Monitor
Making the health sector work for patients

Local price setting and contracting practices for NHS services without a nationally mandated price

A research paper

24 September 2013

About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

We exercise a range of powers granted by Parliament which include setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences we issue to NHS-funded providers.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are run well, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

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Executive summary

In 2004, the NHS introduced national prices to reimburse providers for some NHS-funded services, mainly in acute care. The set of NHS services under the scope of national prices has increased over time and now accounts for approximately £29 billion of NHS spending. However, the majority of NHS services do not have a national price. Commissioners purchase services without fixed prices through a process we refer to in this report as “local contracting”, which includes setting prices for them.

From 2014/15 NHS England and Monitor will have joint responsibility for the whole NHS payment system in England, including both national prices and local contracts. Together with our stakeholders we have set about designing an overarching payment system: this will include methods for setting prices at a national level (as well as rules for varying those prices) and setting prices at a local level.

Over the past year, NHS England and Monitor have been working with a wide range of stakeholders to understand better all aspects of the current payment system and how it can be improved to do more for patients. Until we understand how the current system works in practice we can neither improve nor judge what type of support the sector most needs.

We know that in 2011/12, local commissioners spent around £40 billion on local contracts, significantly more than they spend on nationally priced services. But despite the sums involved, until now there has been comparatively little study of how effectively local contracting delivers its objective of better outcomes for patients within the budget available. To begin to address that question, we carried out the research for this report, based on interviews with commissioners and providers about how they make contracts.

Contracts are the means by which commissioners and providers formally agree on such fundamentals as the specific services being purchased, performance requirements, and approaches to risk sharing, as well as the price paid. NHS England and Monitor are tasked with developing a payment system that encourages contracting behaviours among commissioners and providers that make the best use of NHS funds for patients. The system should ensure, for example, that commissioners use contracts as levers to secure better quality and better value services. But to achieve improvements, it is vital that we recognise the contracting challenges local commissioners face and identify where and how we can best support them**.** Moreover, Clinical Commissioning Groups (CCGs) have only recently started their new and challenging role. They need time to establish themselves. Measures to improve local contracting must take these circumstances into account.

The findings from this research have helped to inform the rules and guidance we have proposed in the *2014/15 National Tariff Payment System: A Consultation*

Notice on local payments for services without a nationally mandated price. It will also help to inform our future programme of work.

For this study we undertook more than thirty interviews with organisations across England. We spoke to local commissioners, mainly CCGs and some Commissioning Support Units (CSUs), and providers covering ambulance, acute, mental health, and specialist and community services.

Based on the views and experiences of this comparatively small sample of people working in the sector, this research is not an exhaustive review of local contracting. However, it does clearly indicate some of the challenges that commissioners face in agreeing local contracts that deliver the best outcomes for patients. Our findings were that effective local contracting in some health care markets is being undermined by several factors, in particular:

1. **The pressure on local commissioners to balance annual budgets may act as a barrier to improving patient care.**

Commissioners are primarily responsible for identifying how to buy better quality services from the budget available to them. They face particularly strong pressures to meet annual budget targets because their funding is allocated on a yearly basis and the allocation system discourages both deficits and surpluses. Sometimes the need to balance the budget in any one year can detract attention from efforts to look at improving the quality of care achieved from the budget available.

2. **Commissioners and providers lack consistently good quality information**

To agree and enforce sound contracts, good quality data is essential. But providers have far better data than commissioners about the work they do and the costs of doing it, which they may be unwilling to share. Even where providers do share information, commissioners are not always able to have confidence in it because the quality of the information is sometimes poor and commissioners lack benchmark data with which to compare provider performance. Although several providers are adopting more sophisticated cost recording approaches, many providers themselves still do not fully understand the costs they incur at the patient or even at the individual service level. Providers need to collect and to share far better data on both quality and costs. This will help enable informed discussions between providers and commissioners about what services are needed for local patients and how they can best be delivered.

3. **Some commissioners do not have strong contracting skills**

Some commissioners do not have substantial contracting expertise, which limits their ability to get the best value from their local providers through the contracting process. For example, some commissioners rarely use locally designed payments approaches as a lever to complement the Commissioning for Quality and Innovation (CQUIN) payment framework, which enables commissioners to reward providers for

excellence by linking a proportion of their payment to the achievement of local quality goals. Local commissioners may also lack expertise in establishing contractual risk sharing mechanisms and in managing risks that may arise during the contract term.

4. Commissioners are not always able to negotiate with providers on equal terms

Providers often have advantages over commissioners in terms of contracting expertise and capacity as well as data. This imbalance can make it difficult for commissioners to negotiate and agree contract terms that deliver the best outcomes for patients.

5. Transaction costs can be high

Managing local contracts can be costly for both commissioners and providers in terms of the time, information and other resources they require. Poor quality information and weak contracting skills inflate these inherent costs.

6. Contract enforcement is not always credible as commissioners are sometimes unwilling to use financial sanctions

Commissioners are sometimes reluctant to enforce contracts, particularly by imposing financial penalties, for fear of exacerbating providers' existing problems. While holding back from enforcement may be in patients' best interest in the short term, as it ensures their continued access to services, it may be against patient interests in the longer term to withhold from providers this potentially powerful incentive to improve quality and efficiency.

7. Commissioners often rely on good relationships with providers to overcome these challenges

In health care, good relations with providers can be crucial to overcoming some of the challenges commissioners face when using contracts to deliver better quality and better value services for patients. For example, they can help commissioners and providers to work together (in a way that is consistent with the statutory framework on procurement, choice and competition), when redesigning services for patients. However, good relationships are not always easy to establish and maintain and continual disruption to those relationships makes effective contracting that benefits patients very difficult.

Some of the issues in local contracting identified through this research are already being addressed in the *2014/15 National Tariff Payment System: A Consultation Notice* due to be published for consultation in October 2013, while others are being considered for the *2015/16 National Tariff Payment System* and beyond.

For example, the *2014/15 National Tariff Payment System: A Consultation Notice* will provide best practice examples of local price setting approaches and a set of

overarching mandatory principles to encourage better relationships between contracting parties for services with locally agreed prices. It will also include provisions to make local contracting agreements more transparent.

For future tariff work, NHS England and Monitor have also begun to explore options for policy development. This work includes, for example, exploring options for:

- providing commissioners with multi-year budget allocations and/or yearly allocations with flexibilities, to help commissioners take a longer term view;
- re-designing CQUIN and considering payment for performance through the national tariff;
- re-designing the contract sanctions and incentives currently available to commissioners through the NHS standard contract

This report highlights how hard it can be for commissioners to create effective local contracts. However, any ideas for improving local contracting should be assessed in the context of the payment system as a whole. One option may be to set national prices for more services. But setting national prices is only one among Monitor's many regulatory tools and may not always be suitable. Other tools, such as improving the quality of data to inform local decision-making, may be more effective in some circumstances.

1. Introduction

Since 2004, national prices have been used to reimburse providers of many important NHS-funded services (mainly acute) according to the type and volumes of clinical activity they undertake. The range of national prices has gradually increased and now accounts for approximately 60% of income for acute trusts in England. For the remaining services, reimbursement is made through contracts arranged between local commissioners and providers. In this report these are referred to as “local contracts”.

Information about the amount of activity (eg, the number of operations) undertaken and the related costs tends to be considerably poorer for these local contracts than for the national system of activity-based payments. In addition, there have been only limited regulatory attempts to ensure that these local contracts are effective in delivering better outcomes for patients for the budget available.

Under the Health and Social Care Act 2012, NHS England and Monitor have a shared responsibility for the payment system for NHS-funded services. These key new responsibilities will help Monitor fulfil our core duty to protect and promote the interests of users of NHS-funded services and to ensure that the provision of services is effective, efficient and economic.

This report covers our initial research into local contracting approaches for NHS-funded services without a nationally mandated tariff. The findings from this research have helped inform both the rules and the guidance we have proposed in the *2014/15 National Tariff Payment System: A Consultation Notice*, to be published in October 2013. It is also intended to help inform our long-term strategy on local payments.

Monitor considers that collecting better evidence on local contracting is vital for two main reasons:

- these services represent a large proportion of NHS spending in England; and
- more effective local contracting will help commissioners obtain good quality and good value services.

Although we do not set national prices for these services at present, we have a responsibility to ensure that they are being contracted and paid for in a way that delivers quality services and better outcomes for patients for the budget available. However, at the moment we have little evidence to judge the effectiveness of contracts as a whole. In addition, most contracts between providers and commissioners combine both nationally and locally priced services. This means that the approaches commissioners and providers take to local contracts might have a significant impact on the effectiveness of national prices in ensuring delivery of high quality and efficient services for patients.

We recognise that CCGs are new to the challenges and complexities that local contracts involve and we want to support them wherever possible. This report is intended as a first step to help Monitor and its stakeholders understand how local contracts work and to begin to provide the evidence we need in order to design a coherent overall payment system.

This chapter sets out:

- current approaches to paying for NHS-funded services;
- how contracts could help commissioners to obtain better quality and improved value; and
- objectives of this research and a summary of the methodology.

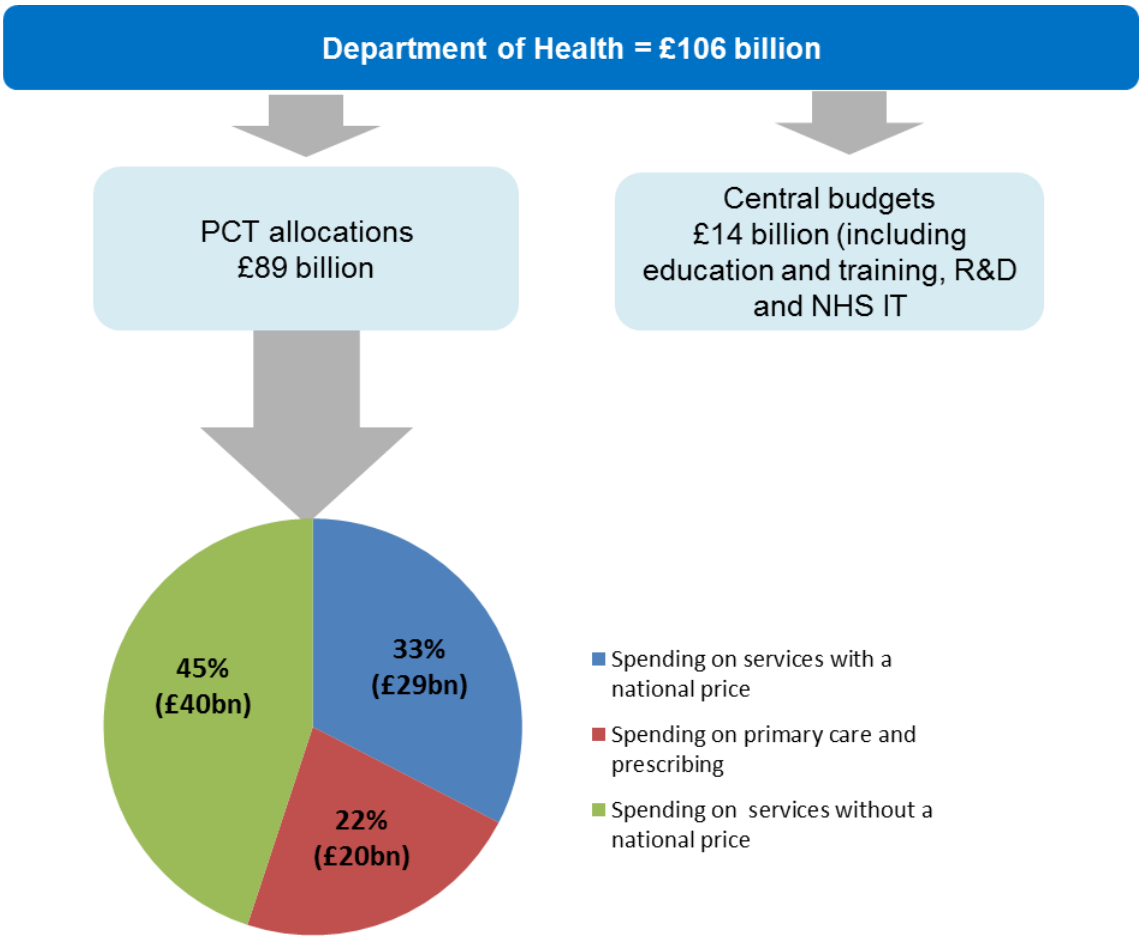
Section 2 provides a summary of the main findings from our primary research and our review of empirical studies. Section 3 sets out the strategic implications of the findings alongside options for NHS England and Monitor for next steps.

