Capital ideas

How to keep spending in an age of austerity

Mental health
Care providers in the doldrums

Franchising
George Eliot calls for help

Competition Commission
Private sector strikes back
Over the past decade, great progress has been made in bringing the free market into the NHS. Independent Sector Treatment Centres (ISTCs), Choose & Book, spot purchasing from the private sector, framework agreements, public-private partnerships, and other initiatives have greatly increased the private sector’s involvement with (and income from) the NHS. With the establishment of Clinical Commissioning Groups (CCGs) run by GPs, ways of involving the private sector are continuing to evolve. CCGs are being more innovative and tendering contracts not only by activity, but also on a care of a population basis. Such contracts are often capitated (i.e. a lump sum is paid to look after a specific number of people), involve prime contractors (as often one operator is unable to provide all services required), and run for many years. “Clinician led commissioning,” said the CEO of NHS England, David Nicholson, in 2011, “will support integrated care and commissioners will have the flexibility they need to be able to bundle services together across a pathway where this makes sense.”

Prime numbers

Dr Druin Burch and Dr Leonid Shapiro of Candesic explore how prime contracting is overhauling the NHS ecosystem

Enter ‘prime contracting’

Prime contractor agreements, where the responsibility of care is effectively passed onto a lead provider, often require the prime contractor to subcontract some services to others in order to deliver the entire pathway of care. This approach allows the CCG to commission care by disease or demographic (e.g. all care for over 65-year-olds or all care for diabetics), rather than by activity (e.g. for 10,000 hip replacements). The CCG invites expressions of interest from prime contractors who then take over responsibility for services, often
to a defined population, negotiating themselves with sub-contractors where necessary. For example, an acute provider who is the prime contractor could subcontract community services to deliver a complete pathway of care. But the CCG is doing more than just commissioning by pathways; they are effectively passing the risk of looking after a segment of the population onto providers, including in some cases private providers (figure 1). In Staffordshire, several CCGs are exploring the possibility of entering into a long term contract with a prime-provider for breast, prostate, bladder and lung cancer care. In Cambridgeshire and Peterborough, a contract for older peoples’ care, worth £800-900 million over five to seven years, is being tendered. These are ‘all you can eat’ contracts where while the funding is fixed, demand is open ended. Other contracts bundle maternity and mental health or out of hours primary care and 111 services, and the number of contracts, their variety and their overall value, is set to expand. Figure 2 details recent such tenders.

Standard NHS contracts have tended to run over a period of a single year. Given the resources involved, commissioning over a longer period makes sense, but it is also hazardous. Geriatrics, for example, will undergo changes over the next few years which any long-term contract for care of the elderly needs to predict. Some, if you start with the right data, are straightforward to model – the demographics are easy to grasp, and no one is going to be surprised by the elderly population growing over coming years. Changes in risk, particularly of cardiovascular diseases, make it harder to predict what will happen to frailty and consequent care needs, and these

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**FIGURE 1**
CAPITATION PASSES RISK ONTO PRIVATE PROVIDERS

Capitation/fixed payments

![Diagram of CCG passing risk to lead provider or coalition, then to provider](image)
have massive implications. Changes in therapies, not merely those dealing with dementia but also those involving any of the countless conditions common in the elderly, are also a known unknown – there is simply no reliable way of knowing how demand characteristics will change. This uncertainty poses difficulties with the move toward longer-term contracts.

Some political support for the entry of private firms into NHS services is ideological but most is pragmatic. In order for cross-party support to be maintained, arrangements need to be advantageous not only for private industry but also for patients and taxpayers. That support is necessary if the market is to remain open and attractive. When PCTs were being eliminated and replaced with CCGs, they were unable to enter into contracts for longer than their own dwindling life expectancy – it is clear that political and organisational changes to the NHS create instability that needs to be considered by those contemplating doing business with it. Complex liabilities on both sides need to be balanced to appropriately share risk and rewards. Understanding how this might happen – and fail to happen – is essential.

How it can go wrong
The 111 helpline shows how easy it is to make mistakes when attempting to commission new services, and how clinical and commercial failure often go together. NHS Direct is withdrawing from its 111 contracts as a result of the service not working as predicted, an example of the potential harms that bidders open themselves up to. The fact that NHS Direct is itself part of the state reinforces the lesson that the potential costs to the NHS of commissioning lie not only in its role as buying services but also, frequently, when providing them.

