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Report: Alliance contracting and lead provider contracting: review of the evidence in the light of the 10 Year Health Plan for England

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Executive Summary

Introduction

The recent 10 Year Health Plan for England proposed the adoption of novel contractual models to better balance financial risk and reward between groups of providers in a way which incentivises them to work together to achieve joint aims. The 10 Year Health Plan announced the introduction of three distinct population-based contract models to roll out nationally over time: the Integrated Health Organisation (IHO) contractual model; the Single Neighbourhood Provider (SNP) contractual model; and the Multi-Neighbourhood Provider (MNP) contractual model. Alongside the introduction of these models, funding and payment mechanisms will be implemented to incentivise providers to work together to achieve common aims, including the use of outcome-based payments and risk-gain sharing arrangements.

The NIHR Policy Research Unit in Health and Social Care Systems and Commissioning (PRUHSSC) has a long-standing interest in the development of models of contract which bring together multiple providers. This report reviews the evidence from previous PRUHSSC outputs concerning the models of lead provider contracting and alliance contracting, in order to consider this evidence in relation to the proposals of the 10 Year Health Plan. As population-based contractual models, the IHO and Single and Multi-Neighbourhood provider contractual models are novel and untested. However, there are similarities with other multi-lateral contractual models. Firstly, in lead provider contracting the commissioner contracts with a lead provider for the delivery of a contract for specific pathways, services or cohorts which is likely to span a number of providers, and the lead contracting agent sub-contracts with other providers to deliver the contract. Secondly, alliance contracting has relevance to the proposed models of the 10 Year Plan, as an arrangement in which multiple contractual partners work together to agree, and then achieve, contractual aims, and which typically uses a risk/reward shared incentive structure agreed between all contractual parties.

Methods

This review of evidence brings together findings from PRUHSSC outputs concerning lead provider contracting and alliance contracting from the period 2016 – 2019. These outputs consist of a literature review of the evidence regarding the use of lead provider and alliance contracting in sectors other than health; empirical evidence from three PRUHSSC case studies of lead provider and alliance contracting in the English NHS; and a review of the empirical evidence from the use of lead provider and alliance contracting in the provision of health services. Additionally, the empirical evidence relating to the use of alliance contracting and lead provider contracting in the provision of health services was updated for this review.

Review of the evidence

The review begins with a description of the lead provider and alliance contractual models, and their use in the English NHS. It considers: the characteristics of lead provider and alliance contracting as they are used in industry; relevant contractual theory, drawn from principal-agent theory, transaction cost theory and the theory of relational contracting; the

nature of lead provider and alliance contracting models in the English NHS; and the use of lead provider and alliance contracting in the NHS.

Drawing on previous PRUHSSC work, the review considers the empirical evidence regarding lead provider and alliance provider contracting in sectors other than health, and the health sector. In relation to the evidence it was noted that, across the board, lead provider and alliance contracting are under researched areas with sparse robust empirical evidence. The review considers the evidence from sectors other than health, and the health sector itself in relation to:

1) The costs of alliance and lead provider contract negotiation, planning and monitoring
2) Who bears the costs of alliance and lead provider contract negotiation, planning and monitoring
3) What agreements are reached regarding the allocation of financial risk
4) How the contracts work in practice
5) The impact of alliance and lead provider contracting
6) Implications regarding the diversity of contractual partners
7) The significance of the wider context

Learning of relevance to the proposals of the 10 Year Health Plan

The review concludes with a consideration of the evidence in the light of the proposals of the 10 Year Health Plan, and highlights the following points:

1) **Expertise in contract negotiation, planning and monitoring is required in both provider and commissioner organisations -** Evidence from the English NHS suggests the negotiation of complex contractual models is resource intensive, difficult and lengthy, and expertise is required in both co-ordinating commissioner and provider organisations. It is crucial that co-ordinating commissioners retain sufficient expertise to have oversight of the development and operation of the local contractual arrangements to identify shortcomings in the performance of the contract, and to regain ownership and control of the contract if necessary. Providers need to have sufficient in-house expertise and ability to take on new contract procurement and management responsibilities, whether as IHO, MNP or SNP contract holders or as NHS lead providers. The evidence from outside the NHS suggests that lead providers may seek to fund transaction costs through mechanisms such as negotiation of lower payment rates with sub-contractors, or the reduction of transaction costs through sub-contracting with a smaller number of providers.

2) **Necessity of good quality data -** Access to good quality data is crucial. Agreement of complex contractual arrangements requires robust data which is trusted by all parties to facilitate the negotiation and agreement of the financial models underlying contracts, and allows the effective monitoring of contracts.

3) **Importance of relationship management –** Evidence from outside the NHS suggests the lead provider model is susceptible to tension between the lead provider and sub-contractors, as lead providers seek to manage their own financial risk by passing it on to

sub-contractors. Such tensions may lead to a loss of goodwill and disrupt collaboration. Evidence from the NHS suggests that factors in the local context may strain relationships, such as dominance of particular organisations, and historical mistrust. Relationships may be strengthened through measures such as local governance models, partnership building by trusted contract managers and guidelines regarding the 'rules of engagement'.

4) **Taking a proportionate approach to complexity -** Complex contractual arrangements should be approached cautiously to avoid transaction costs that are disproportionate to eventual gains. Case study examples from the English NHS suggest provider appetite for financial risk has been low, with outcome-based payments which tend to be inconsequential in nature, and difficulties agreeing risk share arrangements. Consequently, the incentives put in place have been weak. All parties should consider the relative risks and benefits before putting in place complex contractual arrangements.

5) **Consideration of diversity of provision -** The evidence from the NHS highlights that third sector providers are valued contributors to multi-lateral contractual arrangements. The review indicated a number of risks to diversity of provision under lead provider models, for example third sector and smaller providers may be unable to bear the transaction costs of negotiation or they may be unable to participate in financial risk sharing. The evidence from outside the NHS suggested that lead providers may choose to contract with fewer, larger providers in order to reduce their transaction costs. If diversity of provision is a policy aim, it may be that measures need to be put in place to safeguard this.

6) **The need for better evidence -** The evidence regarding the use of multi-lateral contract models of alliance contracting and lead provider contracting in the English NHS remains sparse. In particular, in relation to the current use of lead provider contracts in the NHS it is not clear whether contracts procured as a lead provider contract have resulted in sub-contracting, and how sub-contract arrangements are functioning in practice in relation to relationship management, negotiation of payment, use of payments for outcomes, monitoring of performance and realisation of transformative potential across providers. In light of the plans for IHOs and Multi and Single Neighbourhood providers it is important that research is conducted so that learning takes place from lead provider arrangements already in place.

This review of evidence forms part of ongoing PRUHSSC work to examine the development of provider collaboration in the English NHS. The interim report which examines how provider collaboratives are developing as a key policy initiative aimed at securing inter-provider co-operation, is available on the PRUHSSC website. In the next phase of the study we are conducting case study research to consider the wider spectrum of the models and structures of inter-provider co-operation which co-exist alongside provider collaboratives, and how provider collaboration is facilitating the shift from hospital to community.

1. Introduction

Both alliance contracting and lead provider contracting are well established in industry and have been available for local adoption in the English NHS as voluntary NHS contractual options for around a decade. The evidence regarding how these contractual models work in practice is highly relevant to the future development of the new contractual approaches of the 10 Year Health Plan for England (UK Government 2025). The NIHR Policy Research Unit in Health and Social Care Systems and Commissioning (PRUHSSC) has a long-standing interest in the development of models of contract which bring together multiple providers. (Sanderson et al 2016, Sanderson et al 2019). This review of the evidence brings together learning from previous PRUHSSC outputs to consider in relation to the proposals of the 10 Year Health Plan. The aim of this review of the evidence is to identify learning of use to policy makers and local stakeholders in the development of new contractual models.

The development of models of contracting in the English NHS is part of an enduring policy drive to breakdown the traditional boundaries which exist between types of care, in order to deliver high quality integrated services, make the best use of resources, reward the delivery of the best outcomes and catalyse new configurations of providers (NHSE 2014, Ricketts 2014). Most recently, the government has reaffirmed the important role contracts can play in bringing providers together, with plans for a new system model which foregrounds the role of contractual and payment mechanisms in supporting integration, shifting resources from hospital to community, and focusing on population health and tackling inequalities (UK Government 2025).