1.1 Reimbursement for NHS-funded services

In 2011/12 around 80% (£89 billion) of NHS funding in England was allocated to local commissioners. (At that time these were primary care trusts – PCTs – which have now been replaced.) Of this, approximately £40 billion was spent on services without a national tariff (see Figure 1.1).[1] This is a significantly larger sum than that spent on reimbursing providers for activity covered by national prices (£29 billion).

[1] *Payment by Results Guidance for 2012-13*, Department of Heath. Available at : https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216212/dh_133585.pdf

Figure 1.1: Expenditure breakdown of health care spending in 2011/12



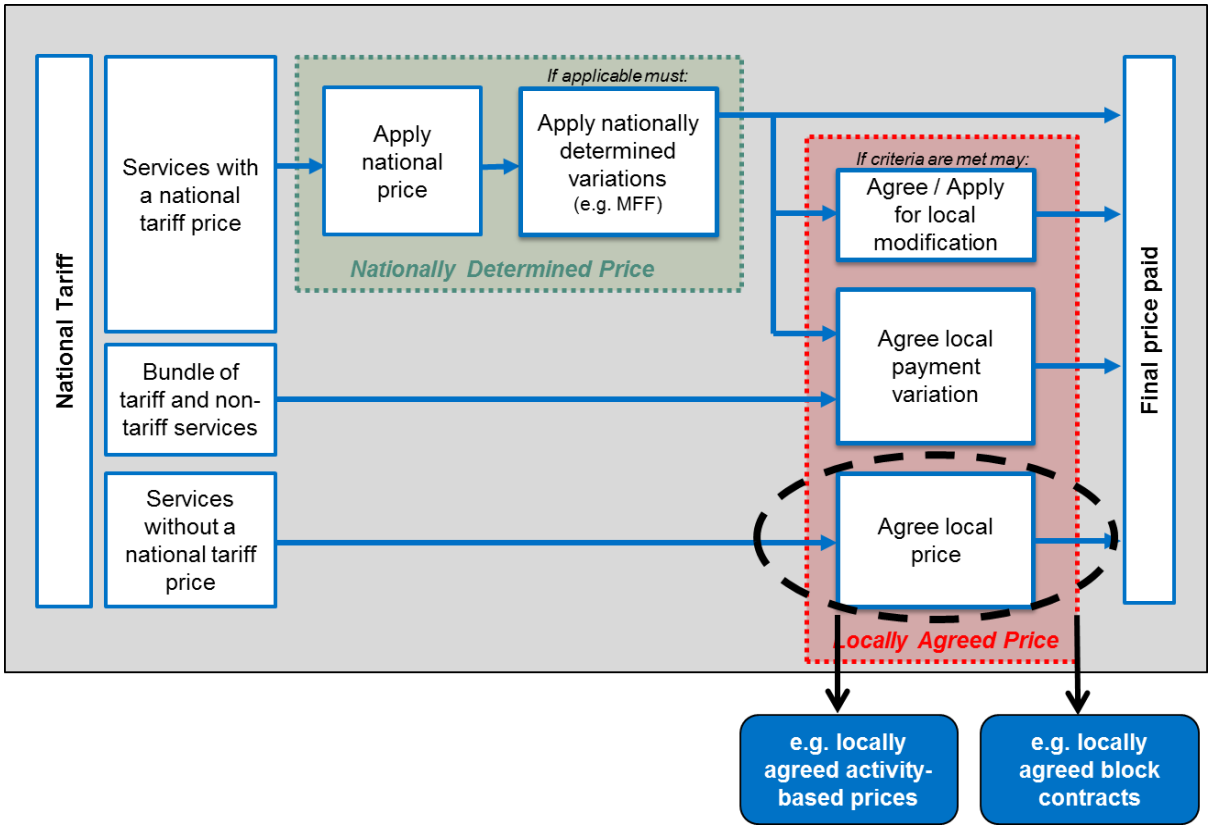
Source: Data from *A simple guide to Payment by Results,* 2011/12 figures

Commissioners are required to use a standard NHS contract to formalise the service level agreements they make with providers. Commissioners generally draw up a single contract each year with each provider they use. With the exception of NHS trusts,[2] these standard contracts are legally binding agreements for all providers of NHS-funded services including NHS foundation trusts and independent, voluntary and social enterprises. This standard contract is nationally determined and contains a number of mandatory clauses including, for example, national targets on waiting times. However, the contract design is intended to provide commissioners with the flexibility to include locally negotiated terms and conditions concerning, for example, quality targets and prices. This flexibility should mean that the contractual arrangements that commissioners enter into with providers meet the needs of the patients in their local health economy.

[2] While not legally binding for NHS trusts, NHS England advises commissioners that the standard contracts with these providers be used with the same level of rigour as if the agreement were legally binding.

The main approaches for reimbursing NHS-funded services as set out in the Health and Social Care Act 2012 are shown in Figure 1.2.

Figure 1.2: Main approaches to paying for NHS-funded services



Annual contracts between providers and commissioners often cover a range of different services. Some of these services will have prices which are set nationally and others will have prices that are agreed locally. As illustrated in Figure 1.2, there are a number of different approaches to paying for the different services.

Approaches to paying for services with locally agreed prices generally fall on a spectrum between “block contract” pricing and “activity-based” pricing. Under a block approach, a provider is paid a lump sum fee in return for providing a set of services for a specific population for a fixed time period (usually a year). These payments do not vary with the number of patients treated. Under an activity-based approach, a provider is paid a specific price for each unit of activity undertaken. Between these two ends of the spectrum are payment approaches that combine both. For example, providers may receive a block payment for a specified baseline level of activity. Beyond that level, providers may be reimbursed on a price per case basis, where the price is agreed in advance. In other cases, unit prices for activities may vary within defined activity tolerance levels. Annual contracts between commissioners and providers will typically contain a mixture of the payment approaches identified above.

1.2 Contracts may help obtain better quality services

The ultimate objective for commissioners is to deliver better quality services for patients for the budget available. Contracts can be key to commissioners meeting this objective as they allow commissioners and providers to agree on issues, including:

- the services that are specified;
- payment terms;
- duration of the contract;
- performance requirements (eg, specifying outcome measures/quality standards);
- requirements on conduct (eg, to mitigate the risk of perverse incentives to over- or undertreat patients);
- non-payment terms (eg, in the event of under performance); and
- approaches to resolving unexpected events (eg, risk sharing arrangements).

Long-term contracts can also be very useful in securing agreements between providers and commissioners where, for example, the investments required in delivering services to patients are:

- very specific (ie, they cannot be easily sold or used in other sectors); and/or
- there is a high amount or uncertainty about external risks (eg, demand and input costs) and about defining and monitoring service quality.

Health care markets are often characterised by these circumstances, making contracts useful in the sector. Contracts can, for example, help overcome the uncertainty that commissioners often face about service quality, costs and efficiency. To illustrate, not only do providers often have more information than commissioners but their incentives are not always aligned. This creates a “principal–agent” problem:[3] commissioners cannot be certain that providers will behave in a way that is in commissioners’ best interests as well as their own. To alleviate this problem, contracts can include incentive regimes designed to align the interests of

[3] A principal–agent relationship exists where a principal (eg, a manager) asks an agent (eg, an employee) to perform a function on their behalf. A problem may arise if the parties have different interests/objectives and information between the two is asymmetric, ie, where one party (in this case the agent) has more information than the other (in this case the principal). This makes it very difficult for the principal to monitor the actions of the agent to ensure that they are acting in the principal’s best interests.

commissioners and providers. For example, they can include risk sharing agreements and reimbursement approaches that incentivise providers to improve quality and efficiency.

Designing such contracts, however, can be difficult. In particular, health care commissioners often have to secure a huge number of different services from a single provider, meaning that negotiations between commissioners and providers can cover hundreds, sometimes thousands, of service lines. This makes the interactions between these two parties complex and intricate.

In addition, in practice commissioners must achieve their objective on service quality and patient outcomes while managing a fixed budget allocated annually. In a period where budgets are under pressure, managing the budget may take priority.

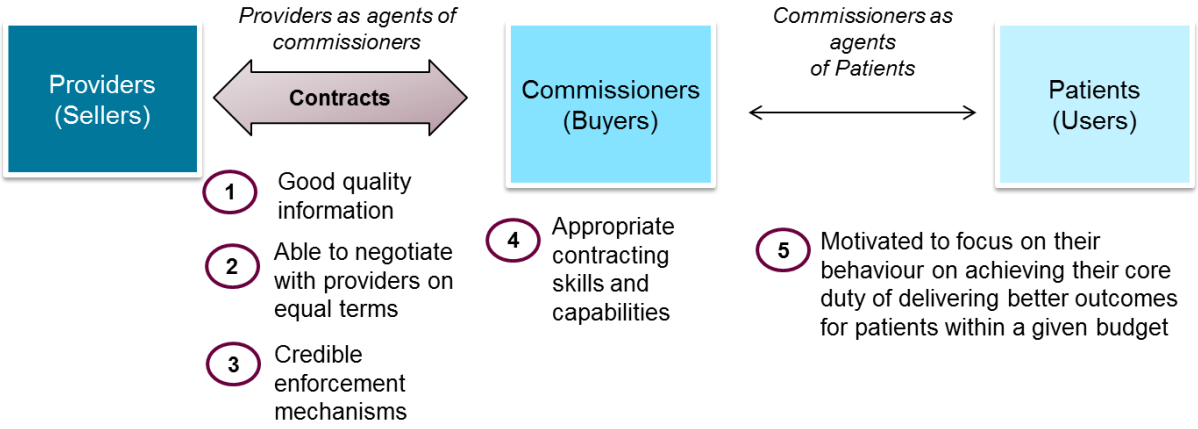
1.3 This research is intended to identify measures to support effective contracting by local commissioners

Commissioners need to:

- be motivated to focus their on their core duty to delivering better quality services and outcomes for patients for the budget available;
- have access to good quality information;
- have appropriate contracting skills and capabilities;
- be able to negotiate on equal terms with providers; and
- have access to and be willing to use credible enforcement mechanisms.

This is illustrated in Figure 1.3.

Figure 1.3: Summary of pre-conditions for effective contracting



CCGs are new to their role and now face a variety of significant challenges. We recognise they need support to improve contracting. Evidence gathered for this research paper on how local contracting is current being conducted should clarify what NHS England, Monitor and those in the wider health care system can do to help local commissioners on that journey.

In addition to setting out the evidence, this report describes:

- the strategic issues raised by our findings; and
- options for next steps for Monitor and NHS England concerning the redesign of the payment system.

How the research was conducted

The research is based primarily on 34 in-depth interviews with commissioners (mainly CCGs and a small number of CSUs in their role as agents for commissioners) and providers across England. They covered the following service areas: acute, specialist, mental health, community care and ambulance.[4] The interviews focused on a commissioner's largest contract with their main provider or, in the case of interviews with providers, their largest contract with their main commissioner.

While several consistent messages have emerged, there are a number of caveats associated with this research. It based on a relatively small sample, and the research also took place between March and May 2013, which was a period of significant upheaval in the sector, particularly for commissioners. The findings therefore do not necessarily represent a comprehensive view of the sector's practices.

[4] We also undertook a small pilot survey of commissioners and providers. As the response rate was extremely low the pilot survey was not extended to a wider group of providers and commissioners. We also undertook a review of the available empirical evidence on contracting for NHS-funded services. The main findings from this are set out in Section 2 (p.14).

Table 1.2 is a high level summary of the topics covered during the interviews. (See Annex 1 for a description of our research methodology.)

Table 1.2: Summary of topics covered during the in-depth interviews

Topic	Main issues covered
Approaches to developing local prices	The specific reimbursement approaches used, details of how prices have been established and agreed, and the main drivers of approaches taken.
Availability of information for local price setting	What quality/cost data is used to established prices, whether the relevant information is available to commissioners from providers or through other means, and the informational challenges providers themselves face.
Local price setting as a driver of quality and efficiency improvements	Whether (and how) local prices are being designed to encourage quality and/or efficiency improvements, and other contractual levers used by commissioners to try and improve quality and/or efficiency.
Approaches to risk sharing for locally priced services	The main risks commissioners and providers seek to manage and the approaches taken to risk sharing.
Nature and importance of relationships for locally priced services	The nature of contracting relationships and the influence these have on effective contracting for services with locally agreed prices.
Ex-post contract negotiations and disputes for locally priced services	The frequency and focus of in-year negotiations/disputes between commissioners and providers and the approaches taken to formalising any in-year agreements made.
Approaches to contract enforcement	Whether and how contracts are being enforced by commissioners.