As the commercial failure of 111

### FIGURE 2
#### RECENT AND FUTURE PRIME CONTRACTOR TENDERS

<table>
<thead>
<tr>
<th>CCG</th>
<th>Services being tendered</th>
<th>Status</th>
<th>Start date</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfordshire</td>
<td>Acute and community musculoskeletal services</td>
<td>Successful bid by Circle (in partnership with Pennine MSK)</td>
<td>Aug 13</td>
<td>£120 million over 5 years</td>
</tr>
<tr>
<td>Brighton &amp; Hove</td>
<td>Integrated Musculoskeletal Service</td>
<td>Forthcoming provider event</td>
<td>2014</td>
<td>N/A</td>
</tr>
<tr>
<td>Bexley</td>
<td>MSK</td>
<td>Expression of interest</td>
<td>Dec 13</td>
<td>£15 million over 3 years</td>
</tr>
<tr>
<td>Surrey Downs</td>
<td>Services currently provided by Central Surrey Health</td>
<td>Central &amp; North West London Foundation Trust; Central Surrey Health</td>
<td>Autumn 2013</td>
<td>£125 million over 5 years</td>
</tr>
<tr>
<td>Bexley</td>
<td>Cardiac</td>
<td>Provider event</td>
<td>Feb 14</td>
<td>£27 million over 3 years</td>
</tr>
<tr>
<td>Oldham</td>
<td>Community services</td>
<td>Expression of interest</td>
<td>Apr 14</td>
<td>£69 million over 3 years</td>
</tr>
<tr>
<td>Thurrock, Basildon,</td>
<td>MSK Integrated Hub Services</td>
<td>Forthcoming: pre-qualification questionnaire</td>
<td>Apr 14</td>
<td>£81 million over 3 years</td>
</tr>
<tr>
<td>Brentwood</td>
<td>MSK</td>
<td>Forthcoming: pre-qualification questionnaire</td>
<td>May 14</td>
<td>3 years</td>
</tr>
<tr>
<td>NHS Midlands &amp; East</td>
<td>Pathology services</td>
<td>Abandoned: anticipated that operational, clinical and financial risks would be too high and benefits would not outweigh costs</td>
<td>Jun 14</td>
<td>£500 million over 5 years</td>
</tr>
<tr>
<td>Cambridgeshire &amp;</td>
<td>Older people’s pathway and community services</td>
<td>Bidders: Albion Care Alliance Community Interest Company; Capita; Circle Partnership; Care UK; United Health; Interserve; Serco; United Health UK; Virgin Care</td>
<td>Jul 14</td>
<td>£800 million over 5 years</td>
</tr>
<tr>
<td>Peterborough</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somerset</td>
<td>Ambulatory care, disease management, rehabilitation, integrated services</td>
<td>Invitation to tender</td>
<td>Jul 14</td>
<td>£6 million over 3 years</td>
</tr>
<tr>
<td>Bristol</td>
<td>Mental health services</td>
<td>Forthcoming</td>
<td>Oct 14</td>
<td>£30 million</td>
</tr>
<tr>
<td>Coastal West Sussex</td>
<td>Integrated Musculoskeletal Services</td>
<td>Invitation to discuss</td>
<td>Early 2015</td>
<td>£175 million over 5 years</td>
</tr>
<tr>
<td>Staffordshire (exclusive of South East Staffs &amp; Seisdon Peninsula)</td>
<td>Cancer (breast, prostate, bladder, lung) and end of life care for all long term conditions</td>
<td>Community, primary care, hospice, acute; aim to appoint provider by 2015</td>
<td>N/A</td>
<td>10 years</td>
</tr>
</tbody>
</table>
contracts show, it is all too easy to get numbers wrong even in the short-term. Not only is the future uncertain – politically, technologically and commercially – but we have a poor grasp on the past and present. The data available to understand healthcare needs is limited. Under the new Health & Social Care Act, CCGs are very limited in the access to patient level information due to strict patient confidentiality provisions. In fact, CCGs have only high level patient information going back one year and they have been forbidden access to previous year’s data on the patients they pay for. Given the huge complexity of modelling, this makes a difficult job very much harder. With so much patient related information unavailable to those seeking to manage the health service, can there be a realistic hope of doing so properly?

Can there be a win-win?
Within this uncertainty, of course, lies the potential for profit. Those better able to understand and predict the situation will reap rewards. That’s fine, so long as the uncertainty is not so huge that, rather than rewarding intelligence, data-gathering and appropriate risk taking, it simply rewards the lucky gambler, a situation in no-one’s longer term interests. Part of the attraction for private bidders is the opportunity to predict and model better than the CCGs while part of the political difficulty is the chance that this might happen rather too often. In order for clinical commissioning to work, bidders need to profit for better reasons than through CCG incompetence. Equally, no one wants a situation whereby the tables are turned and the CCG are able to successfully tender out services at a price that is impossible to deliver, leading to eventual failure and provider withdrawal. It is in everyone’s interests to make sure that the system works as efficiently as possible and that neither risk nor reward are too one-sided.