A key function of contract is to minimise uncertainty and to allocate risk between the contracting parties (Friedman 1965). Traditional bilateral contracts can allocate risk between a commissioner and provider, however such bilateral contracts are not well suited to encourage collaboration between multiple providers, and efforts to improve collaboration between multiple providers may encounter challenges due to the uneven distribution of risks and benefits across providers. The recent 10 Year Health Plan and associated guidance

(NHSE 2026a) propose the adoption of novel contractual models to better balance financial risk and reward between groups of providers in a way which incentivises them to work together to achieve joint aims. These models can be considered multi-lateral as multiple organisations are involved in delivering the contracted service, the contractual relationships create a network of agreements rather than just a simple bilateral contract, and performance, risk, and payments are distributed across several parties.

The 10 Year Health Plan refers to the introduction of three distinct population-based contract models which it is proposed will roll out nationally over time: the Integrated Health Organisation (IHO) contractual model; the Single Neighbourhood Provider (SNP) contractual model; and the Multi-Neighbourhood Provider (MNP) contractual model. Alongside the introduction of these models, funding and payment mechanisms will be implemented to incentivise providers to work together to achieve common aims, including the use of outcome-based payments and risk-gain sharing arrangements (NHSE 2026a).

The aim of the proposed Single and Multi-Neighbourhood provider contracts is to create the conditions to design and deliver integrated services within and across neighbourhoods, with the potential for more incentive and outcome-based payments at greater scale (NHSE 2026a). The proposed Single Neighbourhood provider contracts will create integrated neighbourhood teams, within a defined single neighbourhood, enabling primary care to take on new neighbourhood services that are not contracted through today's general practice contracts (NHSE 2026a). Multi-Neighbourhood Providers will co-ordinate the delivery of services across multiple neighbourhoods, unlocking advantages and efficiencies from working at greater scale (DHSC 2025). This model will be underpinned by new risk sharing approaches. These contractual models are intended to bring together primary care, community services, mental health, social care, and voluntary sector input under one contractual framework in order to deliver enhanced services in a single neighbourhood, or to deliver care across multiple neighbourhoods (DHSC 2025).

The Integrated Health Organisation (IHO) model allows investment and savings to occur in the same place through the adoption of a contract which gives providers a whole population health budget for the population of a defined geographical area (NHSE 2026a). The intent is that this model will address NHS fragmentation and create incentives to invest in community-based preventative care (NHSE 2026a). IHO contract holders will be responsible for allocating resources and planning services to meet the needs of the population. In doing so, it

is expected the IHO contract holder will contract with other providers, including MNPs for the provision of neighbourhood services, and will take on local contract management responsibility for GMS (or PMS or APMS) general practice contracts, as well as pharmacy, optometry and dentistry (NHSE 2026a). This will be enabled by an alignment of the IHO population with one or more MNP footprints. IHO contract holders may also put lead provider arrangements in place for specific services 'where there is another provider in the area well placed to lead resource allocation for a specific pathway' (NHSE 2026a).

IHO contracts will only be held by NHS organisations. It is proposed that NHS Advanced Foundation Trusts (a new form of NHS FT reserved for 'highly capable' providers) will act as the host of the IHO contract, providing some services directly and establishing sub-contractual arrangements with other service providers for the provision of the remaining necessary local services (NHSE 2025a). Advanced NHS FTs will undergo an assessment in order to be able to hold an IHO contract which will assess a candidate Advanced NHS FT's ability to take on leadership for population health improvement, lead beyond organisational boundaries, and manage additional financial and clinical risk. The assessment will also consider the ICB's intentions and wider stakeholder support. It is also intended that a separate assurance of commissioner and provider capabilities to manage contract specifics will take place prior to the start of any contract (ibid). IHO contract holders can be community, mental health and acute trusts, and it is suggested that routes will be identified for neighbourhood providers to lead an IHO, either through partnering with trusts that can hold an IHO contract such as through an alliance agreement or joint venture, as part of an NHS organisation, or by forming an NHS organisation themselves. NHS England will designate the first wave of providers eligible to hold IHO contracts in 2026 and it is anticipated that over time 'they will become the norm' (UK Government 2025).

The IHO and Single and Multi-Neighbourhood provider contractual models are novel and untested. These models share fundamental similarities with other multi-lateral contractual models, in particular lead provider contracting, in which the commissioner contracts with a lead provider for the delivery of a contract likely to span a number of providers, and the lead contracting agent sub-contracts with other providers to deliver the contract. The IHO, SNP and MNP models differ from NHS lead provider arrangements because contract holders take on the whole population risk for a geography, whereas NHS lead provider contractual arrangements relate to specific pathways, services or cohorts (NHSE 2026a). However, despite this important distinction, there are fundamental similarities regarding the use of sub-

contracting to align incentives across providers. In addition, another form of multi-lateral contracting, alliance contracting, has relevance to the proposed models of the 10 Year Health Plan, as an arrangement in which all contractual partners work together to agree, and then achieve, contractual aims, and which typically uses a risk/reward shared incentive structure agreed between all contractual parties.

2. Methods

This review of evidence brings together findings from PRUHSSC outputs from the period 2016 – 2019 concerning lead provider contracting and alliance contracting. These outputs consist of: a literature review of the evidence regarding the use of alliance contracting and lead provider contracting in sectors other than health; empirical evidence from three PRUHSSC case studies of alliance contracting and lead provider contracting in the English NHS; and a review of the empirical evidence from the use of alliance and lead provider contracting in the provision of health services, which was published alongside the empirical evidence in a single output. A description of the methods used in these outputs is given in Appendix 1, and the outputs are summarised in Table 1 below.

Table 1: PRUHSSC outputs included in the review of the evidence

Source	Date	Evidence	Purpose
Sanderson et al 'Alliance contracting, prime contracting and outcome based contracting: What can the NHS learn from elsewhere? A literature review' new-contractual-models-literature-review-final-july-2016.pdf	2016	Literature review of evidence relating to alliance, lead provider and outcome-based contracting in sectors other than health. Search of four databases for a combination of keywords. and Google Scholar search	To review the international cross sector evidence concerning the characteristics of these contractual models, the process of their implementation, and their impact
Sanderson et al 'New Models of Contracting in the NHS' new-models-of-contracting-final-report-1-.pdf	2019	Three in-depth case studies of the introduction or operation of Alliance contracting and lead provider contracting in the English NHS	To explore why NHS commissioners are choosing new models of contracting, the characteristics of these models, how they are used in practice, and the impact they are having
Sanderson et al 'New Models of Contracting in the NHS' new-models-of-contracting-final-report-1-.pdf	2019	Review of empirical evidence relating to use of alliance contracting and lead provider contracting in relation to the provision of health services	To review the international evidence concerning the use of these contractual models, and their impact in the provision of health services

For this review of the evidence, these earlier PRUHSSC outputs were reviewed to consider the learning which might be of most relevance to the proposals of the 10 Year Health Plan.

Additionally for this review, empirical evidence relating to the use of alliance contracting and lead provider contracting in the provision of health services was updated by an internet search and snowballing from references to encompass more recent empirical evidence, including academic studies, and grey literature such as research reports, working papers, and policy reports. A search was also conducted of the Health Services Journal for relevant news stories relating to the use of these models in the NHS.

3. Overview of alliance contracting and lead provider contracting

The alliance contracting and lead provider contractual models originate in industry, and this section describes the models as they are conceptualised in industry. The models serve to give providers more control over how to realise contractual aims and facilitating the sharing of risks between providers. While sharing this overall similarity, the models are conceptually distinct, as described below and summarised in Table 2.

