event-Summary.pdf [Accessed 26/11/14]

Last year Croydon CCG, together with the local authority, created an integrated health and social care contract for over 65s. It is worth an estimated £1.7 billion over 10 years and will look to the provider alliance model and outcomes based capitation to incentivise contractors to achieve a greater level of integration. The contract, due to commence in 2016, will include a full range of services from social care and non-elective acute care, to mental health and continuing care.

South Somerset's Symphony Project is designed to establish greater collaboration between primary, community, acute and social care, particularly for people with complex conditions. It is explicitly based on the 'principle of collaborative care, centred around the needs of individual patients.'²⁷ This means that there will be joint responsibility for all organisations, including Yeovil District Hospital Foundation Trust, Somerset County Council and Somerset Clinical Commissioning Group, to deliver outcomes, structured within an alliance contract.

TRULY INTELLIGENT COMMISSIONING

Commissioners face a daunting task. They must balance price and outcomes in a hugely complex environment that includes national and health sector procurement law, politics, public opinion, clinical evidence and guidance, as well as diminishing budgets and increasing demand for services.

Encouraging alliances to be a part of the marketplace would demonstrate intelligent commissioning. This involves encouraging diversity amongst the public, private and third sectors in which an alliance contract becomes a genuinely viable option.

1. Commissioners should try to ensure that there are no barriers to new market entrants, with recourse where necessary to Monitor in the exercise of its competition powers. When choosing who to collaborate with, an open process of requesting Expressions of Interest (EOIs) and Pre-Qualification Questionnaires (PQQs) (where relevant) should be completed to ensure that commissioners work with the best that the market can offer. It may be necessary to undertake a process of market-testing to encourage applications, to ensure providers understand what is involved in the alliance contracting process and to ensure that every sector is mobilised for the opportunity.
2. Although alliance contracting is predicated on a close working relationship with the commissioner, a competitive process can still encourage multiple partnerships and alliances to come forward within what is permitted under procurement legislation. Time must be given for providers to develop partnerships with the blend of skills and experience that commissioners want. Providers will be able to examine, within an open process, each other's credentials, conduct due diligence and form a partnership that is based on mutual trust and shared objectives.
3. A second qualification stage would establish partnership credentials and appetite for sharing risk and reward, but may also involve specific examination of experience, expertise, cultural fit, and ability to offer value for money.
4. There should be a level of competitive process that is proportionate to the scale of the opportunity. Before a commissioner decides who to share risk and reward with, a competitive process with different alliances and partnerships could test each partnership's ability to respond in areas that are important to the service, provided of course that

²⁷ Centre for Health Economics (2014) The Importance of Multimorbidity in Explaining Utilisation and Costs across Health and Social Care Settings: Evidence from South Somerset's Symphony Project University of York. Available at: http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP96_multimorbidity_utilisation_costs_health_social%20care.pdf [Accessed 24/02/15]

any process treats bidders equally. In alliance contracting it is often the case that the commissioner will start with a specific price in mind. It may be that a value for money test can be completed that encourages providers to demonstrate their ability to offer savings on this price. However, an intelligent qualification process that weighted savings appropriately against partnership ability would be necessary to avoid selecting an alliance that suggested large savings in their bids, but then resisted any further conversation about price during the formal contracting process, for example, by ensuring any commitment in a bidder's response is made binding.

Contestability

Outright competition is not always necessary to motivate producers to deliver better services at lower cost. It is sufficient that they face the credible threat of competition from new entrants or regulation from within the Alliance.

Commissioners, looking both to the market and the Alliance, would be capable of identifying a failing provider and taking action. In collaboration with the Alliance, they could replace partners long before any failure affects services significantly. The risk and reward model would create an environment in which providers would be less likely to tolerate 'slippages' in the quality of service delivery by their partners, adding a further element of contestability.

Given the NHS' focus on integration, many studies have been made to assess the benefits that arise from the better coordination of services. For example, a study has been taken of care for older people in Torbay.²⁸ Integrated care services were piloted in 2004, and now serve between 25,000 and 40,000 people. There has been increased spending on intermediate care services targeted at prevention and low-level support. This resulted in a reduction in the daily average number of occupied beds of Torbay Care Trust from 750 in 1998/9 to 502 in 2009/10.²⁹

It is now time for alliance contracting to be explored further by the NHS, and actions taken to ensure that commissioners have the flexibility to engage with this sort of working.