How might this be approached?
Outcome and process measures could be agreed upon. Performance bonds might guard against withdrawals on the side of successful bidders. But consideration would also be needed for what would happen if the medical environment changed. Imagine, for example, a contract to provide services to patients with type 2 diabetes that was based in large part on the current standard outcome measure of glycated haemoglobin. Widely used as a
Finance

surrogate for the effectiveness of diabetic treatments, recent trials have thrown the relevance of glycated haemoglobin into doubt. Services commissioned around a performance indicator are vulnerable to changes in practice that alter the utility of that indicator. Criteria may need to be set for renegotiation contracts mid-way through. Appropriate safeguards will need to be put in place to cope with the chance of providers pulling out, with enough flexibility to leave them able to do so should the basis of the original agreement turn out to have been sufficiently badly mistaken, or its operating environment to have profoundly changed.

The King’s Fund points out that “high performing integrated systems use capitated budgets for almost all care [and that] their main focus is on population based budgets not disease or condition based budgets”. Attempting to move toward the latter involves a degree of learning for CCGs and bidders alike, as well as for bidders in relation to their sub-contractors. Many of these groups are unlikely to have much experience or history of working together, particularly at the interface between NHS organisations and private providers. Could some of the risk and reward be shared by avoiding prime contractors altogether? The construction industry has pursued alliance contracting as a way of spreading risk, and in pilots the Department of Health has found this to work well. It might be a better way of reducing contractual, legal and political hazards, and for dealing with complexity in a sector far more intricate than construction.

Another challenge prime contractors have is how to be both a provider and commissioner of care at the same time. They must be both shrewd commissioners (to ensure they deliver what they have promised within budget) and a profitable provider (thinking about their provider margins). They have to make decisions of whether to deliver services themselves, even if it will be at a higher cost, or outsource to cheaper providers. The governance around how they decide this is crucial in aligning organisations to deliver on the original CCG contract (figure 3). CCGs must abide by strict procurement rules. Prime contractors have more flexibility. This could be a driver of value creation through prime contracting as contractors, once they win the larger tender, could more efficiently subcontract services than CCGs have been able to under the traditional model. A private provider prime contractor can choose whoever they want, on whatever financial terms they choose, without complicated and bureaucratic public tendering procedures (figure 4). Another benefit is that prime contracting can be used as a way of pooling some of the health and social care budgets without taking the radical step of pooling these budgets at source. If local authorities and CCGs tender concurrent contracts for identical populations, a prime contractor can win both tenders and pool the budgets to deliver care to the population as best as it sees fit, without regard to which pot the money comes out of.

On the flip side, the initial tender to award the prime contract can add unnecessary costs, not only to the CCG but to other NHS and private organisations that bid on it. For example, the contract for integrated care of the elderly in Cambridge & Peterborough is expected to start in 2014, to last for five to seven years and be worth £800-900 million pounds. Bidding for a deal of that complexity takes investment, perhaps £2-3 million
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Private sector opportunities
Private organisations have a number of ways in which they can get involved in and benefit from the raft of prime contracting tenders being offered by CCGs. They can of course become prime contractors themselves, however, they can also provide support services to prime contractors such as care pathway design and management, care co-ordinator personnel and operations, procurement and commissioning services to help subcontract necessary local services, call centres, IT solutions, telehealth solutions, risk management and much more. They might offer traditional medical services to prime contractors and in effect become subcontractors. The key success factors will differ for each strategy.

For those organisations wanting to become lead contractors, the key to success will be to price and scope the contract out correctly in the first place. We have seen how little data CCGs have and how unpredictable demand evolution can be over a long term contract. Getting the numbers right will be the most important driver of a profitable or loss making prime contract, and this can be many tens of millions in either direction. For service providers, there will be numerous new services demanded and required by prime contractors. Support service providers who anticipate these and are first to market with proven and tested solutions, perhaps based on experience from abroad, will have an edge.

Finally, for subcontractors, identifying new care services that will be demanded by prime contractors, such as ones that can be used to reduce overall care costs, will be equally vital. One example is step down care, perhaps delivered in a nursing home staffed by junior doctors or senior nurses such that patients who would normally be cared for in an acute hospital can be cared for in a lower acuity care setting for less than half the cost.

Prime contracting, although new, is growing and is here to stay. It is inevitable for the private sector to play an increasingly leading role in it and the care it provides. While there is still much uncertainty of how things will play out, one thing is for sure: in order for society to meet the needs of its ageing population, the NHS and private sector will have to pull together and share both risks and upsides in the new world of integrated care.