Table 2: Characteristics of alliance contracting and lead provider contracting as used in industry

Model	Defining characteristics
Alliance contracting	• Single alliance contract between the commissioner of the service and the organisations delivering the project • Risk/reward incentive structure shared across alliance partners giving collective ownership of risks (win together/lose together model) • Recruitment of alliance partners without competitive tender process • Emphasis on coproduction, facilitated by governance structures and relationship building activities to encourage collective responsibility • Contract may include no dispute clause
Lead Provider contracting	• Commissioner contracts with a single (lead) provider for the delivery of a service likely to span a number of organisations • Lead contractor has responsibility for managing the supply chain, including the commissioning sub-contractors • Lead contractor may also provide some services • Lead contractor often paid on an outcome-based model

In lead provider contracting (also known as prime provider contracting) the purchaser contracts with a supplier for the delivery of a contract which is likely to span a number of providers. The lead provider sub-contracts with other providers to deliver the contract. Lead provider contracts have been characterised as taking a 'black box' approach. This approach is one where the purchaser specifies the outcome they want, but does not prescribe how the lead provider should achieve it, giving the lead provider flexibility and freedom regarding

how these outcomes are achieved. The model is based on the belief that purchasers should move away from micro managing complex supply chains, and that moving this responsibility to a lead provider will result in more efficient achievement of desired outcomes (Corrigan and Laitner 2012, Matthews and Parker 1999, O'Flynn et al. 2014).

Alliance contracting is distinct from other partnership approaches such as strategic alliances, partnering and joint ventures, although the diversity and looseness of terminology associated with the term 'alliance' can cloud the distinction between alliance contracting and other partnership approaches in practice. Alliance contracting aims to overcome the 'adversarial nature' of traditional contracting (Jefferies et al. 2014), by using a model in which all contractual partners work together to agree, and then achieve, contractual aims. Typically a single alliance contract is agreed between the purchaser of the service or project and the providers which will deliver this. The development of the relationship between alliance partners is important, with an emphasis on co-production and relationship-building activities. Alliance partners are expected to resolve issues without recourse to the courts for dispute resolution, and contracts may include a unanimous decision-making protocol and no blame/no dispute clause (Chew 2004, 2007, Davies 2008, Gransberg and Scheepbouwer 2015, Rowlinson et al. 2006).

Alliance contracts are underpinned by a risk/reward shared incentive structure which states the division of financial rewards and penalties according to a fixed pre-agreed ratio between parties to reflect performance against targets. In this way, all alliance partners win together or all lose together through a shared 'collective ownership of risks' (Rowlinson et al. 2006). Typically the purchaser is a participant in the risk/reward structure. For example in a construction alliance contract, the owner would share in cost overruns (Department of Infrastructure and Transport 2011).

4. Contractual theory

In order to understand lead provider contracting and alliance contracting it is necessary to consider them in the light of the theory of contracts. The theory of contracts is based in economic and socio-legal theory. The three approaches to the theory of contracts which are discussed here are principal-agent theory, transaction cost economics and relational contracting.

Principal-agent theory and the allocation of financial risk

A fundamental characteristic of these new contractual models is the creation of incentives for service providers based on the allocation of risk. A contract is put in place when one party (a principal) desires an outcome but the activities to achieve this must be undertaken by another party (an agent). All contracts carry the risk that the agent will act in their own interests rather than those of the principal (Jensen and Meckling 1976). While many contracts use monitoring of agent performance against the contract to ensure the agent is acting in the principal's interests, lead provider contracting and alliance contracting aim to achieve the alignment of the agents' incentives with those of the principal through the sharing of financial risk between multiple agents (lead provider contracting) and between principal and agents (alliance contracting). Effective risk allocation occurs when risk is allocated to those who can control it, thereby incentivising those with responsibility for the risk to act to mitigate it. In the NHS, payment structures can allocate financial risk between those commissioning and providing services in order to incentivise demand management, improve efficiency, and, through the use of risk share arrangements, encourage providers to work collectively.

Transaction cost theory

Transaction costs are a key concept in contractual theory. Transaction costs refer to the cost of making exchanges, both the costs of negotiating, specifying and drafting a contract (*ex-ante*) and the costs of monitoring and enforcing compliance with that contract (*ex post*) (Coase, 1937, Williamson, 1985). Unlike contractual models which have an emphasis on the *ex-post* monitoring of agent performance against the contract, lead provider and alliance contracting emphasise the *ex-ante* elements of the contractual process, namely the agreement of the arrangements to share risk. It is therefore likely that the *ex-ante* process in relation to these models will incur significant transaction costs. In order to align incentives the principal needs to be able to specify current and future requirements, and quantify the performance targets and the appropriate payment structure, and the agent needs to ensure that the targets are reasonable and achievable. Where risks are being shared between multiple agents, those agents need to agree the principles about how risks will be shared.

Relational contracting

While the contract document endeavours to deal with future arrangements, it is impossible to foresee all possible contingencies and eventualities at the outset due to bounded rationality (Simon, 1957). As it is therefore difficult to specify and measure all aspects of agent performance, the contract cannot be 'complete' (Williamson, 1985) or entirely 'discrete' (Macneil, 1978, Vincent-Jones, 2006). In these circumstances, relational contracts might

evolve and permit efficient trade (Macneil, 1981). In relational contracts, adjustments are made to the initially agreed terms during the course of the contractual relationship to deal with unforeseen contingencies (Vincent-Jones, 2006). Economic and socio-legal theories of contracting generally, together with empirical evidence on contracting and pricing in the NHS, indicate that the allocation of financial risk is often handled differently from the stipulations of formal contractual provisions (Macneil, 1978, Petsoulas et al., 2011, Williamson, 1985). Trust in particular is acknowledged to be important as a mechanism which enables the management of risk where complete contracts cannot be written, due to ignorance or uncertainty about the possible actions of others (Luhmann 1979, Nooteboom 2002, Sako 1998,). In situations where the contract encounters high levels of uncertainty regarding the future, reliance on the relational elements of the contract is likely to increase (Macneil 1978, Williamson 1985).

5. Alliance contracting and lead provider contracting models in the English NHS

In the last decade, the NHS has adopted the use of alliance contracting and lead provider contracting as a voluntary contractual model. The models have been refined to meet the requirements of the NHS context. In particular, this has involved setting the relationship with the NHS Standard Contract, which is mandatory for use by commissioners when commissioning clinical services other than primary care.

NHS lead provider arrangements

An NHS lead provider arrangement is one in which a single lead provider takes full contractual responsibility through a service contract (i.e. NHS Standard Contract) for a specific pathway, service or cohort. In the latest NHS Standard Contract and NHS Template Sub-contract the lead provider is referred to as the 'head' provider, and the Standard Contract is referred to as the 'head' contract. The head contract allocates risk and reward between the commissioner and the head provider. The head provider sub-contracts specific roles and responsibilities (and allocates risk associated with their performance) to other providers (NHSE 2026b). It is recommended that the head provider uses the NHS Template Sub-contract for the Provision of Clinical Services in order to achieve a higher degree of contracting consistency and less negotiation for the parties involved (NHSE 2026c). The head provider remains responsible to the commissioner for the delivery of the entire service, including for the co-ordination of the sub-contractors to deliver the entire service. While the

head provider is likely to be a provider of clinical services itself, it could sub-contract all but the co-ordination role.

Commissioners are advised to strike a careful balance, aiming for an appropriate and manageable level of oversight of the contractual arrangements while avoiding micro-management of operational detail (NHSE 2026b). The NHS Standard Contract places controls on the head provider, including that all sub-contracting requires prior written agreement by the co-ordinating commissioner (General Conditions- GC12.1), thereby ensuring commissioner control over what, how and to whom the provider sub-contracts the performance of its contractual obligations. Where the sub-contract is proposed with a provider with complex organisational arrangements (involving parent and subsidiary companies, for instance) or raises issues around VAT applicability, it is suggested that the co-ordinating commissioner should take legal advice, while the head provider should cover the cost of obtaining advice (NHSE 2026b). Furthermore, the head provider requires the permission of the co-ordinating commissioner to terminate a contract or let a sub-contractor further sub-contract its obligations (General Conditions – GC12.5). The co-ordinating commissioner also has powers to require the replacement of sub-contractors in specific situations, such as persistent breach of quality requirements (General Conditions - GC12.13).

In terms of payment and pricing, the NHS Payment Scheme does not apply to the NHS Template Sub-Contract and the head provider and sub-contractor can agree their own pricing mechanism (NHS England 2026c, p15). The exception to this is 'Framework Agreements' where pre-approved organisations which have been assessed and are able to provide high-quality, goods and services at an agreed price. While the price can always be linked to an NHS Payment Scheme Unit Price if that is seen as appropriate, it appears that head providers have freedom to negotiate local payment terms.

