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## CONFERENCE ABSTRACT

# Developing a whole systems joint outcomes approach to contracting for integrated health and social care for older people

16<sup>th</sup> International Conference on Integrated Care, Barcelona 23-25 May 2016

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**Background:** In the climate of service reorganisation and sensitivity surrounding cost, health and social care systems are confronting many pressures. In England for example, most of the funding is tied up in acute and long term social care, current NHS contracts are widely regarded as insufficient for the transformation agenda and stifle innovation, and Payment by Results does not incentivise the reduction in admissions or social care changes but in fact acts as a perverse incentive (Curry et al 2011).

As a consequence, commissioners of health and social care must rapidly consider contracting arrangements to drive forward service integration that is person-centred, innovative, sustainable and transferable. The aim of this project was to develop and externally validate a contracting model blueprint for long-term conditions that was integrated care focused, evidence-based, collaborative and based on achievable joint outcomes. The intention of the model was to ensure high quality integrated care for people with long-term conditions to support self-management and end of life care.

**Literature review, method and outcome:** There were three phases to this project:

1. A critical international literature review of contracting models from within health and social care and industry was undertaken, in order to underpin the model with theory and evidence of effectiveness. This identified eight key contracting models (Alliance, Lead Provider, Partnering model, Outcomes-base commissioning, Accountable Care Organisations, value-based healthcare, incomplete contracts and the Alzira model). Overall there is little evidence of effectiveness, but much on values and principles underpinning the models and an equal amount of qualitative and anecdotal data theorising success and failure (Billings & de Weger 2015).

2. A design group of stakeholders from Clinical Commissioning Groups, acute and community health and social care, contracting and legal services, and technologists from industry was convened to develop the model. It met at monthly intervals over a six month period. A set of underlying principles were initially determined upon which a model should be developed that were person-centred (eg promoting self-management and high quality integrated care) and organisational (eg motivate the workforce, be flexible and innovative). These were isolated from best practice aspirations within professional and integrated care literature (eg Godwin

et al 2014). Secondly, relevant aspects identified in the literature review were extracted for inclusion. This included aspirational leadership and incentivisation from Accountable Care Organisation principles, trust and relational embeddedness between organisations from Alliance models, and person-centred values from outcomes-based commissioning approaches.

Following the six months of design, the model consisted of two levels of detail with four overarching core elements – a) (joint) outcomes; b) partnership: collaboration and leadership; c) financial: incentives and risk; and d) legal. Each core element then had a series of more detailed contracting criteria, followed by further detailed specifications to guide the contract development.

3. This model was subsequently validated with a wide range of national and international experts to ascertain relevance and applicability across diverse contexts. The model has been assessed through consultation with five national and four international contracting, legal and long term care experts, and with organisations such as Monitor, the European Centre for Social Welfare Policy and Research, and NHS England. In addition it has been presented at webinars, conferences and discussed with professionals. Overall, those experts and bodies consulted expressed favourable opinions and were in agreement that the contracting model had face validity and potential in the field of integrated care.

**Discussion and Conclusion:** This contracting blueprint signals a significant departure from how current contracts are developed, agreed and operationalised in England, tuned as it is towards integrated care and joint outcomes, and potentially can provide a 'backbone' for the achievement of the transformation agenda. However, despite the extensive validation and perceived relevance of such a model, it must remain aspirational until tested in the field. This is even more so, in that the strive for evidence to strengthen the conceptual development of the model was largely faulty, weak or absent; hence the literature underlining its development was equally aspirational.

However, new agendas require new thinking. Work is underway to explore technological solutions to its application, developing software that will simulate bespoke contracts for localities using the model as a framework for developing joint outcomes.

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**Keywords:** contracting model; joint outcomes; transformation

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