2. Main findings

Summary

NHS commissioners' core duty is to deliver better quality services and outcomes for patients for the budget available. Yet achieving it can be challenging, especially when they face a demanding fiscal environment coupled with growing pressures on services.

In principle, commissioners should allow providers to recover the (efficient) [5] costs they incur in delivering services. In some instances, local contract approaches can be designed in a way that links the price that providers are paid to the quality of services as well as improvements in efficiency of provision. There may also, however, be some reimbursement approaches that may have the opposite effect by distorting the incentives that providers face to improve quality and efficiency.

Our in-depth interview programme with commissioners and providers (complemented by a review of the limited existing research on contracting in the NHS) identified a wide range of approaches that commissioners and providers are currently taking to local price setting and contracting, the drivers underlying these approaches, and the main challenges that commissioners and providers face with local contracting more generally.

We have grouped the findings into three main sections:

- **Section 2.1** sets out our general findings in relation to the types and frequency of usage of local contracting approaches, as well as the main underlying drivers of these approaches. We found that most local contracts are block contracts, particularly for community and mental health services. Where activity based prices have been agreed, many have been based on poor quality data and do not reflect the true cost of provision.
- **Section 2.2** sets out our findings on the central role that annual budget balancing requirements can play in motivating commissioners to focus more on budget management than on using local contracts to drive better quality services that are delivered more efficiently. We also found that:
  - recent changes to the system were consistently cited as a key reason for the slow progress in developing more sophisticated contracts; and
  - commissioners adopt different strategies for sharing demand risk using contracts and that that in practice risk sharing is often carried out informally between commissioners and providers.

[5] Efficient costs are those which provide a given level of quality and/or output with minimum waste of time and expense.

- **Section 2.3** discusses our finding that even in the absence of the budget balancing requirement there may still be a number of important challenges facing local price setting that could undermine efforts towards improving service quality and efficiency. We found that:
    - Commissioners use CQUINs as the main financial tool to encourage improvements in quality.
    - The main approach to efficiency in local contracts is to apply the same price deflator as used for nationally priced services.
    - The transaction costs of developing local activity-based tariffs can be high.
    - The degree and direction of cross-subsidies between services paid for through local contracts and those with a national price is unclear.
    - Relationships play an important role in determining the information imbalance between providers and commissioners.
    - Poor quality information is holding back efforts to improve local contracts.
    - Commissioners' contracting skills and resources put them at a disadvantage to providers.
    - Bargaining power is determined by several factors and can reside with commissioners or providers, although providers tend to have the upper hand.Mature and trusting relationships are currently critical to effective contracting but the nature of relationships varies widely.
    - Contracts are often renegotiated in-year and approaches to contract enforcement vary widely.

A thread that runs throughout is the importance of good working relationships in aligning local contracting with patient interests. The research suggests that, in practice, the quality of actual relationships can vary widely across commissioners and providers.

The findings of this research may not provide a comprehensive picture. Hence they should be considered alongside the broader body of work being carried out jointly by NHS England and Monitor on the overall payment system (including national prices) and how it could be redesigned to work better for patients.

2.1 Types of local contract approaches

FINDING 1: There is a broad range of approaches to developing local prices and different service segments can be grouped into categories of approach.

The interviews uncovered a spectrum of local price setting arrangements, which fall into three high-level categories, summarised below.

Block contracts

Block contracts do not vary with levels of activity. Overall, these were the most common type of local contract identified, and covered the largest volume of services: the interviews suggested that at least 90% of locally priced services were contracted this way in 2012/13 and 2013/14. We found examples of block contracts covering services both with and without a national price.

Several interviewees said that some of these block contracts were a "product of history", with their value based on the previous year's with a deflator/inflator typically applied to the whole contract value. Interviewees were generally unable to provide details of how the original value of the block contract was arrived at and agreed.

Local currencies and local prices

"Year of care" was the most common example of a currency[6] developed at a local level. Interviewees gave examples of year of care payment arrangements developed for contracts covering long-term specialised services, such as care for HIV patients, and for community services. This is the local currency that both commissioners and providers are most interested in developing further. We did not find examples of any other local prices being established for a locally-defined currency, only local prices for services with nationally mandated currencies.

National currencies and local tariffs

National currencies have been introduced in a number of areas. We found that local activity-based prices have been established for these currencies, some with marginal rates applied to activity above a specified level, for example, for critical care and ambulance services.

In general, the local activity-based prices established for these services were based on the full cost of provision at the time the currencies were originally introduced. However, interviewees highlighted that problems with cost allocations informing the

[6] In an NHS contract, a currency is a defined "unit" of health care to which a price is attached. NHS England is responsible for defining currencies for nationally priced services. A currency may define, for example, an activity, pathway, capitation level, provision of a particular service or patient outcome. A "year of care" defines an agreed scope of health care covered by a price per patient per year.

original currencies mean they do not always reflect the actual cost of provision, with some higher and some lower.

Price-setting in practice

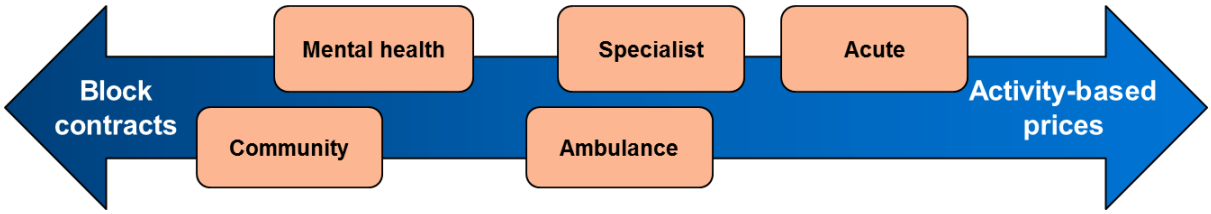
At the level of individual services, however, the price setting approaches used are often less clear-cut than implied by the overview above. Within each service type, and across England, a range of practices is used; for example there were several instances of contracts switching frequently between block contracts and activity-based tariffs.

In general, interviewees could provide few details on how prices (whether activity-based or block) were originally agreed. In most cases, this was because prices for a number of services had originally been set many years ago and a detailed rationale for how they had been set was unavailable. Some local activity-based tariffs were established as far back as 2004, when national prices were first introduced, while others were introduced more recently. This can make robust evaluation of effectiveness hard.

In addition, a number of providers indicated that, although cost data reporting is improving, at the time at which many of these local activity-based prices were originally agreed it was often of very poor quality. Provider costs do appear to be fully reimbursed at the whole contract level. Yet a number of providers noted that many of the prices set for individual services were based on poor quality data and did not reflect the true cost of provision. This suggests that cross-subsidisation between services is widespread among providers. It also implies that discussions between commissioners and providers about individual service level prices are likely to be difficult, since re-pricing can have important consequences for the sustainability of other services.

Despite the general finding that price setting approaches are relatively underdeveloped, the interviews also suggest that each service is at a different stage along the spectrum between block contracts and activity-based local reimbursement arrangements (See Figure 2.1).

Figure 2.1: Overview of where different types of services sit on the spectrum between block and activity-based contracts



While the approaches to local contracts identified by the interviews were varied, both within and across services types, there is a general consensus among both commissioners and providers that contracts should reflect actual costs and activity as well as drive service improvements. Both providers and commissioners conceded that currently this was not always the case.

In contrast, there is much less consensus among interviewees about the direction of travel that local contracts should take between activity-based prices and block contracts.

2.2 The impact of budget balancing on local contracts

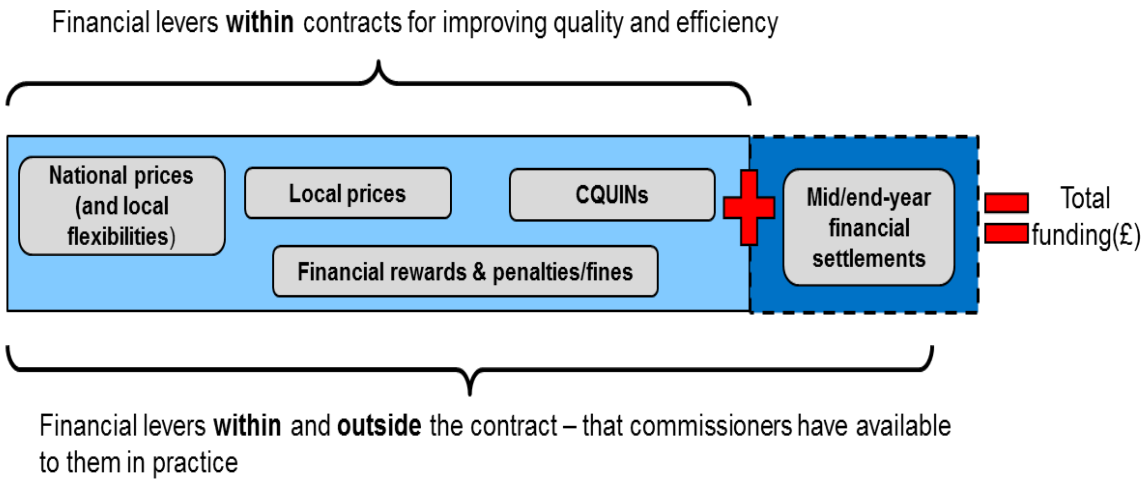
FINDING 2: Managing annual budget risk is a main driver of local price setting behaviour and so contracts do not always focus on promoting patient interests.

Our findings suggest that the requirement for commissioners to balance their annual budgets is the primary driver of local price setting and contracting approaches. More specifically, commissioners tend to manage their funding constraints by agreeing price setting and contracting arrangements that meet their short term objective of containing costs within a fixed financial "envelope" rather than on driving quality improvements and greater efficiency.

This means that local prices, along with other so called "in-contract" financial levers, often end up being used as budget management tools (see Figure 2.2). In some cases, the tools used can be particularly blunt. Some commissioners, for example, make mid and/or end-of-year financial settlements with providers – which are not necessarily part of the original contract value that was agreed – to ensure the total contract value fits within the financial envelope. These are referred to in this report as "out-of-contract" financial levers. "In-contract" financial levers include items such as:

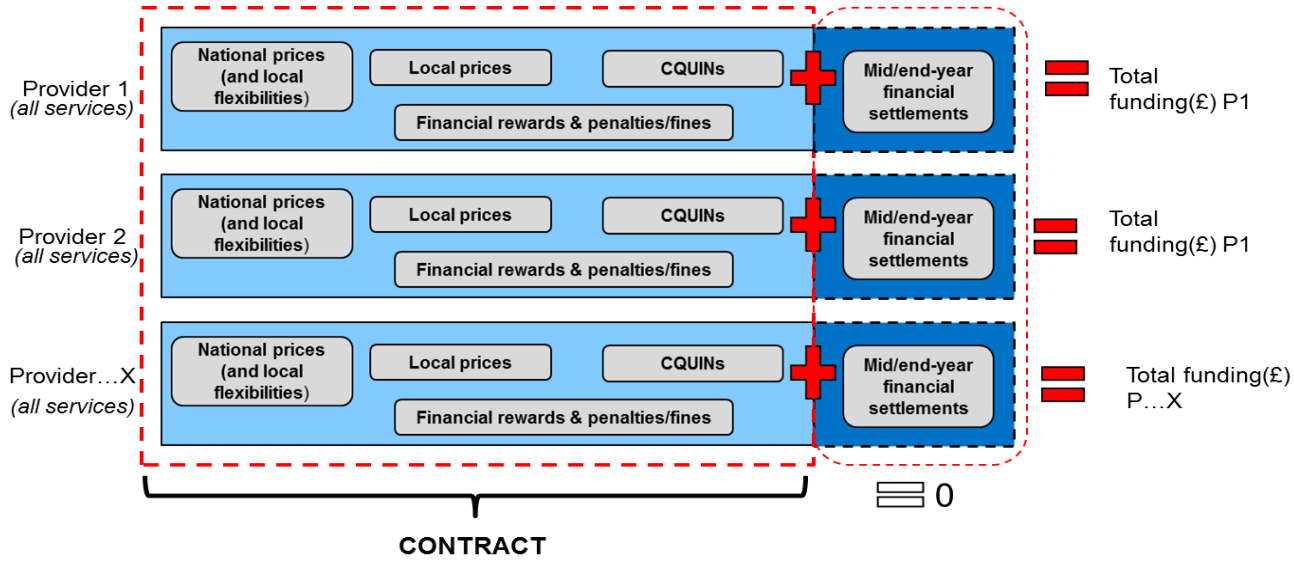
- local variations to national currencies and tariffs;
- local prices;
- the Commissioning for Quality and Innovation (CQUIN) payment framework, which enables commissioners to reward providers for excellence by linking a proportion of a provider's payment to the achievement of local quality goals;
- penalties or fines; and
- other types of rewards.