NHS Alliance Agreements

The alliance contracting approach was first developed in the English NHS in 2016 as a way to bring providers together around a common aspiration for joint working across local health and care systems. The NHS Template Alliance Agreement does not replace or in any way override the NHS Standard Contract, and providers party to an NHS Alliance Agreement will each hold a bilateral NHS Standard Contract for the provision of services. However the key characteristics of alliance contracting can be accommodated through using the Alliance Agreement as an overarching 'umbrella' agreement that sets out how parties will work

together in a collaborative and integrated way (NHSE 2015). This template consists of sections for local completion detailing: the objectives and principles of the Alliance; partner roles in the Alliance, and the governance of the Alliance; agreed arrangements relating to the Services Contracts, ensuring improved coordination of care and greater collaboration; and performance management, financial risk and benefit sharing mechanisms.

6. Sharing of financial risk and reward

Lead provider and alliance contracting are commonly supported by the development and formalisation of approaches which allow financial risk to be shared amongst groups of providers, and which reward the achievement of cross organisational outcomes (Monitor, 2014). Two such mechanisms are multilateral gain/loss sharing and outcome-based payments (Monitor and NHS England, 2015).

Multilateral gain/loss share arrangements can be deployed to share financial risk between organisations (Monitor, 2015a), by realigning the financial incentives of individual organisations to incentivise the delivery of outcomes for the whole system and protect providers from a sudden loss in revenue or from an unpaid increase in activity. This is achieved by allowing parties to the arrangement to distribute any savings and losses from system change among themselves, thereby mitigating financial risk and incentivising the achievement of system rather than organisational goals.

Outcome-based payments links a share of payment to the achievement of defined outcomes (in place of payment for processes such as numbers of episodes of care delivered). Contracts using outcome-based payments seek to realise efficiency gains through transferring risk to providers, giving them greater flexibility in delivery, but paying only in return for successful performance. Outcome-based payments may have many benefits, including: enabling a focus on co-ordinated patient centred care; increasing accountability to ensure best value care; allowing commissioners to define outcomes clearly and contract for those they want achieve; enabling better alignment of patient pathways and care processes with outcomes; and better co-ordination (Monitor, 2015b). When used in lead provider or alliance contract models, outcome-based payments can be used to align incentives across a number of providers. Outcome-based payments may have varying degrees of relative importance within service contracts dependent on the proportion of the overall payment which is dedicated to performance in relation to outcomes.

7. Use of alliance contracting and lead provider contracting in the English NHS

While the lead provider and alliance models have been available for adoption in the English NHS for the last decade, their prevalence in practice is not clear.

We reviewed ICB-led procurements using the 'Find a Tender' website (www.find-tender.service.gov.uk) and identified 25 examples of procurements in the period 2022-2025 that were specified by the ICB commissioner as suitable to be provided using a lead provider model. The lead provider model is prominent in mental health, learning disability and autism services under the 'NHS-Led Provider Collaboratives' policy (NHSE 2019), but this review of evidence did not identify any empirical studies relating to these arrangements. A small number of NHS lead provider contractual arrangements became high profile because of problems which were encountered. The 'UnitingCare' lead provider NHS contract for Cambridgeshire integrated older people's healthcare and adult community services, awarded in 2015, was terminated after only eight months, at least in part due to significant issues not having been resolved during the negotiation period, and misunderstandings regarding the degree of risk to which commissioners were being exposed (National Audit Office, 2016). In 2018, Virgin Care terminated parts of an NHS lead provider contract for community services in East Staffordshire, after failing to reach a funding agreement with the commissioner (HSJ 2018). Recently, a number of high value lead provider contracts have been procured, most significantly the lead provider contract for community health services awarded to the HCRG Care Group by Bath and North East Somerset, Swindon and Wiltshire ICB. This commenced in April 2025 with an annual value £138million.

Alliances appear to be a popular model for formalising a commitment to partnership working, for example in Place based Partnerships. However, it is not clear to what extent these alliances are underpinned by financial agreements. Case study examples (e.g. Addicott 2014, Hutchison 2025, Sanderson et al 2019) indicate how and why alliance agreements are being put in place in the NHS. These sources suggest that alliance agreements are being used in relation to the provision of complex services which span organisations, and focus on the delivery of services to a specific population (e.g. older people) or as part of a particular care pathway (e.g. cancer, mental health). However, despite the existence of the model NHS Template Alliance Agreement, it is not evident that the model has been widely adopted.

8. What does the empirical evidence tell us?

This section considers the empirical evidence from previous PRUHSSC outputs concerning lead provider and alliance contracting. This evidence consists of three PRUHSSC case studies of NHS lead provider and alliance contracting, and PRUHSSC reviews of the relevant empirical literature. Other reviews of the literature both in general, and in relation to health services, have considered lead provider and alliance contracting to be under researched areas (Billings and Weger 2015, Chen et al 2012, Gallet et al 2015, O'Flynn et al 2014), and this was reflected in the sparsity of robust empirical evidence uncovered by the PRUHSSC literature reviews which are included in this review of the evidence.

What are the costs of alliance and lead provider contract negotiation, planning and monitoring?

The evidence regarding alliance and lead provider contracting suggests contractual parties will incur significant transaction costs in relation to contract negotiation and planning, and the ongoing monitoring of contractual arrangements. In the NHS setting these costs are also high due to the novelty of such contractual arrangements and the subsequent lack of in-house expertise, sufficient data systems and good quality baseline data.

Research indicates that the process of negotiating alliance and lead provider contractual arrangements locally is time-consuming and complex (Addicott 2014, Jones et al 2024, Mason et al 2015, Sanderson et al 2019). In relation to an English NHS musculo-skeletal (MSK) service lead provider arrangement, Jones et al (2024) concluded that the time and effort required to set up and manage the contract was very significantly disproportionate to the value of the contract. While noting that the service had been a success, delivering outcomes and reducing the demand for acute intervention for MSK conditions, the authors concluded that 'the commissioning responsibility and workload is shifted to the lead provider and has probably increased in totality rather than reduced' (Jones et al 2024, p 60).

Early case study evidence of the development of alliance contracting and lead provider contracting in the English NHS found the local development and agreement of contractual arrangements may take years (Addicott 2014, Sanderson et al 2019). This extended timeframe can have indirect implications, for example changes in leadership may weaken support for the contractual model during lengthy negotiation periods (Sanderson et al 2019).

There is also a risk that lengthy negotiations will not result in agreement of contractual arrangements. In two of the three PRUHSSC case studies of alliance and lead provider contracting, no agreement was reached on key issues between contractual parties (Sanderson et al 2019). This failure was linked to provider distrust of the underlying financial model, the lack of robust activity data, and more broadly, a lack of alignment of organisations' interests (ibid).

Management expertise is crucial to support the negotiation of alliance and lead provider contractual arrangements. Experienced managers can foster more efficient contracting processes, develop better contracts, and shift relationships toward a more collaborative, problem-solving approach (Caetano and Cabral 2025). Early evidence from the NHS found negotiation of contractual arrangements necessitated the extensive utilisation of legal advice and support from management consultants (Sanderson et al 2019). Risks associated with commissioner inexperience and the negotiation of the unfamiliar procurement and legal landscape are illustrated by the example of the failed 'UnitingCare' lead provider NHS contract, which was terminated after only eight months, due to unresolved issues and misunderstandings regarding commissioner exposure to risk (National Audit Office, 2016). The House of Commons Committee of Public Accounts (UK Parliament 2016) stated in response that public bodies will not achieve value for money from their contracts until they become more commercially skilled, and greater clarity was needed regarding where responsibility lies for checking the resilience of partnerships and commissioning and contracting arrangements.