²⁸ Goodwin, N. et al. (2012) Integrated care for patients and populations: Improving outcomes by working together. The King's Fund and Nuffield Trust. Available at: <http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf> [Accessed 24/02/15]

²⁹ Ibid.

Given the time needed to co-design a service, agree outcomes and define performance frameworks, alliance contracting requires an understanding that this time is well-invested.

To ensure alliance contracting can effectively help the NHS meet its mission to deliver more joined up care, we need a clear articulation of how it fits within current commissioning processes, as well as supportive practices to inform commissioners and providers of its benefits.

NATIONAL POLICY

Commissioners need clear guidance on what constitutes alliance contracting, and when it can be deployed.

Monitor published the paper Substantive guidance on the Procurement, Patient Choice and Competition Regulations in December 2013. In outlining models of integrated care, the document stated that a commissioner might procure services from 'an "alliance" of providers that will work together to provide different elements of the patient's care.'³⁰ This shows that arrangements could exist in which there is not just one 'prime' provider, but a number of providers working together towards a common set of commissioning outcomes.

³⁰ Monitor (2013), Substantive guidance on the Procurement, Patient Choice and Competition Regulations. Available at: http://webarchive.nationalarchives.gov.uk/20140106173514/http://www.monitor-nhsft.gov.uk/sites/default/files/publications/SubstantiveGuidanceDec2013_0.pdf [Accessed 26/11/14]

Alliance contracting in the NHS

NHS England's NHS standard contract can be used for many innovative contracting models, in particular because recent versions allow for increased flexibility on contract duration and pricing. However, it does not currently allow a single overarching contract to be awarded to a number of providers.

This does not rule out using a modified version of alliance contracting. Many of the other key features of alliance contracting can still be accommodated in a contractual structure that replicates the single overarching contract models. This type of structure may involve the following features:

- Providers retain their individual service contracts
- Commissioners and providers enter into an overarching agreement which sets out high level principles for integrated working and seeks to link risk and reward across the parties

The overarching agreement may be a legally binding agreement or a non-legally binding memorandum of understanding or charter; though a legally binding agreement would add complexity.

Key issues that commissioners and providers will need to consider when developing an NHS alliance contracting model are:

- Procurement obligations
- Payment terms including variations to national tariff, incentives and sanctions
- Patient choice and compliance with competition law
- Integration with the implementation of personal health budgets
- Governance arrangements
- Allocating risk and reward
- The framework of contractual documents needed to implement the model

Source: Hempsons (2015) Can alliance contracting help deliver integrated care? Healthcare Newsbrief

Alliance contracting, as with all commissioning activity, must align with EU public procurement rules which have recently been reformed. The Council of the European Union adopted new directives on public procurement that came into force on 17 April 2014. The Directive was implemented into legislation by the Public Contracts Regulations 2015, which came into force on 26 February 2015. Significantly, the reforms should have the practical effect of making the procurement process more flexible and less time consuming.

The New Regulations will not however apply to any contract for NHS healthcare awarded before 18 April 2016, which are within the scope of the sector procurement legislation, the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. The government

is currently considering how the two procurement regimes will operate alongside each other and will set out a conclusive way forward in July 2015. The New Regulations will however apply immediately to local authority contracting (which is not covered by the NHS rules).

The specific changes that are of relevance to alliance contracting include:

Increased Flexibility: the New Regulations allow for some more flexibility as to when a new tender is required (or not) during a contract. For example, there is more clarity on what constitutes a 'substantial modification' which requires a new process to be run.

Innovation Partnerships: where Commissioners will be able to state a requirement that their needs be met by an innovative product or service not currently available on the market. Minimum qualitative requirements can be published and one or more respondents can be selected to become the commissioner's innovation partner(s) engaging with the commissioner to best meet those requirements. Financial negotiations continue through all phases of a project. Commissioners can often be reluctant to engage with providers for fear of prejudicing procurement but early engagement is a prerequisite for Alliance Contracting. Innovation Partnerships may provide commissioners with a framework in which to carry out early Alliance shaping.