Figure 2.2: Overview of the spectrum of in- and out-of-contract financial "budget management tools"



As commissioners have to manage their affordability risk across all of the providers from whom they buy services, there is likely to be an important degree of interplay between providers in a commissioners portfolio on both the in-contract and the out-of-contract approaches the commissioners take to contracts in the portfolio as a whole (See Figure 2.3). Having to manage a local economy-wide portfolio of providers suggests that the financial position of one provider in a given local economy may be an important determinant of the contracting behaviour the commissioner adopts with its other providers. A commissioner's purchasing decision might be influenced by a feeling that it should support a local provider of essential services in financial difficulties.

Figure 2.3: Overview of local economy-wide affordability risks facing commissioners



A majority of those interviewed reported that the need to keep within their overall budget allocation often ”trumped” the local price setting arrangements. Even where commissioners and providers have worked together to develop activity-based tariffs for locally priced services, keeping within the overall financial budget means that in practice these are not always adhered to. In some cases locally agreed activity-based prices are bypassed by reverting to block contracts part way through the year if available funding is, or is expected to be, exceeded. One provider, for example, said that it had reverted to a block contract in 2013/14 for the provision of ambulance services; this was driven by the CCGs in order to help manage the risk that the 111 call service was unsuccessful. In contrast, many of these services were, in the previous 2012/13 contract, reimbursed on the basis of activity.

The focus on managing affordability risks was cited as a key reason for agreeing block contracts in the first instance, even by those who conceded that contracts should better reflect actual costs and activity as well as drive service improvements. Block contracts are often favoured as they are seen as an effective way to manage affordability risks and transaction costs. A lack of easily available and robust data was also cited as a driver underpinning the prevalence of block contracts, particularly for community and mental health services. However, the general sentiment among interviewees was that managing affordability risk is often such a high priority that even if good quality data existed the move away from block contracts in these areas would still be frustratingly slow.

FINDING 3: Recent changes to the system were consistently cited as a key reason for the slow progress in developing more sophisticated contracts.

The system has changed significantly over recent years. Most interviewees saw this as an important factor slowing progress in developing more sophisticated approaches to local contracts. In particular, the interviews revealed that in some instances commissioners have reverted to simple block contracts to:

- manage the transition to CCGs;
- create stability in order to achieve strategic aims; and
- enable the quick development of integrated care and/or care outside hospital.

Respondents also explained that the changes to the system have significantly affected contracts for specialised services. A number of providers and commissioners indicated that progress, both in terms of developing new tariffs and/or price renegotiations on existing tariffs, has been put off as a result of the uncertainty about the payment strategy that NHS England and Monitor will adopt.

Another finding was that the new commissioning organisations have disrupted many of the relationships that had been built over time between providers and commissioning teams at the now defunct PCTs. Staffing difficulties in PCTs were

highlighted in the interviews for this research as resulting in a lack of continuity in working relationships over time. This is consistent with findings in a recent empirical study by Allen et al. (2011).[7]

FINDING 4: Contracts are used to manage and share demand risk – often informally.

The interviewees identified unanticipated growth in activity as the main source of affordability risk that commissioners often seek to manage through the contract. This is clearly of most concern where providers are paid according to the activity they undertake. Unexpected growth in activity also poses important risks for providers. If they are unable to accommodate additional demand within existing capacity – and cannot turn patients away – they may have to invest further in order to generate this additional capacity. If they have to fund this additional investment out of their own income it will reduce their surplus, potentially pushing them into deficit, irrespective of whether they are reimbursed through activity-based tariffs or block payments.

In general, activity is monitored monthly against the forecast levels of activity that are agreed at the start of the year and are set out in the contract Activity Plan. Activity Plans also tend to include "forecast thresholds" for a given service line. These are intended to function as early warning signs: when providers' actual activity exceeds these thresholds the commissioner should be notified. Providers are expected to give the commissioner reasons for the over-activity and to ensure that appropriate remedies are put in place.

The interviews identified a range of approaches to sharing activity risks between commissioners and providers. In some cases activity-based contracts were used that exposed commissioners to the full risk from any unanticipated rise in activity. Although these were used in only a few cases, the interview findings suggest that those providers with a very high degree of bargaining power tended to be those most likely to be reimbursed on this basis.

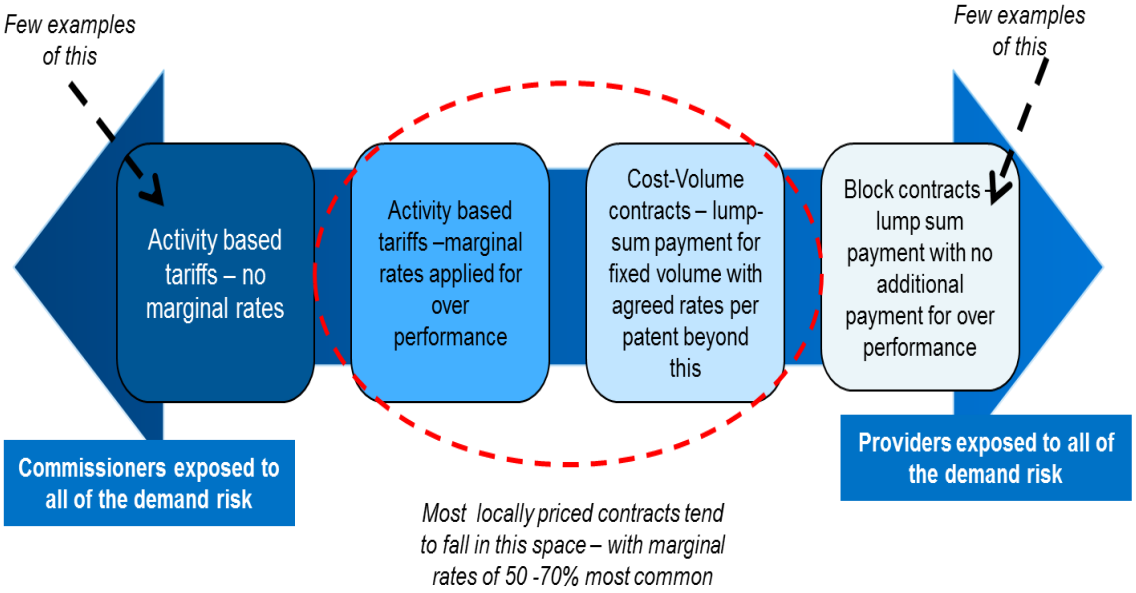
The interviews also identified approaches that transferred all risks to providers. This occurred with "pure" block contracts with no additional payments for unanticipated activity. Our findings suggest, however, that this can sometimes come at a cost to commissioners and, more importantly, to patients. In one example, an NHS foundation trust agreed to a block contract in which it would take on the activity risk in return for the commissioners agreeing to relinquish their right to impose fines on it. Although the contract did include clauses which technically gave the commissioners the ability to fine the trust, the provider told us that even if fines were imposed (eg, for missing CQUIN targets) there was an expectation that they would still receive the same overall income by having this money returned to them through alternative

[7] P. Allen et al. (2011), "The use of standard contracts in the English NHS: A case study analysis", *Journal of Medical and Social Science.*

means. More generally, it is possible that providers would seek to manage this risk by reducing volumes (eg, by increasing waiting times or increasing referral thresholds) which could be to the detriment of patients' interests.

In most cases, the formal approaches taken to risk sharing identified in the interviews tended to sit in between these two extremes (see Figure 2.4).

Figure 2.4: Summary of formal risk sharing approaches identified



Most commonly, the interviews found that commissioners seeking to share risks with their provider tended to apply marginal payment rates for performance above a pre-agreed level of activity (often known as over-performance). In some cases, these are applied to contracts with local activity-based prices, with providers paid a proportion of the full activity-based price for volumes above an agreed threshold. In other cases, a provider is paid a lump sum for any activity up to a fixed volume and marginal rates are applied to activity above that level. In general, the marginal rates agreed between commissioners and providers, for both activity-based and cost–volume contracts, were in the region of 50-70%. While considerable effort appears to go into reaching local agreements on marginal rates each year, these negotiations tend to focus on activity forecasts and at which level of activity the marginal rate kicks in, not the rate itself.

There were some differences in the ways that commissioners viewed these types of arrangements in contracts. Some regarded in-year negotiations and "freeze points" (ie, reverting to a block contract) for activity-based contracts as the most effective way to manage activity risk while others found in-year negotiations to be a distraction and drain on resources which could be avoided through better upfront contract design.

These findings are consistent with evidence from other research studies. These found that, in practice, risk-sharing between providers and commissioners often

involves “non-contractual” solutions and relational contracting creating in-year compromises that sometimes ignore contractual provisions.[8]

2.3 Additional challenges facing local contracting

This section summarises the key findings on factors – aside from annual budget management – that are likely to be undermining the role that local price setting could play in delivering improvements to service quality and efficiency.

FINDING 5: Commissioners use CQUINs as the main financial tool to encourage improvements in quality.

In theory, there are a number of local price setting arrangements that could be developed to improve quality. These include best practice tariffs, outcome-linked tariffs, pathway tariffs, year of care tariffs, or payments to encourage experimentation with service design. However, our findings suggest that local price setting arrangements themselves are rarely designed with an explicit focus on incentivising improvements in quality. This does not imply that commissioners fail to consider quality. Rather, the interviews suggest that commissioners tend to rely on the Commissioning for Quality and Innovation (CQUIN) framework as their main financial lever for rewarding improvements in service quality.[9] To a lesser extent, commissioners also used financial penalties attached to key performance indicators (KPIs) as a tool for encouraging improvements in quality.

A number of those interviewed were pleased with the CQUIN framework. For example, they applauded its effectiveness in attracting the attention of finance directors, which helps encourage providers to focus on improving quality in areas directly linked to CQUIN income. However, the interviews also highlighted pitfalls of the current system of CQUIN payments. Some interviewees, mainly the providers and experts we spoke to rather than commissioners, noted that:

- the list of local CQUIN targets can sometimes be so long that the financial incentive applied to each target ends up being relatively small;
- CQUIN targets may be set out in the contract but they sometimes lack input from clinicians and are not communicated to front line staff so are ignored;
- CQUIN negotiations can be highly resource intensive and divert attention away from the development of local activity-based prices; and

[8] P. Allan et al. (2012), “Study on the use of contractual mechanisms in contracting”, *Policy Research Unit in the Commissioning and Healthcare system.*

[9] The CQUIN payment framework is a mandatory aspect of all NHS standard contracts. CQUIN payments up to a maximum of 2.5% of the contact value are made to providers if they meet a set of national and locally set quality targets. 20% of this is linked to national targets and the remainder (0.5 % of the contracts value) to local CQUIN goals.

- year-on-year changes of CQUIN targets and indicators gives providers too little certainty to make sustained efforts towards meeting targets and to institutionalise changes in organisational behaviour.

Findings from the interviews also suggest that CQUINs are sometimes paid upfront to providers, at least in part, regardless of whether quality performance thresholds are met. In one case, an NHS foundation trust was guaranteed 70% of the total CQUIN payment regardless of performance with just the remaining 30% linked to performance.[10]

Many of these issues with the current operation of CQUIN are consistent with the findings of a recent evaluation of the CQUIN framework carried out on behalf of the Department of Health in 2013.[11] [12] This report also emphasised that staff on the commissioning side of the process involved in negotiating CQUIN schemes often had little or no knowledge of other financial levers available to them to help deliver better quality services. The report suggested that this may be a result of the way communication flows between commissioners and providers, resulting in a lack of joined-up thinking about the variety of levers available.

FINDING 6: The main approach to efficiency in local contracts is to apply the same price deflator as used for nationally priced services.