Further costs relate to the increased requirements for data and monitoring, particularly in relation to lead provider contracts and the use of outcome-based payments. Evidence from outside the NHS suggests that where lead providers take on new responsibilities for the negotiation, implementation and monitoring of sub-contracts, this incurs costs relating to the development of information systems and bespoke performance assessment tools (Finn 2011, Bemelmans et al 2012). A study of lead provider contracting by the UK Department of Work and Pensions (DWP) for the provision of employment services concluded that skilled contract managers acting for the lead provider were required to facilitate performance management of sub-contractors and ensure that key quality indicators were met (Finn 2012). Additionally lead providers may need to make investments in supply chains such as in staff training and recruitment (Finn 2011, Finn 2012).

Evidence relating to the use of outcome based payments outside the NHS suggests that the use of outcome-based payments has also been found to necessitate the development of new information systems, with investment in bespoke data collection and analysis, development of measurement methodologies and monitoring systems (Mason et al 2015, Selviaridis and Wynstra 2015). The negotiation and specification of outcomes measures should be seen as an ongoing and iterative process, beyond the contract specification (Arthur and Kennedy 2014, Gelderman et al. 2015, Hannah et al. 2010, Sturgess et al., 2011), involving periodic review and validation of the modelling and assumptions behind the performance specification process (Arthur and Kennedy, 2014) and the revisitation of the target and incentive structure to create a more nuanced scheme in the light of experience, and to avoid unrealistically high targets (Gelderman et al 2015, Hannah et al 2010, Hudson et al 2010).

Evidence regarding the establishment of outcome measures in the English NHS highlights the challenges of locating sufficient capability, skills and resources to measure outcomes and agreement of performance thresholds (Sanderson et al 2019, Taunt et al 2015).

Who bears the costs of alliance and lead provider contract negotiation, planning and monitoring?

In relation to alliance contracting, negotiation costs are spread across all contractual parties (which may include both providers and commissioner) in the period after the alliance partners have been selected. During this period, alliance parties work together to establish a commercial framework of risk and rewards, performance indicators and costs (Davies 2008, Jeffries et al 2014). Costs are commonly shared between alliance partners, which may raise issues for smaller partners. NHS case study research indicates that third sector parties are at risk of exclusion at various stages, including bearing of costs of the negotiation period, and the sharing of financial risk (Sanderson et al 2019) (see ‘Wider considerations: Diversity of contractual partners’ below).

The lead provider model transfers the transaction costs of negotiating and managing sub-contracts to the lead provider. Evidence from outside the NHS suggests that lead providers may seek to address these transaction costs through seeking additional funds from the co-ordinating commissioner, or taking a management fee from subcontractor payments (Mason et al 2015). Lead providers may also attempt to reduce transaction costs by conducting business with a restricted number of subcontractors (Bemelmans et al 2012). In relation to

public services, the overall commissioner commonly retains oversight of the activities of the lead provider for reasons of accountability. Studies of lead provider contracting for the provision of employment services contracts of the UK DWP reported the overall commissioner retained a substantial 'stewardship' role, centred on ensuring the maintenance of a diverse delivery network, setting principles to guide behaviour between lead providers and their supply chains (including equitable treatment for smaller providers), and monitoring supply chains to ensure that there was no inappropriate transference of risk (Mason et al 2015, Finn 2011, 2012).

What agreements are reached regarding the allocation of financial risk?

An important aspect of lead provider and alliance contracts is agreeing how financial risk will be allocated between contractual parties such as through multilateral gain/loss share agreements, and choice of payments mechanisms such as outcome-based payments. There is limited evidence regarding both the process of agreeing the allocation of financial risk, and the nature of the agreements reached. The evidence in relation to the English NHS highlights the difficulty agreeing risk share arrangements. Where outcome-based payments are used, these tend to be inconsequential in nature due to the very small proportion of the overall payment tied to the achievement of outcomes.

Case study evidence from the English NHS highlights that a lengthy negotiation period may fail to result in agreements regarding the allocation of financial risk (Sanderson et al 2019). The PRUHSSC case studies of alliance and lead provider contracting indicated contributory factors to this failure included a lack of a single set of activity data across providers, provider distrust of the service provision/ financial model proposed by the commissioner, and poor financial position of the local health economy. In one of the PRUHSSC case studies, agreement was reached to share financial risk between parties. Factors associated with this agreement were the adoption of a co-production approach to the financial model, and the modest nature of the risks. In this case study, the general principle was agreed that any savings or losses resulting from changes in activity would be shared across the provider alliance members. This study also highlighted restrictions on third sector and smaller partners participation in risk share agreements. Smaller parties (e.g. third sector providers, GP federations) were deemed too small to share the financial risks, and additionally some third

sector organisations were unable to participate due to constitutional restrictions on spending charitable funds on statutory services (see section on 'Diversity of Provision' below).

In relation to lead provider contracting, the lead provider decides what risks are passed on to sub-contractors. The nature of these arrangements is often not described in the empirical evidence. A National Audit Office review of the DWP 'Pathways to Work' lead contractor delivery models found that on average, sub-contractors were being paid around three quarters of what lead contractors were paid for securing a successful job outcomes (NAO 2010). As noted above, the UK DWP adopted a substantial 'stewardship' role in relation to lead provider contracts including describing the principles which should guide the ethical and contractual relationships between lead providers and their subcontractors (Finn 2023).

A potential payment mechanism to share risk in alliance and lead provider contracts is to link payments to the achievement of outcomes. Overall, the evidence from the public sector did not contain examples in which outcomes were linked to payment in a significant way, and indicated that there are both practical barriers (Frontier Economics & the Colebrooke Centre 2014), and limited evidence to support financial incentivisation of outcomes (Marshall et al 2014). Outes Velarde et al (2024) reviewed the international evidence regarding the use of outcome-based contracts in the provision of public services by non-governmental delivery organisations, and could not identify an example of an alliance contract where outcomes were linked to payment. A NAO review (2015) of the evidence regarding the UK government's use of outcome-based payment arrangements to deliver public services concluded that schemes linking payments to outcomes are 'hard to get right and are risky and costly for commissioners' (p8).

There is little empirical evidence of payments linked to outcomes through lead provider or alliance contractual arrangements in the English NHS. Clark et al (2015) describe outcome measures developed for a mental health services alliance agreement, but it is not clear whether these were linked to payments. What evidence there is regarding payments for outcomes suggests that outcome-based payments are for very modest amounts (e.g. 1%-2.5% of the contract value) (Sanderson et al 2019, Taunt et al, 2015). An exception to this is Jones et al's (2024) description of a £15 million Musculo-Skeletal services lead provider contract in North Central London ICS, where it is reported that 10% of the contract is tied to outcomes, however it was noted that the agreement and measurement of outcomes tied to financial

payments/penalties proved to be complex, and these measures were hard to agree because they were tied to financial payments/penalties.

The use of the alliance contracting model in the health sector internationally shows a trend towards using the model without payment mechanisms to incentivise co-operation (Charles 2017, Collins 2019, Love et al 2018, Nicholson et al 2025, Robertson and Ewbank 2020, Timmins and Ham, 2013). An example is the use of the alliance model in the Canterbury District Health Board of New Zealand, where it is reported that multi-agency collaborative decision making is guided by alliance principles without any underlying risk and reward incentive structures (Collins 2019). Instead the alliance decides how best to deploy savings from efficiencies across the system, with an emphasis on ensuring the sustainability of organisations in the alliance (Collins 2019). This approach might more accurately be termed 'partnering' as arrangements do not include a formal contract or a risk and reward mechanism (Chen 2012).

How do the contracts work in practice?

In the literature drawn from outside the NHS arguments are made, in relation to both alliance and lead provider contracting, that providers may be incentivised to agree to inaccurate costings at the outset. In relation to alliance contracting relationship, concerns have been raised in industry, in the light of project underruns against the target outturn cost, that there is a temptation at the start of the contractual process for agents to overestimate the costs involved (Love et al. 2010). Conversely, in relation to the lead provider model, both the lead provider and sub-contractors may be incentivised by the process of competitively awarding contracts to make over-optimistic claims regarding performance and costs, which may lead to unviable cost and performance undertakings from successful contractors (Finn 2012, Hudson 2010).