New approach to contract value: the 'Part A/Part B' services distinction under the previous EU regime has been replaced in the Directive (and likewise in the New Regulations) with a 'light touch regime' for health and social care services. There is a new financial threshold for the Light Touch Regime of €750,000 (around £600,000) for these services which means that any contract over this value will need to be tendered unless specific exemptions apply. This should mean that more contract opportunities for healthcare services will be subject to an EU tender process although, as noted above, there will be uncertainty on this point until the conflict between the Directive and the NHS procurement rules is resolved in 2016. It is hoped that the final position will support alliance contracting whilst still complying with the general EU Treaty principles of transparency, non-discrimination and equal treatment. While the New Regulations allow for more flexibility where commissioners are looking at smaller scale, local procurement, it is unlikely that an alliance contract will be appropriate for very small opportunities.

SME Access: a number of measures have been introduced to ensure an easier bidding process for small and medium-sized enterprises. Although contracting authorities will not be obliged under the New Regulations to divide applicable contracts into 'lots' to help SMEs to bid for elements of a contract, they will be required to provide reasons if they decide not to lot. The government has noted that contracting authorities will have to therefore consider the possibility of division into lots when planning procurements. Guidance will also be issued on the use of lots. They will also be protected from having to show a turnover level which exceeds twice the value of the relevant contract at the pre-qualification stage. SMEs will be able to 'self-certify' that they meet selection criteria at the pre-qualification stage, rather than sending in the usual tranche of documents. In an alliance contract, dividing up into smaller lots will not be immediately relevant. It is however a challenge for small charities to engage as equals with larger organisations when commissioners are comparing balance sheets first and foremost. The explicit understanding that it is harder for smaller organisations to engage in large procurement exercises is an implicit invitation to support alliance contracting nationally.

THE CHALLENGE FOR PROVIDERS AND COMMISSIONERS

Awareness of new contracting forms, especially Alliance Contracting, is growing within the health sector but recognition of their potential is still limited amongst commissioners and providers.

A change in outlook and behaviour needs to be encouraged. Commissioners often respond positively to new ideas, but a culture of risk transfer, rather than risk sharing, is still embedded within a system dominated by traditional, vertically structured, contracting models. The challenge is to provide accessible terms of reference that cover competition and procurement rules, to show that alliancing should never be dismissed as too complex or costly.

The NHS Commissioning Assembly has shown evidence of exploring the concept of Alliance Contracting as an overarching model in which contracts such as the 'prime' approach can be included.³¹ Commissioners need clear information on the applicability of alliance contracting and the specific ways in which it can be constituted.

Awareness of alliancing amongst providers is similarly limited, despite consortium-working becoming increasingly widespread in the third sector. As much as it provides an opportunity to smaller third sector organisations to enter into a broader range of public service delivery opportunities, it must be acknowledged that the model requires investment. Collective responsibility shields parties from taking on undue fiscal burden, and outcomes are agreed democratically, yet the complex nature of projects to which alliance contracting is most appropriate presents a challenge to the alliance as a whole, in which every partner will have an equal interest. Therefore, every partner must have an equal understanding of the risks.

RECOMMENDATIONS

So that commissioners and providers may have the knowledge and resource they need to effectively deploy alliance contracting, it is clear that collaborative commissioning techniques should be explicitly supported by the next government. Alongside national guidelines, however, third sector bodies need to be proactive in encouraging the sector to recognise the benefits of alliancing, and how to be a truly valuable part of integrated care in the NHS.

Policy Framework

1. A Collaborative Commissioning Unit should be established in the Cabinet Office's Government Innovation Group, to examine how collaboration and consortia building can transform public services. For example, it should stipulate how alliance contracting can be used in such a way that it develops existing engagement with collaborative working amongst third sector consortia. This could be a series of workshops run for key consortia and commissioners in the UK, delivered in association with third sector infrastructure bodies working alongside system partners.
2. The new EU public procurement regime allows for award criteria which balance best price with quality including social, environmental and innovative characteristics. It is clear that these criteria are very relevant for alliance contracting and this should be recognised when aligning the New Regulations with health and care services.
3. NHS England and Monitor must try to ensure that other health sector-specific legislation supports sustainable alliance contracting.
4. NHS England should consider how alliance contracting can be embedded into initiatives targeted at better integration of health and social care, such as taking on a specific role in the Integration Pioneer programme.