The predominant approach taken by commissioners to encourage providers to make efficiency improvements is to apply the efficiency deflator set for national prices to the local contract value (whether activity-based or block contracts). This approach is consistent with the advice set out in earlier guidance for locally priced services from the Department of Health.[13]

However, where commissioners take a different approach to managing their financial risk, they sometimes create disincentives for providers to improve efficiency. For example, one trust was required to retain a historical block arrangement for its community services, so that the commissioner could cap its exposure to financial risk. According to the trust, this has inhibited transfer of patients between the community and acute services. This is because activity-based prices for acute services give the provider an incentive to treat patients in an acute setting although it

[10] In this particular case, the provider also noted that large discounts had been applied elsewhere in the contract although it was not clear whether the guaranteed component of the CQUIN payment was agreed in return for these contract discounts.
[11] R. McDonald et al. (2013), *Evaluation of the commissioning for Quality and Innovation Framework – Final report*, University of Nottingham and the University of Manchester.
[12] This author obtained copies of every CQUIN scheme from a large majority of providers and explored the process surrounding CQUIN using observations of 373 meetings in 12 case study sites, as well as 230 formal interviews with NHS staff from those sites. Formal conversations were also conducted with NHS staff immediately prior to or just after meetings.
[13] *Payments by Results Guidance for 2013-14*, Department of Health. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214902/PbR-Guidance-2013-14.pdf

may be more cost effective (and perhaps better for the patient) to treat in a community setting. Some providers also noted that certain commissioners often try to claw back any efficiency savings by trying to negotiate lower prices the following year, and so create a disincentive for providers to make efficiency savings in the first place.

We saw only one example where a commissioner had tried to encourage greater efficiency through the local reimbursement structure. The commissioner agreed with the trust to a one year non-recurrent 50:50 efficiency saving arrangement for any cost reductions achieved for high-cost drugs. These were reimbursed on a pass-through arrangement.[14] We found no examples, however, of any similar approaches applied to the delivery of clinical services.

A small number of commissioners were keen not to get drawn into discussions about how providers deliver efficiency improvements. In their view, it is their responsibility to ensure that the provider maintains quality while delivering required efficiency savings. They believe how this is done is the responsibility of the provider, not the commissioner.

FINDING 7: The transaction costs of developing local activity-based tariffs can be high.

Developing more sophisticated contracts for services, especially those involving activity-based prices, can be time consuming. It often requires a lot of good quality information. This can be costly to generate where systems to collect it are not currently in place and building such systems can result in lengthy negotiations and disputes. These costs are amplified where the process for setting local prices includes developing local currencies.

[14] Normally, if a patient's drugs cost £100, providers would pass the entire bill straight onto the commissioners. In a 50:50 deal, if the commissioners buy the drugs for £50, saving £50, then they keep £25 of this saving and the commissioner only pays out £75 in total, so both sides win. The cost of drugs is included or excluded from locally priced services in a manner consistent with the rules applied to national prices.

Interviewees identified a number of other factors that tend to exacerbate these transaction costs:

- Local service currencies often vary, making it hard for commissioners to compare data on prices agreed between commissioners and providers in other areas. It also makes it difficult for a provider to benchmark their own performance against that of other providers. Without comparable currencies, commissioners have to invest more in getting data from their provider. For example, they may have to establish prices through a bottom-up costing exercise and negotiate the margin. Such cost information may be more or less forthcoming from a provider depending on their relationship with the commissioner.

- Even where standardised currencies exist, agreeing prices for those currencies can be hard if there is no reference cost data. Both commissioners and providers often use reference cost data to help establish local prices as reference costs are transparent and independent. Although both commissioners and providers are aware of problems with reference data arising from, for example, discrepancies in cost allocation methods used by different providers, both acknowledged that this data was often better than nothing.

Several commissioners and providers noted how these transaction costs often reinforce the appeal of block contracts. For example, both commissioners and providers noted that avoiding activity-based prices meant they had far fewer things to negotiate and argue about each year.

Not only do high transaction costs discourage initial setting of individual activity-based prices for services, they also tend to discourage commissioners from systematically revisiting agreed prices to make sure they are getting value for money from these services. This is particularly the case where the affected services represent a relatively small proportion of a commissioner's overall contract value with a provider. Rather, providers and commissioners tend to select carefully a small sub-segment of services they wish to renegotiate. Providers will select services they believe are being under-funded and where they believe they can make the most gains from a price renegotiation. Similarly, commissioners will select those services they believe they are over-funding and where they believe they can make the most savings from renegotiating the price. In practice, some requests to renegotiate prices will be rejected and others accepted, with generally a large degree of "give and take" between commissioners and providers.

FINDING 8: The degree and direction of cross-subsidies between services paid for through local contracts and those with a national price is unclear.

The interviews suggest there may a high degree of cross-subsidisation between services with and without a national price. However, this cross-subsidisation may take place in both directions. Local payments are sometimes used to help to offset all or part of the budgetary impact of unexpected yearly volatility in national prices. Interviewees also told us that, in some cases, this volatility (combined with other problems with the current payment system) means some national prices are simply not applied at the local level. This finding supports evidence gathered by PwC in their recent evaluation of the reimbursement system in the NHS.[15]

The interviews also suggest that local price setting approaches have sometimes been adjusted to offset the impacts of overall increases in national prices as well as yearly volatility. Sometimes local prices are adjusted immediately, to neutralise the rise in national prices and keep the total annual contract value constant. In other cases, the losses and gains from changes in national and local prices are netted off over a longer period (often 1-3 years).

Some commissioners have found that incrementally "unpicking" services contracted on a block basis to introduce activity-based prices tends to be inflationary. This has made them wary about moving more services to this payment approach. What is not clear, however, is whether unpicking all the services in a provider contract paid for on a "block" basis would raise the overall cost of the contract. The outcome is likely to depend on the size and direction of any cross-subsidy between services in the current contract that are locally priced and those with a national price, and the extent to which providers can use information asymmetries to their advantage. For example, the net impact would be inflationary if:

- providers are using income from services with national prices to cross-subsidise underfunded locally priced services;
- detailed examination of a service in the contract identified poor quality as a result of underfunding, which the commissioner would have to pay more to correct; or
- providers were using local contracts as a means to recover all or part of their fixed costs, whether or not they were also spreading some of these costs across nationally priced services.

This study identified some instances of the third example. However, what was not clear was whether providers were recovering a disproportionate amount of their fixed

[15] *An evaluation of the reimbursement system for NHS funded care* (2012), a report for Monitor by PwC.

costs through local contracts because they were unable to recover a proportionate amount of these costs from their nationally priced services. In addition, it was unclear whether providers were doing this deliberately or were simply double counting because they had a poor cost allocation system.

FINDING 9: Relationships play an important role in determining the information imbalance between providers and commissioners.

The interviews highlighted that effective local contracting depends on the following information:

- a clear and detailed definition of services (including the activities that are included within the service, resource requirements and the outcomes desired);
- data on expected activity levels for the year ahead;
- data on the costs of the services (including information to enable commissioners to benchmark provider costs for the service); and
- data on quality.

The provider is the source of much of this information.

There were mixed views among providers on how much information they should share with their commissioners. Some providers were generally reluctant to share all relevant information with commissioners out of concern that commissioners might use this information against them in both current and future price negotiations. However, other providers have pursued a relatively “open book” arrangement whereby they share most or all of the information they have with their commissioners. These providers generally see no commercial disadvantage in sharing data that is not outweighed by the benefits of a stronger relationship. Providers and commissioners in such relationships described them as long-term and based on trust.

FINDING 10: Poor quality information is holding back efforts to improve local contracts.

Our interviews confirmed recent evidence that some providers themselves have poor information systems. This means they do not always have a good understanding of their own business costs, particularly the specific costs of delivering individual services to individual patients. As a result, neither commissioners nor providers always have the cost information they need to price services appropriately. For example, one trust’s poor quality data made monitoring monthly activity very challenging so it failed to agree an activity plan with its commissioner. They eventually resolved the resulting stalemate by agreeing a block contract, which

included not only services without a national price but also services with nationally mandated prices, bypassing current rules on national prices.

Interviewees highlighted a number of information sources that they draw on to establish the costs of delivering a specific service or set of services. These are set out in Table 2.1 along with issues about their usefulness that interviewees raised.

Table 2.1: Types of information used to establish services costs and associated issues

Type of information	Issues raised by interviewees
Reference costs	These are sometimes used to benchmark costs where information on provider costs is not available or of unreliable quality. Even where relevant information from a provider is available, commissioners can sometimes prefer to base prices on reference costs because the latter are public, transparent and independent. However, problems with the quality of reference costs (for example, inconsistent or inaccurate approaches among reference cost providers to assigning costs) are widely recognised. This means that some commissioners and providers opt not to rely on them, while others found them helpful only as a starting point for negotiations. In addition, reference cost data are less useful where local currencies differ, making it hard to compare like with like. Reference prices are also not available for all services. In these cases, commissioners can only rely on data from the provider.
Non-mandatory prices[16]	A number of interviewees used these as the basis on which they negotiated prices. However, providers are often understandably reluctant to use them where they are lower than the price providers currently receive. Commissioners are similarly unwilling to refer to them where they are higher than the price commissioners currently pay.
Bottom-up cost modelling	This approach was popular for setting prices for new services where both reference cost data and non-mandatory tariffs were unavailable. However, this approach can be subject to challenges about the quality of the data used and commissioners do not always have confidence in these data.

[16] The Department of Health's Payment by Results guidance includes a small number of prices and currencies that are not mandated, which can be used to help local contracting.

FINDING 11: Commissioners' contracting skills and resources put them at a disadvantage to providers.

A number of interviewees, both providers and commissioners, suggested that commissioners are often at a disadvantage to providers in terms of both the scale of available resources (ie, staff and time) and the skills and capabilities of those contracting teams. Both sides acknowledged that this can give providers the upper hand in contract negotiations.

The interviews identified two main reasons for this disadvantage:

- **High staff turnover.** One provider noted that five different people had led their contract from the commissioning side in the past year. The provider observed that, once the dissolution of PCTs was announced, the PCT must have lost staff more rapidly than usual and found it harder to attract high quality replacements.
- **Limited experience of having worked on the provider side.** A number of providers felt that commissioners typically had little experience of working on the provider side. Lacking this experience makes it difficult for commissioners to understand how to achieve greater value through their contracts. Such experience would help them, for example, to know what additional information to ask for and put them in a strong position to challenge the information provided.

In contrast, the providers we interviewed often had developed and experienced contracting teams staffed by people with several years or even decades of experience in negotiating NHS provider contracts. However, this was not always the case. We also found large variations in the size and experience of contract teams, even among providers of a similar size.

FINDING 12: Bargaining power is determined by several factors and can reside with commissioners or providers, although providers tend to have the upper hand

Bargaining power can affect contract negotiations both before and after the contract is officially agreed. Differences in bargaining power will be reflected in, for example:

- any price discounts or increases negotiated before and after official agreement;
- the type of payment approach (eg, block or activity-based) and the degree of risk sharing (eg, sharing the impact of unanticipated increases in demand); and

- the type and scale of targets (eg, on quality – such as CQUIN or KPIs – and/or on efficiency) that are negotiated.

In general, the interviews suggested that providers have more bargaining power than commissioners. Not only do providers tend to have information advantages over commissioners, they are often at a relative advantage in terms of contracting skills and capabilities.

In addition, the role and influence of the Strategic Health Authorities (SHAs) in disputes have, on occasion, favoured providers. For example, if a trust was on a path to NHS foundation trust status, the SHA might try to remove any obstacles in its way such as risks to financial performance. Commissioners were also influenced by the need to keep the provider financially viable and stable, particularly those applying for foundation trust status. This inhibited many commissioners from pursuing a more aggressive negotiating strategy. We found almost no examples where bargaining power resided with commissioners rather than providers.

FINDING 13: Mature and trusting relationships are currently critical to effective contracting but the nature of relationships varies widely.

One of the most consistent messages from these interviews and earlier studies of contracting in the NHS is that the nature of the relationship between providers and commissioners is currently extremely important to the design, negotiation and implementation of contracts.[17] For example, the interviews highlighted the extent to which relationships determine how much information providers are willing to share with commissioners. Interviewees typically described strong relationships as "trusting", "open", "responsive" and "with aligned values". They suggested that good relationships provide a means for negotiating change and heading off disputes before they become litigious. In contrast, interviewees noted that when a relationship had broken down, reaching agreement became far more challenging.