In the English NHS, two high profile historic examples illustrate the risks inherent in over-optimistic initial assumptions in the lead provider model. Firstly, in relation to the failed UnitingCare contract stakeholders had concerns from the outset about the financial viability of the contract which included an estimated 10% cost reduction over the five-year life of the contract (NAO 2016). Secondly, it was reported that Virgin Care terminated parts of a lead provider contract for community services won in 2015, after failing to reach a funding agreement with the commissioner for additional funding. The elements handed back to the

commissioner were all services the lead provider did not directly provide, and responsibility for subcontracting, planning, co-ordinating and integrating services (HSJ 2018) At the time the deal was signed, commentators warned the contract would be handed back after an initial period due to the savings required (HSJ 2019).

In relation to lead provider contracting, the scope for opportunistic behaviour during the performance of the contract is exacerbated where a 'hands off' approach adopted by the commissioner. A possible negative effect of incentive payments for outcomes is the encouragement of gaming (Frumkin 2001, Jacob and Levitt 2003). Lead provider models outside the NHS, including those with some degree of outcome contracting, have reported gaming activities such as 'cherry picking' of easier clients (Hudson et al 2010), data recording irregularities (i.e. over/under reporting) (Lu and Ching-To Albert 2006, Caldwell and Howard 2014), poor quality service and the skimping of service provision (Hannah et al. 2010). The aspects of alliance contracting which set it apart from other types of partnership working (i.e. the agreement of risk sharing across all parties) may reduce the scope for opportunistic behaviour, and there is some evidence that this is successful (Laan et al. 2011).

Incentivization and regulation can be tailored to mitigate for gaming, such as for example requiring providers to accept all referrals in order to prevent cherry picking (Finn 2011).

What is the impact of alliance contracting and lead provider contracting?

The cross-sector literature is surprisingly light on evidence relating to the benefits of these contractual approaches, and a number of studies conclude that it is difficult to draw any conclusions in this regard due to difficulties with attribution and measurement (Caldwell and Howard 2014, Buchanan and Klinger 2007, Henneveld 2006, Bresnen and Marshall 2000, Love et al. 2010). This reflects the complexity of these contractual models and of the environments in which they are deployed. Some of the improvements achieved, such as the financial benefits of improved risk management, are difficult to quantify (Matthews and Parker 1999), and the impact of the contractual model may not be immediately discernible (Finn 2011).

The evidence from sectors other than health is mixed regarding the impact of the models. There is some evidence that lead provider contracting can reduce costs (Holti et al. 2000,

Lane et al. 2013, Ndekugri and Corbett 2004). The alliance contracting literature reports that many construction projects were completed within the target costs and timescales using alliance contracting principles (Gransberg and Scheepbouwer 2015). However, there is also scepticism regarding reported cost savings, in particular in the alliance contracting literature from the construction sector, due to the practice of alliance partners (over) estimating their capital expenditure requirements (Love et al. 2010; Chen et al. 2012). Furthermore, any benefits may be due to the implementation of good practice project delivery methods and the identification of good quality contractors rather than any elements inherent in the contractual models themselves (Bresnen and Marshall 2000, Buchanan and Klinger 2007, Davies 2008). Other evidenced benefits of alliance contracting include the development of innovations, improved relationships between contractual partners and improvement in non-cost outcomes (such as enhanced reputations and improvement of competitive advantage) (Chen et al 2012). The lead provider literature includes a small number of studies that suggest sharing of good practice occurs amongst supply chain members (Lane et al. 2013) and that there is better coordination of services as a result of the lead provider approach (Muir et al. 2010). The lead provider literature suggests that there may be limited incentives for innovation (Langfield-Smith 2008), and other priorities such as efficiency savings may take priority (Hudson et al. 2010, Finn 2013).

There is very limited robust evidence regarding the impact of these models in relation to health services. Findings from the PRUHSSC case studies in relation to the contribution and impact of the contractual models in the NHS were limited by the extent to which the intent of the contractual models had been realised in the case studies (Sanderson et al 2019). One alliance case study had progressed the contractual arrangements sufficiently to influence the reconfiguration of services and other impacts, such as the achievement of financial savings. In this case the service reconfiguration aims and savings targets had been achieved. The view of the alliance members was that the alliance structure was central to the achievement of its aims, in particular that it had enabled the parties involved to focus on ‘best for service’ and ‘best for service user’ objectives rather than acting in organisational interests.

The National Development Team for Inclusion’s report (2019) on alliance commissioning in mental health found evidence of benefits from two case studies of alliance contracts in the English NHS, including reduction in referrals to secondary care, reduction in waiting times for secondary care, significant savings and improvement in wellbeing. However, the underlying mechanisms of the contractual arrangements were not made clear. A common

example of the success of the Alliance model is the Canterbury Health System alliance in New Zealand, which resulted the transformation of the system, addressing system wide financial and performance problems, and creating an extensive system of care coordination across hospital, community, social, and primary care, in which emergency medical admissions, lengths of stay, and readmissions fell (Timmins and Ham, 2013, Mays and Smith, 2013, Nicholson et al 2025). Notably, the alliance did not establish any financial mechanisms to share risks and rewards across providers. Similarly, the financial underpinning of other alliances which are thought to have achieved success in terms of service delivery and costs are often not detailed (Nicholson et al 2025).

Despite the relative prominence of the lead provider contractual model in the English NHS, this review only identified Jones et al (2024) account of the MSK lead provider contract which noted that the service had been a success, delivering outcomes and reducing the demand for acute intervention for MSK conditions.

Wider considerations: Diversity of contractual partners

Lead provider contracting and alliance contracting present challenges to securing diversity of provision and in particular the inclusion of smaller third sector organisations. In relation to competitive procurements of lead provider contracts and sub-contracts, evidence outside the NHS suggests that third sector organisations may be at a disadvantage, firstly in terms of having the necessary capacity to meet the demands of the procurement process, and secondly in terms of being able to win contracts in systems dependent on extensive discounting and large up-front resources (Bennet 2017). With models which seek to shift more risk towards providers, there is concern that provider markets may become skewed towards a small number of larger providers both statutory providers and larger independent (for profit) providers, with smaller and third sector (VCSE) providers struggling to absorb the risks of these contractual models (Mason et al. 2015, Carter et al 2025). Increased financial risk may conflict with mission statements and organisational commitments of third sector organisations (Bennet 2017).

NHS case study research indicates that third sector parties risk exclusion at various stages, including bearing of costs of the negotiation period, and the sharing of financial risk (Sanderson et al 2019). In contrast with these barriers to participation, third sector partners are considered by statutory providers to be valuable contractual parties with potential of

significant added value, including having a substantial impact on progressing negotiations and bringing partners together (Sanderson et al 2019). Ways of enabling third sector organisations to participate in NHS alliance arrangements include subsidisation of ex-ante transaction costs of the third sector organisation by Alliance partners, and excluding third sector organisations from risk sharing arrangements (Sanderson et al 2019). In relation to lead provider arrangements, an alternative approach adopted in relation to the lead provider contracting by the UK DWP for the provision of employment services was to set central expectations for lead providers' supply chains when tendering and contracting ('the Merlin Standard'). However, this scheme has not been found to be particularly effective in changing practice (Mason et al 2015).

Wider considerations: significance of context

Considerable attention has been given to understanding the vital role of context when selecting arrangements which aim to achieve large scale transformation such as contractual arrangements (Maniatopoulos et al 2020, Redgate et al 2023). Relevant local factors which may explain the conditions in which such arrangements are successful include quality of relationships, suitability of the service area (Sturgess et al, 2011), the complexity and nature of the mechanisms used, such as contractual mechanisms (Aunger et al 2021, Caetano and Cabral 2025), and the characteristics of the institutional environment (Caetano and Cabral 2025). In relation to lead provider and alliance contractual arrangements in health, evidence suggests that local challenges which may present a barrier to reaching agreement include dominance of particular organisations, historical mistrust, siloed organisational culture and poor financial health (Lovelock et al 2017, Gurung et al 2022, Sanderson et al 2019). Wider structural factors such as different funding models also present barriers (Akmal and Gauld 2021, Gurung et al 2022).