Alliance Contracting on the Ground

5. The Commissioning Academy should develop a special stream in partnership with LGA, NHS England and DCLG to ensure that commissioners can be appropriately trained in alliance contracting in the health and care system
6. Targeted work should be undertaken with local commissioners to disseminate the potential of alliance contracting and to influence its adoption.
7. Support materials for good practice in alliance contracting should be made available on key websites such as Commissioning Assembly and Funding Central.

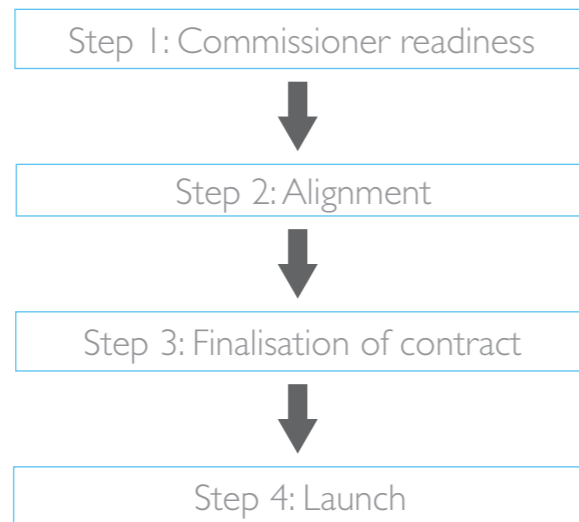
This could be made accessible via the ACEVO website and would contain the latest case studies, alongside good practice tools and techniques. To aid this, a link could be forged with LH Alliances, who have already started to develop web-based resources of this nature.

8. Existing third sector funding programmes, such as the Lottery Fulfilling Lives programme, should be made available to alliance contracting initiatives.

APPENDIX I: STEPS INVOLVED IN BUILDING AN ALLIANCE CONTRACT

The following 4 step process chart (see figure 1) mirrors the information contained on the LH Alliances website.³²

Figure 1: 4 Step Approach (LH Alliances)



Step 1: Commissioner 'readiness'

The first step involves the commissioner addressing key issues:

a. Commissioner leadership and capability

Leaders and key players should be ready for alliance leadership roles and have secured the skills and capacity to develop and implement an alliance contract.

b. Clarity on service and outline contract

There must be clarity about the service scope and purpose as well as an outline of contract elements, including the proposed commercial framework.

c. Co-designed outcomes

Outcomes for the service should be co-designed with service users and frontline staff so that they represent value from all perspectives.

At this stage it is important not to have a detailed service specification. That comes later (see end of Step 3), once the right relationships have been established.

Step 2: Alignment

It is important to have:

- The right partners
- Aligned business and personal drivers

- Commitment to an alliance way of working: collaboration, openness, innovation

a. Alignment through procurement

Procurement is not solely based on price competition but should consider alignment of business drivers and demonstration of commitment to collaboration and innovation.

The selection process is used to drive new thinking and develop momentum around collaboration and innovation.

b. Alignment without procurement

Where an alliance is formed with existing providers, considerable time and effort may be needed to address alignment, get misalignments on the table and help people let go of the past.

Step 3: Finalisation of contract

Once the alliance members are agreed and alignment confirmed, the participants finalise details together:

a. Contract

- Principles that will determine behaviours between the alliance members
- Governance and roles
- Performance framework with key results areas that link to the outcomes
- Commercial framework, including gainshare and painshare regime and any staging of payments

b. Service design

- Implementation plan
- Target costs

All of the above elements are openly negotiated and collectively agreed.