Almost all interviewees, on both the commissioner and the provider sides, emphasised their desire to avoid both disputes and the need for contract enforcement. However, while the interviews suggested that formal disputes are rare, not all relationships are working well. Some were more formal and a few openly adversarial.

These findings are consistent with the 2011 study by Allen et al., which found that personal friendships between directors of finance on both sides of a contract on

[17] This is likely to be particularly true for less detailed or "incomplete" contracts. For example, according to Williamson (1999), "Faced with incomplete contracts, governance mechanisms that facilitate cooperation (through ex post gap filling, dispute settlement, and cooperative adaptation) take on importance as contractual hazards build up." Williamson, Oliver E. 1999. Public and Private Bureaucracies: A Transaction Cost Economics Perspective. *Journal of Law, Economics, and Organization* 15, no. 1:306-342. (p. 321).

occasion helped their respective organisations to reach mutually acceptable agreements.[18] Supporting the findings from our interviews, this study also found that:

- commissioner/provider relationships ranged from formal to civil to very friendly, with a continuing back and forth between formality and the informality that promotes practical working relationships; and
- the absence of competition also affected contractual relationships. In most cases, both commissioners and providers saw no competitive alternatives to each other. Their mutual dependence meant they had to make arrangements work. If relationships did break down, many turned to SHAs and Monitor for assistance.

Many current NHS contracting relationships are fairly new and it is not yet clear how they may evolve. In addition, the introduction of CSUs has added a new dynamic to the provider/commissioner relationship.[19] At the time of our interviews, however, CSUs were very new and it was not yet clear what specific role they would be taking in negotiating and leading contracting discussions as part of their new intermediary role in the commissioning process.

Interviewees also suggested that the new, clinically-led commissioning groups (CCGs) have started to challenge the status quo. Some acute providers believe that CCGs are better placed to identify opportunities to improve patient outcomes for the budget available than their predecessors. However, in general, providers still doubt whether CCGs are adequately resourced to cope with the challenge they face.

FINDING 14: Contracts are often renegotiated in-year and approaches to contract enforcement vary widely.

Once a contract is signed there is still a considerable amount of in-year negotiation and reconciliation. Common topics for in-year discussions and/or disputes include:

- **Activity volumes, charging and coding.** These issues arise particularly in contracts with activity-based prices. Discussions are generally about managing pressure on commissioners' budgets. For these types of contracts, quarterly contract negotiations and "freeze-points" are not uncommon as a means of ensuring the overall contract value does not push commissioners into deficit. Freeze points often lead to suspending activity-based tariffs and reverting to a block contract for the rest of the year.

[18] P. Allen et al. (2011), "The use of standard contracts in the English NHS: A case study analysis", *Journal of Medical and Social Science.*

[19] CSUs are designed to offer efficient, locally-sensitive customer facing services to CCGs. NHS England identifies several areas in which CGGs are likely to need support including: transformational commissioning functions such as services redesign; and transactional commissioning functions such as market management, health care procurement, contract negotiation and monitoring and information analysis.

- **Value of local activity-based prices.** Commissioners and providers sometimes try to renegotiate prices after the contract has started. In practice, some of these requests will be rejected and others considered. What tends to result is a process of give and take between commissioners and providers, both within and across contract periods.

As noted above, commissioners and providers generally avoid formal negotiations and disputes. So unless the relationship has completely broken down, in-year discussions often take place informally. One commissioner noted that their renegotiations are not reflected in formal amendments to the original contract, only in an email trail (though this is still legally binding). In another case, however, a provider said that their renegotiations were both formalised in writing and so common that they had their own templates.

With respect to contract enforcement, the interviews and the empirical literature suggest that commissioners use a variety of approaches, particularly when enforcing financial penalties. Overall, our findings indicate that commissioners try to balance maintaining good relationships with holding providers to account. Where possible, commissioners generally avoid taking formal enforcement action against providers, such as imposing fines or penalties for failing to meet targets, despite the risk that penalties then lose credibility as a threat. The interviews suggested three main reasons for this:

- commissioners recognise the value of joint working and so rather than fining providers for failing to meet contract terms they prefer to collaborate to solve problems;

- commissioners felt that imposing financial penalties could sometimes exacerbate providers' performance problems; and

- an SHA's concern about the financial viability of providers applying for NHS foundation trust status sometimes discouraged commissioners from taking enforcement action.

Nevertheless, some commissioners were generally enthusiastic about using financial penalties. A number of the providers interviewed had also recently experienced financial penalties, particularly for failing to meet CQUIN targets.

3. Conclusions and next steps

This research has identified a number of specific challenges that local commissioners currently face in contracting for services with no national price. These challenges may mean that in practice local contracting behaviour does not always promote the best outcomes for patients for the budget available.

In general, our research suggests that commissioners:

- are under strong pressure to manage their budgets annually, so their incentives may not always be fully aligned with patients' interests;
- often lack the information they need to contract well and providers are not always willing or able to share it;
- are sometimes in a poor position to negotiate with providers on equal terms; and
- can find it hard to enforce contracts since they do not always have the information they need and may fear destabilising a local provider.

As a result of these issues, our research suggests that commissioners often rely on good relationships with their providers to contract effectively.

In contrast to their agreement on the problems, there was much less consensus among our interviewees about whether local contracts should move towards more activity-based prices and less pricing on a block contract basis. Some interviewees were keen to move towards having more services covered by nationally mandated prices because this would:

- reduce the transactions costs incurred in setting local prices;
- help to facilitate and improve dialogue between providers about service redesign; and
- help to incentivise providers to make more efficiency improvements by allowing providers to benefit from these savings for longer than under local price setting (as it would reduce the scope for commissioners to claw these savings back soon after the savings are made by seeking to renegotiate prices).

However, other interviewees were more sceptical about moving away from local price setting to more activity-based national prices for several reasons. National prices:

- reduce commissioners' control over their expenditure, compounded by the significant volatility in national prices year on year;
- leave commissioners less scope for allocating risk to providers; and
- leave less scope for service innovation (eg, developing prices for pathways that cut across existing service boundaries).

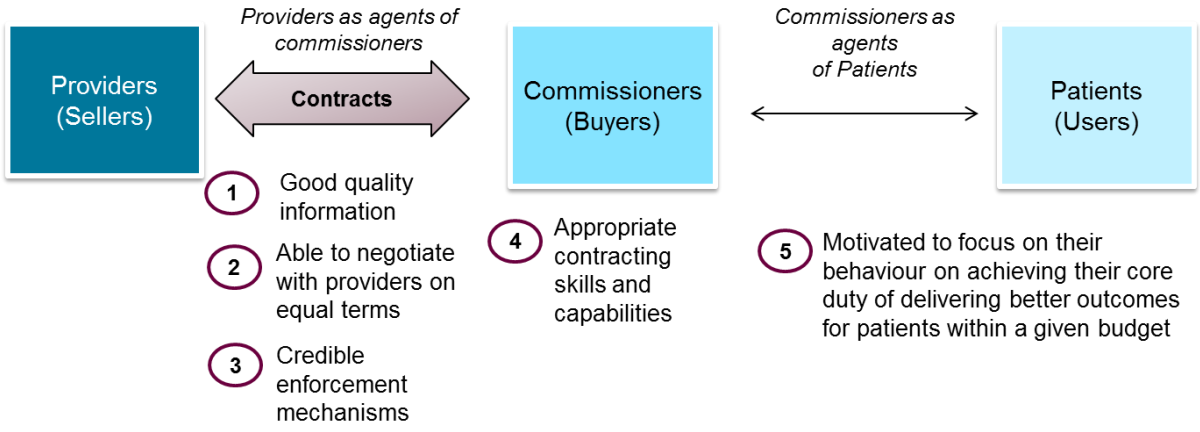
While this research highlights a number of challenges to effective local contracting for services with no nationally determined price, it only provides a partial insight into challenges facing the wider payment system. There is a large body of evidence indicating that the part of the current system covered by national prices face similar issues. For example, a report by PwC for Monitor evaluating NHS payments highlighted several problems primarily relating to the significant and unexplained variation in the data used to calculate prices. This leads to significant annual variation in prices which undermining incentives and leading providers and commissioners to abandon activity-based prices.

Implications of our findings on delivering better care for patients

Our findings raise a number of important issues about the role that local contracting currently has in delivering better quality care for patients.

These can be categorised according to the set of conditions that we know are important for effective contracting (see Figure 3.1 below).

Figure 3.1: Summary of the pre-conditions necessary for effective local contracting



3.1 The pressure on local commissioners to balance annual budgets may act as a barrier to improving patient care

Commissioners are required to deliver better outcomes for patients for the budget available. However, they face particularly strong pressure to meet annual budget targets. These annual allocations coupled with a lack of flexibility to run deficits or carry surpluses across financial years can make it difficult for commissioners to make longer-term planning decisions that commit resources and involve some element of risk but could lead to improvements for patients. In the context of local contracts, this is likely to be particularly relevant where local reimbursement approaches designed to improve quality and efficiency require the redesign of a local service over a number of years which may require running deficits across financial years.

These constraints do not necessarily imply that the local contracting approaches currently taken by commissioners are compromising quality. Rather, the general result appears to be that local contracting approaches focus on maintaining the status quo in terms of quality and efficiency instead of seeking ways to improve both further. However, the conflicting incentives that commissioners face as a result of these systemic constraints have important implications for the effectiveness of NHS England and Monitor's regulatory levers, and these need to be explored further.

Some of the problems arising from the misalignment between commissioners' budget-balancing objective and patients' interests could be alleviated by making local contracting arrangements more transparent. This could help improve accountability for the local contracting decisions of commissioners, as the rationale and process for these decisions are currently very opaque. However, efforts to improve transparency are likely to face several hurdles, including that:

- there has been little transparency in local price setting arrangements so far, so introducing more would require significant changes in behaviour; and
- prices are often renegotiated during the contract term so the form and value of local reimbursement applied in practice may bear little resemblance to the original contract.

3.2 Commissioners do not always have access to good quality information

Our findings suggest two types of problem associated with information in local contracts:

- the information available on costs and activity for both individual providers and nationally (for benchmarking purposes) is often of poor quality; and
- providers are not always willing to share their information with commissioners.

Information quality

Providers often lack good information about service quality and costs. For example, they do not always have a detailed understanding of the costs they incur providing individual services and/or service bundles. Without good information on quality and costs, local price setting approaches are less likely to be effective in driving improvements in quality and efficiency. Although providers are increasingly adopting more sophisticated cost recording and allocation techniques, such as Patient Level Information Costing Systems (PLICS), most still lack a detailed understanding of the costs they incur at the patient or even at the individual service level.

This suggests that:

- in many cases prices in local contracts may not reflect the true cost of provision;
- it is very hard for both providers and commissioners to determine how efficiently individual services are being delivered and so to identify where efficiency improvements can be made; and
- even if providers share cost information, commissioners are not always able to trust it enough to use it.

The lack of good quality information at the provider level also indicates that there is likely to be a high degree of cross-subsidisation between services lines (including between nationally and locally priced services), which may also vary between providers. The potential scale and direction of cross-subsidisation taking place is difficult to quantify and the financial impact on individual providers and commissioners of expanding activity-based pricing (whether nationally or locally) is potentially very hard to predict. For example, if national prices were expanded to include a service previously on a block contract that used to cross-subsidise other services, then either:

- some local services or, on occasion, providers might become unviable; or
- remaining locally priced services would have to be renegotiated to make up for the shortfall in overall income.

This does not mean that unravelling these cross-subsidies would not be worthwhile. Prices that do not accurately reflect costs act as poor signals for the efficient allocation of resources by providers and commissioners. In addition, the ability of providers to cross-subsidise loss-making and inefficiently-provided services may also affect competition to provide these services. For example, it may make it difficult for alternative providers who do not have a cross-subsidy to compete as they will not be able to provide those services at the same price or level of quality.

Information asymmetries

In most cases, providers own the information commissioners need to contract effectively. The research suggests that some (though not all) withhold useful information from their commissioner, with effects similar to those of poor quality information: commissioners do not always have a good understanding of the services they are purchasing, the quality of these services, nor how efficiently they are being provided. This obliges commissioners to rely on other means to address information gaps such as benchmarking provider costs and prices against those in other localities. However, this can be very difficult:

- local currencies may vary significantly, which may make comparing information across providers hard; and
- there have been few examples of commissioners sharing information with each other to support local price setting.