Empirical evidence from the English NHS relating to contracting in general indicates a heavy reliance on relational networks and norms (Hughes et al.2013, Hughes et al 2011), and the quality of relationships between contractual partners is an important aspect of both alliance and lead provider contracting. Evidence from outside the NHS suggests that lead provider contractual arrangements are not typically conceptualised as relationship driven, and there is potential for relationships to become strained if risk and cost pressure is passed down the supply chain (Finn 2011, Gallet et al 2015, Matthews and Parker 1999). Distrust may occur

between lead and sub-contractors due to the perception that lead contractors are profiting from the contracts at the expense of sub-contractors (Gallet et al 2015, Maddock 2013, Matthews and Parker 1999, Finn 2011). Investments in developing and sustaining relationships may be required (Bemelmans et al 2012, Finn 2011).

Trust is a fundamental aspect of alliance contracting to allow the alliance to effectively navigate pre-existing arrangements, strategy development and service redesign (Lovelock et al 2014, Sanderson et al 2019), and the emphasis given to the development of close trusting relationships between alliance partners is a unique aspect of the model. Although there is some evidence (relating to the alliance model) that contractual arrangements can improve relationships between partners (Brunner et al 2018), others conclude that contractual arrangements should not be viewed as a replacement for the need for strong relationships (Addicott 2014, Sanderson et al 2019). The development of trust takes time, a shared vision and commitment (Lovelock et al, 2014) and the use of contractual models can also magnify conflicts (Addicott 2014).

9. What are the lessons for the proposals of the 10 Year Health Plan?

This review of the evidence has considered findings from PRUHSSC outputs concerning alliance contracting and lead provider contracting from the period 2016 – 2019. These outputs consist of: a literature review of the evidence regarding the use of lead provider and alliance contracting in sectors other than health; empirical evidence from three PRUHSSC case studies of alliance contracting and lead provider contracting in the English NHS; and a review of the empirical evidence from the use of alliance and lead provider contracting in the provision of health services.

Despite the sparsity of robust empirical evidence, the review has highlighted critical points which should be considered in the light of the proposals of the 10 Year Health Plan.

Expertise in contract negotiation, planning and monitoring is required in both provider and commissioner organisations

Alliance and lead provider contracts carry significant transaction costs in relation to contract negotiation and planning, and the ongoing monitoring of contractual arrangements. The

negotiation of these complex contractual models in the English NHS is resource intensive, difficult and lengthy (Sanderson et al 2019). One case study of an NHS lead provider contract with outcome-based payments indicated that workload may have increased in totality (Jones et al 2024).

Evidence suggests that expertise is required in both the co-ordinating commissioner and lead provider organisations. It is crucial that co-ordinating commissioners retain sufficient expertise to have oversight of the development and operation of the local contractual arrangements to identify shortcomings in the lead contractor's performance, and to regain ownership and control of the contract should the lead contractor fail (Kebede 2011, Finn 2011). As noted in the 10 Year Plan, ICBs have a very important ongoing role in relation to the proposed novel contractual models: *'setting population health outcomes, monitoring delivery against agreed outputs and ensuring quality, choice and waiting lists are maintained through their contractual levers*' (UK Government 2026). The NHS Standard Contract makes clear that, in the case of lead provider contractual arrangements, the co-ordinating commissioner retains oversight and control of sub-contracting arrangements, including assessing the implications of complex sub-contracting arrangements. Importantly, ICBs will also remain the direct commissioners for services in areas not covered by the IHO contractual model. The ongoing resource implications of this oversight need to be clearly recognised and adequately resourced.

Additionally, it is also crucial that providers have sufficient in-house expertise and ability to process information to be able to take on new responsibilities, whether as IHO, MNP or SNP contract holders or as NHS lead providers. If this role is not funded at the outset, the evidence suggests that lead provider may seek to fund transaction costs by other means. Possible avenues which would be open to IHO, MNP or SNP contract holders or NHS lead providers would be negotiation of lower payment rates with subcontractors, or reduction of transaction costs through reduction of the number of sub-contractors. In relation to the IHO, MNP and SNP models, and NHS lead provider contractual arrangements, this may create unwanted effects such as causing tension between 'head' and other providers, and reducing diversity of provision. The evidence suggests that providers need to develop information systems, performance monitoring tools, as well as employing skilled contract managers to facilitate performance management of sub-contractors. Providers also need commissioning skills to take on new responsibilities for deciding how the population health budget should be spent to deliver health services to the local population, performance management skills and

procurement expertise. A significant risk lies in providers having to procure the sub-contracts, such as within the IHO model, where they will need to navigate the complex regulations regarding procurement and competition, such as the Provider Selection Regime (Bliss 2025, Osipovic 2026).

Current plans envisage an allocation of population health resources and expertise across ICBs and providers which is negotiated locally as IHO contracts are established, with ICBs refocusing on robust oversight of these new arrangements, ensuring that IHO contract holders are using their budget optimally to meet population health need (NHSE 2025b). The review of the evidence highlights the importance of adequate expertise residing in both ICBs and providers in order for the negotiation, implementation and oversight of these novel contractual models, and other contractual models such as lead provider arrangements, to be successful. The evidence suggests that transferring resources from ICBs to providers is unlikely be a sufficient approach to provide the resources required in both organisations. It may be that, in relation to the proposed IHO, SMP and MNP contractual models, transaction costs will be reduced somewhat as national support will be given, such as through the proposed blueprint of new delivery models to support commissioners and providers to develop local system architecture, and a package of action learning support for ICBs and their key partners regarding how to contract differently (NHS England 2026). The extent to which this will enable local teams to avoid some of the difficulties previously encountered in relation to local negotiation of contractual terms, such as reaching local agreement on service models and the allocation of financial risk between providers, is not clear.

Necessity of good quality data

The review of the evidence shows that access to good quality data is crucial. Agreement of complex contractual arrangements requires robust data which is trusted by all parties to facilitate the negotiation and agreement of the financial models underlying contracts, and allows the effective monitoring of contracts.

Importance of relationship management

IHO and Multi/Single Neighbourhood models are focused on the benefits of close co-ordination across providers, using contractual arrangements and payment mechanisms to

support integrated care delivery, aligning incentives and enabling a shift of resources from hospital to community. Success will depend upon unity of effort across multiple providers across acute, community, mental health and primary care, and it is clear that good relationships will be needed. Guidance for the IHO model highlights that the IHO lead provider will need to be a 'trusted convenor' who can demonstrate 'broad support from system partners', and has the ability to 'lead beyond organisational boundaries' (NHSE 2025a).

The evidence from outside the NHS shows that the lead provider model is susceptible to tension between the lead provider and sub-contractors, as lead providers seek to manage their own financial risk by passing it on to sub-contractors. Such tensions may lead to a loss of goodwill and disrupt collaboration. It is also the case that factors in the local context may strain relationships, such as dominance of particular organisations, and historical mistrust.

One measure to reduce the risk of this tension occurring in the NHS is to involve sub-contractors in the governance model of contract holders. IHO contract holder organisations will be responsible for proposing an IHO governance model which develops, or brings in, expertise which allows the Board to make decisions about the full range of population services, such as stakeholders from primary care and neighbourhoods (NHSE 2025a). This may consist of alliance-like arrangements which include representatives of sub-contractors, such as a model similar to the alliance governance model. However, importantly, such arrangements will not alter the individual accountability of the IHO lead provider for the performance of the contract, and there may be instances where interests do not align.

The review of the evidence suggests other measures to protect good relationships between lead providers and sub-contractors. These include ensuring that lead providers employ trusted contract managers who are skilled at building trusting relationships. The use of national policy guidelines which set out the expected 'rules of engagement' for lead provider and sub-contractor relationships is a mechanism which has been used in other settings.

Taking a proportionate approach to complexity

The review of the evidence suggests that complex contractual arrangements should be approached cautiously to avoid costs that are disproportionate to eventual gains. There is potential for high complexity in the contractual landscape envisaged in the 10 Year Plan for

Health. For example, it is envisaged that use will be made of risk sharing approaches and outcome-based payments, and there is the possibility of nested sub-contract arrangements, whereby IHO sub-contractors may also put in place sub-contracts. All of the sub-contracts for health services provision established by the NHS trusts and FTs must be procured in compliance with the Provider Selection Regime regulations, which is also a source of complexity. A further possible source of complexity is the negotiation of prices with sub-contractors. In relation to the current NHS sub-contract, it is the case that lead providers have freedom to negotiate their own prices with sub-contractors if they wish. It is not clear if this freedom will also apply to the novel contractual models proposed in the 10 Year Plan, or the extent to which this freedom is being exercised in practice in relation to NHS lead provider contracting.