Step 4: Launch

Planning for the launch of the alliance contract should include:

a. Staff information sessions

These should be targeted at staff in all alliance member organisations.

b. Early meetings of Alliance Leadership Team/Board and Alliance Management Team

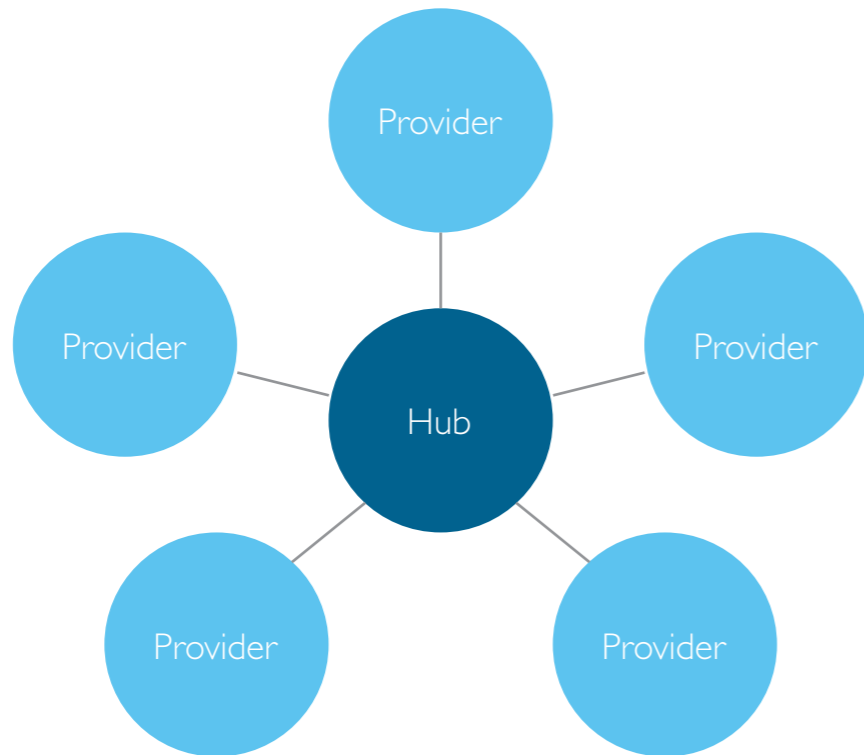
Facilitation of meetings and external support for individuals should be considered to ensure the teams are working as high performance teams from the outset.

c. Continued support

Further leadership and management development support should be planned, as appropriate.

The typical legal structure of this super provider model is a company limited by guarantee with registered charity status. Through formation of the company structure, the partners are expressly 'ring-fencing' their risk into the corporate vehicle, at the same time as securing rewards as a result of the vehicle bidding for and winning contracts, which are then sub-contracted to the consortium/company members.

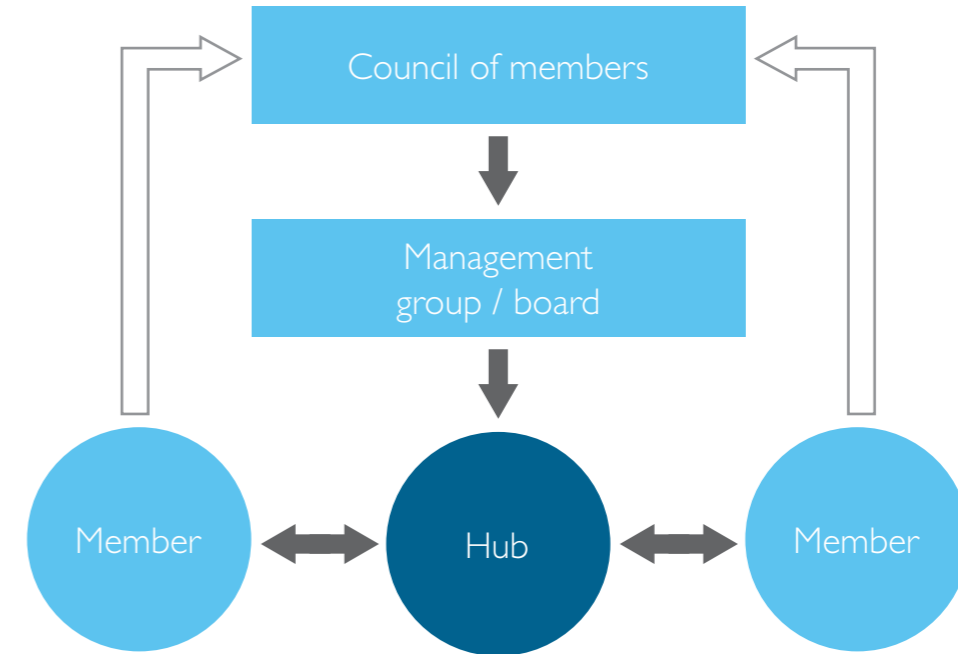
Figure 2: Super Provider Internal Operating Structure