As with the incentive alignment problems highlighted above, this could be made easier if contracts were more transparent, though this would require significant changes in behaviour.

3.3 Commissioners do not always have access to the right contracting skills

Our research suggests that commissioners may need additional support to equip themselves with the contracting skills and capabilities they need to negotiate local contracts that fulfil their potential to deliver better outcomes for patients for the budget available. Improving these skills will also help commissioners exploit any bargaining power they have over providers in negotiating local prices and payment terms, as well as contract terms more generally. Problems we have identified include:

- a lack of understanding as to how local prices can be used to complement CQUIN objectives;
- a high degree of variation in approaches to risk sharing that may not be explained by variation in uncertainty and commissioners' risk appetites; and
- a potential lack of clinical engagement in local currency design.

The research suggests that some commissioners do not consider how to use local price setting approaches as a lever that complements the objectives of CQUIN for delivering quality improvements. As more nationally priced services have quality incentives embedded in their reimbursement structure, patients of locally priced services may find themselves at a disadvantage in terms of service quality improvements. In addition, our research suggests that the CQUIN framework is sometimes applied by local commissioners both inconsistently and in a way that does not support its original intentions.

Secondly, effective risk sharing between providers and commissioners will help to ensure that both have the right incentives to deliver better quality services for patients more efficiently. However, our research has highlighted a high degree of variation in the approaches being taken to this. This may, in part, reflect different appetites for risk among commissioners. We also know that not all risks can be identified before the event and our research indicates that risk sharing agreements are often pragmatic responses to events that materialise during the contract. However, the variability of agreements and the time and resources required to negotiate them suggest there may be a lack of expertise in establishing effective contractual risk sharing mechanisms. There may be value in exploring whether any work on constructive engagement[20] could and should cover this.

The recent establishment of CSUs introduces a new relationship to the contracting process as well as potentially changing the relationship between providers and commissioners.

3.4 Commissioners are not always able to negotiate with providers on equal terms

For commissioners to be able to contract effectively, they need to have at least as much bargaining power as providers. However, this research suggests that providers tend to have better information and contracting skills, which means that bargaining power is often biased in their favour. This could pose risks to patients' interests if providers exploit their bargaining power by negotiating, among other things, higher prices and/or fewer or less stringent performance targets. They may also use this power to shift excessive contract risk onto commissioners.

Supporting the availability of more and better quality information and the development of better contracting skills in the ways identified above may be important in helping to ensure a balance of bargaining power between providers and commissioners.

3.5 Transaction costs are often very high

In general, establishing more sophisticated contracts, such as those including activity-based local prices, can be a very costly process for both commissioners and providers in both time and resources. The transaction costs associated with reviewing and renegotiating prices or other contractual terms (such as key

[20] Constructive engagement refers to how providers and commissioners work with each other to decide on the best service mix, delivery model and payment approach for patients. To engage constructively, commissioners and providers must: agree a framework for negotiations in line with existing guidelines on the standard contract; share information in a timely and transparent way; involve clinicians in decision-making; and define short- and long-term objectives before they starting negotiating.

performance measures) can also be very high. For example, commissioners and providers are very reluctant to review activity-based local prices every year, reflecting a rational response to these transaction costs where they are estimated to be larger than the expected benefits. This can result in beneficial price stability, which leads to more effective planning and investment decisions, but left too long it can also mean that prices are not updated to take account of efficiency improvements.

Many of the challenges that commissioners face in local contracting such as poor quality information, information asymmetries, weak contracting skills, weak bargaining power and poor contracting relationships, are inflating the already high transaction costs associated with establishing local price setting agreements and reviewing them regularly. This does mean that relieving these problems may help lower transaction costs.

3.6 Contract enforcement is not always credible as commissioners are sometimes unwilling to use financial sanctions

The reluctance by some commissioners to enforce contracts for fear of exacerbating provider problems in the short-term may be driving poor incentives in the longer-term. This reluctance may be a rational response to genuine concerns about providers' sustainability and the quality of and access to services for local patients in the short term. However, it may generate perverse incentives for providers in the medium to longer term. The lack of a credible threat of enforcement may undermine providers' incentives to make the investments and changes to their business practices necessary to ensure that they meet the targets commissioners set for them in the first place.

However, balancing this trade-off will be challenging, partly because it raises the question of what the most appropriate mix of incentives and sanctions should be. Furthermore, the issues uncovered by this research about contract enforcement concern all services, irrespective of whether they are locally or nationally priced, and therefore are relevant to the incentives NHS England and Monitor may introduce into both national prices and local price setting rules.

3.7 Commissioners often rely on good relationships to overcome many of these challenges

Contracting in health care markets tends to be relational rather than transactional. This research illustrates how crucial good, mature and trusting working relationships can be for effective contracting, by helping to alleviate several of the main challenges. For example, they can help to balance informational asymmetries between providers and commissions by encouraging providers to share more information with their commissioners, in contrast to more transactional, adversarial and less trusting relationships, which tend to do the opposite. They can also be extremely important in helping commissioners and providers to work together (in a

way that is consistent with the statutory framework on procurement, choice and competition), when redesigning services for patients. Good relationships can also help to reduce many of the transaction costs associated with local price setting as well as focus the attention of providers and commissioners on promoting better patient outcomes.

The research also suggests that good relationships may be extremely valuable in two cases.

- Where there is significant uncertainty about what might happen during the course of the contract meaning that contracts must be open to re-negotiation to take account of unexpected events (such as severe weather conditions). Good and trusting relationships can be very valuable in helping both parties work together to reach mutually acceptable agreements and avoid protracted and difficult contract renegotiations.

- Where a proposed local payment approach is likely to lead to a loss for one party. In some cases, a proposed payment approach – while likely to deliver better quality or efficiency for patients – may make one of the contracting parties worse off. Good relationships may help facilitate agreements even where this is a likely outcome, for example, by encouraging each party to accept compromises where necessary.

While good relationships can play a central role in helping to align local contracting behaviour with promoting patient interests, they are not easy to establish nor maintain. Further, continual disruption to those relationships makes effective contracting that benefits patients very difficult.

Next steps

The findings from this research have helped to inform both the rules and the guidance on local payments for services without a national price that we will be proposing in the forthcoming *2014/15 National Tariff Payment System: A Consultation Notice*. The notice document will, for example:

- showcase best practice examples of local price-setting approaches (potentially complemented by regular webinars aimed at providing advice/guidance on local price-setting issues/problems);

- include a set of overarching principles for commissioners and providers based on: promoting the best interest of patients, transparency, accountability, and constructive engagement; and

- include provisions to make local contracting agreements more transparent to help improve accountability and limit the incentives to shift “bad” behaviours to locally priced services.

The findings from this research will also help to inform our longer term programme of work in re-designing the payment system for NHS-funded services for *The 2015/16 National Tariff Payment System* and beyond. To do this, NHS England and Monitor have begun work on exploring options for further policy development on some of the issues identified through this research. This work includes, for example, exploring options for:

- providing commissioners with multi-year allocations and/or yearly allocations with flexibilities (identifying potential risks for further distortions to promoting patient interests) to reduce the pressure on commissioners to balance annual budgets and allow them to focus more on the longer term interests of patients and tax payers;

- re-designing the CQUIN framework and consider payment for performance through the national tariff as an alternative to help encourage commissioners to consider a wider range of levers to drive better quality;

- re-designing the contract sanctions and incentives available to commissioners to help ensure contract sanctions are credible and mitigate risks of creating perverse incentives among providers; and

- supporting the accelerated improvement of provider cost recording and allocation methods, including information to assist benchmarking.

This report highlights how hard it can be for commissioners to create effective local contracts. However, any ideas for improving local contracting should be assessed in the context of the payment system as a whole. One option may be to set national prices for more services. But setting national prices is only one among Monitor’s many regulatory tools and may not always be suitable. Other tools, such as improving the quality of data to inform local decision-making, may be more effective in some circumstances.

Annex 1: Primary research – summary of our approach

This annex provides a summary of the approach we took to gathering the primary evidence for this research, which we commissioned 2020 Delivery to undertake. There were two main strands to the primary research:

- a pilot survey of commissioners and providers on details of their local contracting experiences in 2012/13; and
- 34 in-depth interviews across Primary Care Trust (PCT) clusters and Clinical Commissioning Groups (CCGs), providers and specialised commissioners.

Pilot survey

We commissioned 2020 Delivery to undertake a pilot survey of commissioners and providers. The survey questions were focused specifically on the local price setting and contracting experiences of providers and commissioners in relation to their largest contract in 2012/13 for acute, ambulance, community, mental Health and ambulance services. For commissioners these were the largest contracts in terms of the proportion of total annual expenditure (by service type) and for providers in terms of the total proportion of income (also by service type).

The main purpose of the pilot was to determine whether a survey approach was sufficiently cost effective and insightful to warrant extending it across a much wider group of local commissioners and providers.

The pilot survey approach and questions were designed jointly by 2020 Delivery and Monitor. The pilot ran from 20 March to 5 April 2013, which was a period of extensive change across the NHS and coincided with the transitioning of commissioning duties from PCTs to CCGs.

Following completion of the pilot survey, we agreed with 2020 Delivery's recommendation not to extend it for either commissioners or providers, for two main reasons:

- the response rate to the survey extremely poor; and
- it was felt that interviews with commissioners and providers provided a considerably higher level of insight into local contracting behaviour than could be drawn from survey responses.

Interviews

Overview

2020 Delivery was also commissioned to conduct 34 interviews with commissioners and providers, across acute, ambulance, community, mental health and specialised services to understand current local pricing practices. Given the decision not to

extend the pilot survey, the findings of this research are based primarily on these in-depth interviews.

Interviewees were required to be as representative of the NHS as feasible in terms of:

- service type (acute, ambulance, community services, mental health and specialised services);
- geographical location; and
- being commissioners or providers.

For each of the service areas, where the information was available, lead commissioners were chosen as interviewees (for example, lead ambulance service commissioners). Furthermore, within the criteria, interviewees were selected based on 2020 Delivery's and Monitor's knowledge of individuals with expertise or valuable perspectives on local contracting, or based on random selection to ensure we met any gaps in the geographical/type criteria.

However, it is important to emphasise that the small size of the interview sample means that, despite these efforts, the findings are drawn from a fully representative sample and so should be interpreted with caution.

A breakdown of interviewees by service area and by region is set out in tables 1.1 and 1.2 below.

Table 1.1: Interviewees by service area

Service area	Commissioner	Provider
Acute	3	6
Specialised Services	2	4
Ambulance	2	2
Mental Health	2	5
Community	2	2
Other: CSUs	4	-

Table 1.2: Interviewees by region

Region	Interviewees
London	9
South East	5
South and South West	4
Midlands and East	5
North East	5
North West	6
Total	**34**

Some organisations do not fit neatly into these sections, for example, organisations that provide both mental health and community services. These organisations are, therefore, listed in the area that was primarily discussed during the interviews.

The aim of the interview questions was to find out more about local contracting practices in 2012/13 for services with no national price.

Eleven overarching themes were identified as being key to providing the information about local contracting practices to inform our research (see Box 1.1 below). These themes were used to develop detailed questions on local the contracting approaches.

Box 1.1: The eleven theme framework:

1. Approach to developing local prices
2. Availability and use of information required for developing local prices (and other payment approaches for services not subject to the nationally mandated tariffs)
3. Issues around local pricing and currency development
4. Use of local pricing as a driver of incentives (quality and efficiency)
5. Use of local pricing to manage activity and demand
6. Approaches to risk-sharing for locally priced services/other services outside of the nationally mandated tariff
7. Nature of the relationship with contracting party for locally priced services/ other services outside of the nationally mandated tariff
8. Transaction costs of contract negotiations for locally priced services/ other services outside of the nationally mandated tariff – and approaches to managing/mitigating them
9. Ex-post contract negotiations and disputes for locally priced services/ other services outside of the nationally mandated tariff
10. Approaches to enforcement of outcomes & targets etc. for locally priced services/ other services outside of the nationally mandated tariff – and their impacts
11. Views on the main challenges (*including views on the issues around commissioner skills/capabilities/interests/conflicts of interest/etc.)* and how the contracting process around local pricing could be improved.