The hub, as the executive engine, negotiates and sub-lets contracts which are accountable to the company Board and membership. The hub may have staff on the payroll of the consortium, (Sheffield Cubed) or the hub's functions may be split and outsourced to members (Greater Together). Typically, these types of consortia tend to have very large membership bases. For example, Sheffield Cubed has over 90 members. Therefore, they have to operate with 2 tier governance structures:

- A council of members, which comprises all the consortium members and meets periodically to determine overarching consortium strategy
- A smaller executive body or board of directors, which is drawn from, and democratically accountable to, the wider membership, and which meets regularly to conduct consortium business – see figure 3.

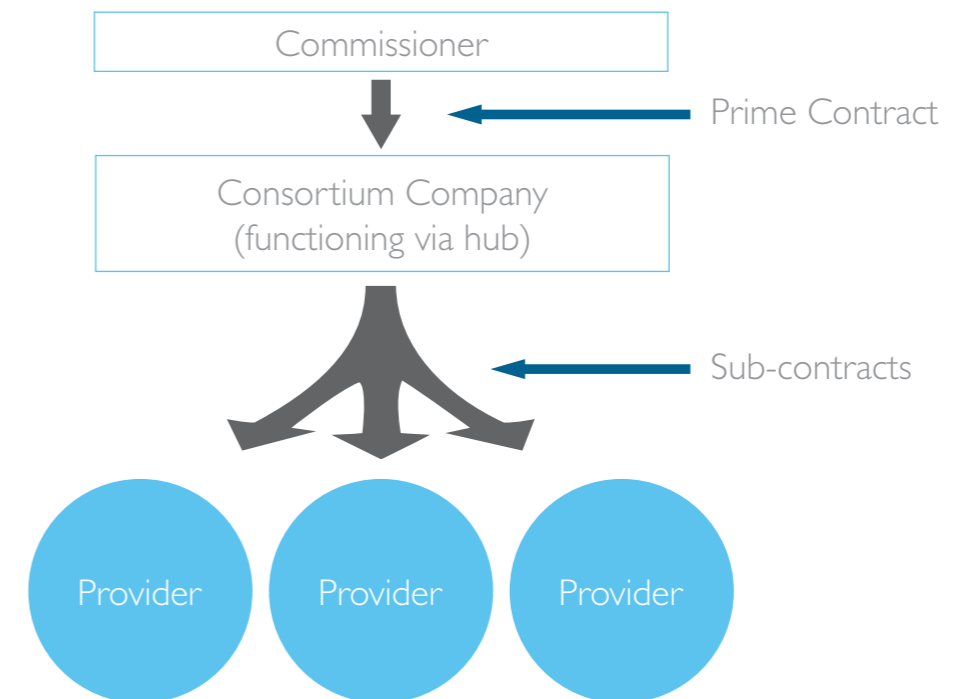
Figure 3: Consortium 2 Tier Governance Structure



Not all consortium members will be actively delivering on sub-contracts at any one time but the consortium will likely be holding a number of contracts simultaneously, small groups of members delivering on each.

This has resulted in a prime and sub-contracting model – see figure 4.

Figure 4: Prime Contractor with sub-contractors model



The result is that risk is balanced as opposed to genuinely shared. The consortium would assume primary responsibility for risk as the prime contractor but some of it would then pass down the supply chain to sub-contractors. For example, the company might pay the sub-contractor a percentage of the contract fee in advance of delivery, so financial risk rests with the company and not the consortium member; but then make subsequent contract payments subject to performance and re-balance risk in favour of the company.

An Alliance would be identified by all partners sharing risk equally. If the virtues of alliance contracts are to be gathered by VCS consortia they must appreciate this distinction. A consortium hub could potentially act as an 'integrator' with an alliance contract structure, leading from within a particular cluster of service providers without becoming the dominant force. The hub would help build consensus on key principles across the Alliance, mediate between interests and operate as the impartial guardian of the whole system outcomes that the Alliance will seek to achieve.

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Andrea Biggs, Chief Executive of Balance CIC

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