Separate questions were developed for commissioners and providers, to reflect their different positions. Additional questions were specified for the various service areas (acute, specialised, mental health, community services, ambulance) where there were unique aspects or concerns that didn't apply to the others. The question list was crosschecked with the hypotheses developed earlier on in the project on factors that might be underlining the effectiveness of local contracting in health care markets. The detailed interview questions are set in in table 1.3 below

These interview questions were used as a guide rather than a strict script and so some interviews will have focused more on some areas than others depending on the individual experiences of the provider/commissioner.

Table 1.3: The detailed interview questions

	Commissioners	Providers
1.	**Please describe the largest contract by value that you signed and the most innovative in 2012/13** • Services, value, etc. **What approach was taken to procuring the services?** (eg, competitive tender, local AQP, no competition – eg, single action tender, roll over) To what degree is the negotiation split across the organisation (eg, CSU involvement)?	**Please describe the largest contract by value that you signed in 2012/13** • Services, value, etc. **How did you win this contract?** (eg, competitive tender, local AQP, no competition – eg, single action tender, roll over)
2.	**Do you do local pricing? If so, what is your approach to determining local pricing and payment terms?** • When do you use local pricing, what type (AQP/IAPT/Year of Care etc.) and why? What specific services do you set local prices for? • Please describe what organisations have responsibility for local pricing negotiation. What role does the CCG and CSU play? • What information (ie, on cost and quality) did you use to set local prices? • Did you have all the information and of the right quality that you needed/would have liked to have had to establish these prices? If not, what was missing/lacking in quality? Where would you expect this data to be sourced from? • Did you ask the provider for this information and how helpful were they in providing it? If they	**Has the commissioner developed local prices for the services you provide? If so, what role did you play establishing these prices? What reimbursement method do you prefer and what are you usually offered? Why is this?** • Which of the services you provide under this contract are covered by local prices? What is the value of these services relative to the total value of this contract (annual)? • How do you cost locally provided services? What data on cost and quality do you collect? • What (if any) informational challenges do you face in calculating the cost of providing local services by service line? To what extent are you/have you tried to address this? • Do you share all of this information with commissioners? Are there any changes/ways that would make it feasible to share? • What information did the commissioner ask for from you in

	did not provide it, do you think they had it? Are you aware of any informational challenges that the providers themselves face? • Do you share any information with the provider? If so, what? • Do you have access to reference prices? Do you have the software to use reference prices? • (If provider selected via competitive tendering process) Do you think you would have had as much access to the data required for local pricing if the contract was **not** competitively tendered for (ie, if you had not received several bids for the contract)? How, if at all, did the data from competing providers provide in bids help you to establish local prices? • Did you speak to providers in the market as part of your process in determining local prices (ie, before letting the contract out)? • What negotiations took place with the selected provider to establish/agree local prices? What aspects of this negotiation process required the most resources and why? • What local requirements do you impose on providers in the contract around on-going information provision (eg, on costs, quality etc.) and why? Do providers meet these requirements? If not, what sanctions/penalties are applied? • What – and how much – ex-ante contract negotiation with the provider do you engage in to establish local prices? What's the nature of this negotiation? What aspects of ex-post contract negotiation process require the most resources and why?	establishing local prices? • Are there any local contract requirements to provide the commissioners with information on an ongoing basis (eg, on costs, quality etc.). Have you been providing this information? • (if procured via competitive tender/local AQP) Do you think you would you have provided the commissioner with more/less information/data (ie, on cost and quality) as you did if you had not had to compete with other providers for this contract? Why is this? • What – and how much – ex-ante negotiation was involved with the commissioner in agreeing local prices for your services? What aspects of this negotiation process require the most resources and why? • Were the currencies for these services also determined locally? What role did you play in this process? How do you think it affects the process of establishing local prices for you/the commissioners? • Do you seek more or less local pricing in your contracts and why? • **Community services:** Are assets fully utilised? Does local pricing affect utilisation? • Does this contract cross-subsidise loss making services for this commissioner? • **Acute services:** Is contract type affected by ability to count services?

	• To what extent did you draw on other commissioner experience in developing local prices? Have you shared your experiences with other commissioners? • Did you also have to design the currencies for these local prices or are they based on national currencies? How do you determine local currencies and what specific factors are relevant? • How does this affect the process for developing local prices? What additional challenges/issues for establishing local prices does this give rise to? • Does the negotiation for Payment by Results (PbR) have any impact on developing local prices (especially in relation to time or resource constraints). If so, what do they need to do for PbR that impacts on resources otherwise available for local pricing? • **Community services, specialised services:** Are assets fully utilised? Does local pricing affect utilisation?	

3.	**Do you use local pricing to encourage improvements in quality and efficiency? If so, what is your approach to this and what metrics/indicators do you use?** • Has/have this approach/these approaches to local pricing been effective in driving quality and efficiency in practice (examples)? • Do you use local pricing to encourage other things such as market entry, investment, innovation, etc.? If so, how and how effective have these been (examples)? • Do you use local CQUIN? If so, how? • Are there any other ways you think local pricing could be used to drive these incentives or any other effective approaches you have observed/know of? • What approaches other than local pricing do you use to try and drive these incentives? Are these more/less effective than local pricing and if so, why? • Do you set specific outcome and performance targets in the contract? How do you monitor these outcomes against targets? How does local pricing support this? • What payment penalties (or otherwise) are levied for failing to meet targets? • Do you use benchmarks to assess provider performance? If so, what indicators do you use benchmarking for and on what set of providers are these benchmarks calculated/identified? Do you find the use of benchmarks effective? Where do you get the data from and are there more you need?	**Do commissioners try and encourage improvements in quality and efficiency? If so, how and how effective do you this has been?** • Has this approach/these approaches to local pricing been effective in driving quality and efficiency in practice (examples)? • How effective do you believe local pricing has actually been in encouraging improvements in quality and efficiency (examples)? • Do you think local pricing could be more effective in encouraging improvements in quality and efficiency? If so, how? Have you observed these approaches in practice by other commissioners? • Do commissioners also use local pricing to encourage other things such as market entry, investment, innovation, etc.? If so, how and how effective do you thinks this has been (examples)? • Do you have specific outcome/performance targets within this contract? How are these supported /reinforced by the design of local prices? • Does the commissioner use benchmarks to assess your performance against these targets? How effective are these in driving your behaviour?

4.	**Do you manage activity and demand through local pricing and if so, how?** • Do you find it effective? (How do you define effective?) • Does this have an impact on effective patient choice (i.e. for services for which patients have a choice of provider)? • What are the payment implications for over-performance as set out in the contract? • To what extent did you negotiate with providers over payment in the event of over-performance? What was the outcome of these negotiations? • How difficult/easy is it to manage activity and demand through local pricing? Is there anything that could make it easier? • If local pricing is not used to manage activity/demand – is this done any other way? If so, how?	**Is activity and demand managed through local pricing? If so, how?** • Does your commissioner manage activity and demand through local pricing? • What are the payment implications for over-performance as set out in the contract? • What impact does this have on your incentives to attract patients/GP referrals? What impact do you think this has had on effective patient choice? • Do these have any other impacts on service provision? • To what extent did you negotiate with the commissioner over payment in the event of over-performance? What was the outcome of these negotiations? • If the commissioner does not use local pricing to manage activity/demand – is this done in any other way? If so, how?
5.	**What risks do you seek to manage through the contract? Does your contract include any risk sharing arrangements and if so what are these and how do you negotiate them?** • Were you happy with the allocation of risk in the contract? • What difficulties, if any, are there in risk negotiations and what would make these easier? • What other contracting approaches do you take to managing risk? How does local pricing support this? • How did the risk-sharing mechanisms play out during the contract?	**What risks do you seek to manage through the contract? Does your contract include any risk sharing arrangements and if so what are these and how do you negotiate them?** • Were you happy with the allocation of risk in the contract? • What difficulties, if any, are there in risk negotiations and what would make these easier? • What other contracting approaches do you take to managing risk? How does local pricing support this? • How did the risk-sharing mechanisms play out during the contract?

6.	**To what extent are local pricing arrangements/agreements the subject of renegotiation/dispute after the contract has been signed?** • To what extent are any changes/agreements made reflected in changes to the original contract? (Generally, how often do these renegotiations occur?) If not, are they formalised in any other way? • Looking back, could the post-contract signature negotiations/disputes have been avoided in any way (eg, through the contract design, information availability, establishing clearer/better risk-sharing arrangements, etc.) or could the time taken/costs involved have been reduced? • Looking back, would you change your contracting approach around local pricing as a result of this experience?	**To what extent are local pricing arrangements/agreements the subject of renegotiation/dispute after the contract has been signed?** • To what extent are any changes/agreements made reflected in changes to the original contract? If not, are they formalised in any other way? • Looking back, could the post-contract signature negotiations/disputes have been avoided in any way (eg, through the contract design, information availability, establishing clearer/better risk-sharing arrangements, etc.) or could the time taken/costs involved have been reduced? • Looking back, would you change your contracting approach around local pricing as a result of this experience?
7.	**Have you ever had to take enforcement action against the provider? Do you face any major challenges concerning contract enforcement? What sort of impacts has enforcement had on the contract and on quality of service?** • If so, why and what approach was taken (what financial/non-financial sanctions were used)? • How effective do you think this approach was? • What approaches do you think would be most effective in driving provider behaviour? How effective do you think financial sanctions are/have been versus non-financial ones?	**Has the commissioner taken any enforcement action against you? What enforcement approaches do you think have the biggest impact on your behaviour?** • If so, why and what approach was taken (what financial/non-financial sanctions were used)? • How effective do you think this approach was? • What approaches do you think would be most powerful in affecting your approach to service provision? How effective do you think financial sanctions are/have been versus non-financial ones?

8.	**What payment method do you use for other services not subject to nationally mandated tariffs (for which local prices are not established)?** • What proportion of the contract value do these services account for? • Why have you not develop local prices for these services? • Is this decision driven by informational challenges, contract length, complexity of services, certainty of demand, competitive tender or the size of investment needed, provider resistance/pressure? • Is there any pressure for this contract to incorporate a cross-subsidy (for loss making services or other)? • Have total prices increased over recent years, and why or why not? **If block:** what would happen if activity based/outcome based contracts were used? **Acute services:** does non-PbR activity or CQUIN play a role in maintaining total contract price? • **Acute services:** is contract type affected by ability to count services?	**How are you paid for other services not subject to nationally mandated tariffs (for which local prices are not established)?** • Was this your preferred method of reimbursement? • What proportion of the contract value do these services account for? • Why do you think the commissioner has not developed local prices for these services? • How do you think quality and/or efficiency would be affected if local prices were used for these services? • Is there any pressure for this contract to incorporate a cross-subsidy (for loss making services or other)? • Have total prices increased over recent years, and why or why not? **If block:** what would happen if activity based/outcome based contracts were used? **Acute services:** does non-PbR activity or CQUIN play a role in maintaining total contract price? • **Acute services:** is contract type affected by ability to count services?
9.	**How would you describe your contractual relationship with your provider?** • How adversarial/friendly is it? What impact has the nature of your relationship had on the overall contracting process for services not subject to nationally mandated tariffs?	**How would you describe your contractual relationship with your commissioner?** • How adversarial/friendly is it? What impact has the nature of your relationship had on the overall contracting process for services not subject to nationally mandated tariffs?

10.	**What do you think are the biggest challenges/costs to setting local prices and using these to improve quality and efficiency?** • To what extent do you think these challenges could be managed by the commissioning organisation (eg, more staff, skills development, forging better relationships with providers, etc.)? – *way of exploring skills/capability gaps* • To what extent do you think these challenges could be managed/mitigated by the provider? • To what extent do you think Monitor/NHS England could/should assist/support commissioners in this and how?	**What do you think are the biggest challenges/costs to setting local prices and using these to improve quality and efficiency?** • To what extent do you think these challenges could be managed/ mitigated by you as the provider? • To what extent do you think these challenges could be managed by the commissioning organisation (eg, more staff, skills development, forging better relationships with providers, etc.)? – *way of exploring skills/capability gaps* • To what extent do you think Monitor/NHS England could/should assist/support commissioners in this and how?
11.	**Has your approach to local pricing for the 2013/14 contract changed from the 2012/13 contract? If so, how? What has been (or what do you think will be) the impact of these changes on encouraging improvements in quality and efficiency?**	**Has the commissioner approach to local pricing for the 2013/14 contract changed from the 2012/13 contract? If so, how? What has been (or what do you think will be) the impact of these changes on encouraging improvements in quality and efficiency?**

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