Evidence of the use of lead provider and alliance contracting in the NHS shows that there has been a risk in the past that the effort negotiating the implementation of such complex arrangements is disproportionate, either to the overall value of the contract, or the effect of a particular mechanism. The English NHS evidence is clear that previously the appetite for financial risk has been low, with outcome-based payments (where used) which tend to be inconsequential in nature, and difficulties agreeing risk share arrangements. Consequently, the incentives put in place have been weak. Therefore all parties should consider the relative risks and benefits, including commissioner and provider appetite for risk, before putting in place complex contractual arrangements.

Consideration of diversity of provision

The 10 Year Plan articulates the value of diversity in the provision of NHS services:

> *Our use of a plurality of providers - from within the NHS, the voluntary sector, the independent sector or social enterprise - will not be limited to elective care. Where there is such rapid innovation taking place today in how services can be transformed through advances in science and technology we want to broaden the ecosystem of providers. (UK Government 2025)*

The review of evidence indicated a number of risks to diversity of provision under lead provider models, for example third sector and smaller providers may be unable to bear the transaction costs of negotiation or they may be unable to participate in financial risk sharing.

Lead providers meanwhile may choose to contract with fewer, larger providers in order to reduce their transaction costs. Conversely, the evidence also illustrates that third sector providers are valued contributors to multi-lateral contractual arrangements. It may be that measures need to be put in place to safeguard diversity of provision in local areas.

The need for better evidence

It appears that the use of lead provider models is increasing in the NHS, and it is unclear how the use of alliance contracting in the NHS is developing. Despite the growing prevalence of the lead provider model in the English NHS, the publicly available evidence regarding the negotiation of these contractual arrangements and their operation is sparse. It is not clear whether contracts procured as a lead provider contract have resulted in sub-contracting, and how arrangements within these contracts are functioning in practice in relation aspects such as relationship management, negotiation of payment, use of payments for outcomes, monitoring of performance and realisation of transformative potential across providers. In light of the plans for IHOs and Multi- and Single Neighbourhood providers it is important that learning takes place from lead provider arrangements already in place through empirical research.

10 Conclusion

In this paper we have reviewed the evidence from previous PRUHSSC outputs relating to lead provider contracting and alliance contracting in the English NHS. Our analysis resulted in six areas which should be considered in relation to the contractual proposals of the 10 Year Health Plan. These are:

1) Expertise in contract negotiation, planning and monitoring is required in both provider and commissioner organisations
2) Necessity of good quality data
3) Importance of relationship management
4) Taking a proportionate approach to complexity
5) Consideration of diversity of provision
6) The need for better evidence

This review of evidence forms part of ongoing PRUHSSC work to examine the development of provider collaboration in the English NHS. The interim report (Petsoulas et al 2025), which examines how provider collaboratives are developing as a key policy initiative aimed at securing inter-provider co-operation, is available on the PRUHSSC website. In the next phase of the study we are conducting case study research to consider the wider spectrum of the models and structures of inter-provider co-operation which co-exist alongside provider collaboratives, and how provider collaboration is facilitating the shift from hospital to community. The study will consider the pre-existing and developing models and structures of inter-provider co-operation, including how these relate to and build on the work of provider collaboratives. We will also investigate whether novel contractual and payment mechanisms (e.g. lead provider contracts, alliance agreements, outcome-based payments) are being considered or adopted to support provider collaboration aimed at facilitating the hospital to community shift. The study will conclude in December 2027.

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APPENDIX 1 – SUMMARY OF METHODS OF PRUHSSC OUTPUTS USED IN THIS REVIEW OF THE EVIDENCE

This output brings together evidence from three previous PRUHSSC outputs concerning lead provider contracting and alliance contracting. The methods of the original outputs are described below.

Literature review of evidence relating to alliance, lead provider and outcome based contracting in sectors other than health

SANDERSON, M., ALLEN, P., GARNETT, E., GILL., R 2016 Alliance contracting, prime contracting and outcome based contracting: What can the NHS learn from elsewhere? A literature review. PRUHSSC development-of-provider-collaboratives-interim-report-060825.pdf

The literature search focused on three models: alliance contracting, prime provider contracting and outcome-based contracting. The search strategies consisted of an initial background search to gain a feel for the literature, including the characteristics of the models and key theoretical concepts, followed by a database review, a Google scholar search and, lastly, snowballing from references. The literature review took a purposive sampling strategy: literature was selected for inclusion based on relevance to the specific research question (learning about the contractual models which could be applied to the English NHS) rather than absolute criteria of methodological characteristics or rigour. This search method was considered apt given the scarcity of relevant empirical studies identified in the background search. The search was not restricted to specific dates. Four databases were selected to reflect a range of disciplines (Abi-inform, Web of Science, Academic Search Complete, Business Source Premier), and searched for a combination of keywords based on the terms 'alliance based contracting', 'prime provider contracting' and 'outcome based contracting'. The inclusion criteria consisted of primary quantitative and qualitative research published studies, or reviews of primary quantitative and qualitative research published studies, and theoretical literature, written in the English language, for which the full text was available. Alongside academic papers, the review included 'grey' literature such as reports detailing relevant policy initiatives and unpublished doctoral theses. The terms of the literature review excluded evidence related to the USA Accountable Care Organisations model. While ACOs have similarities to both lead contracting and alliance contracting, these are deployed within a significantly different environment and take a different contractual form, for example, providers in an ACO form a single legal entity (Barnes et al. 2014).

The database search identified 706 documents. These were reduced to 26 based on relevance following a review of article title and abstract. Google search and snowballing from references identified 49 further relevant documents, and 66 documents were included in the final review following the removal of duplicates. Five literature reviews relating to the use of the new contractual

models in industry were identified (Selviaridis and Wynstra 2015; Chen et al. 2012; Hypko et al. 2010; Bemelmans et al. 2012; Finn 2011).

Three in-depth case studies of the introduction or operation of Alliance contracting and lead provider contracting in the English NHS

SANDERSON, M., ALLEN, P. OSIPOVIC, D., MORAN, V. 2019. New Models of Contracting in the NHS. PRUHSSC. new-models-of-contracting-final-report-1-.pdf

The research consisted of three in-depth case studies (case studies A, B and C) to investigate how new models of contracting are being used in the NHS. Each case study relates to a new contractual arrangement being put in place by a Clinical Commissioning Group (CCG). The research questions were:

1. why commissioners choose particular models of contracting, and what they think such models can achieve

2. in detail the characteristics of these new contractual documents, in particular how outcomes are specified and how financial risk is shared between the parties

3. how the contracts are used in practice, in particular whether the contractual documentation is adhered to, and if not, in which ways it is not

4. the strengths and weaknesses of the different contractual models, both in respect of encouraging cooperation between providers and achieving better outcomes

5. how the NHS Standard Contract is used in conjunction with the new models of contracting, and whether any problems arise in attempting to do so

6. how the new contractual models contribute to reconfiguration of services in local health economies

Possible case study sites were identified by reviewing a database of relevant media reports and through building on existing research contacts/insights. We shortlisted a number of possible sites by locating publicly available information (most commonly Board papers) to identify a shortlist of contractual arrangements which included a variety of types of contract and payment mechanisms (e.g. alliance agreements, lead provider contracts etc), also taking into account the variety of types of services subject to those contracts and the value of the underlying service contracts. The first stage of data collection was conducted between October 2016 and March 2017 (with two supplementary interviews in May June 2017). A second stage of data collection took place between April and July 2018.

The field work consisted of three main activities: we analysed the contracts and supporting documents produced in each area; we interviewed the relevant senior managers of the organisations which were party to the contracts; we observed meetings of the contracting parties at which they specified and monitored performance in relation to the new contractual models. During the first stage of fieldwork we interviewed 20 people (in 17 interviews) across the three case study sites. During the second stage of research we interviewed 8 people (in 7 interviews) across the three case study sites. Representatives of all contractual (or proposed contractual) partners were interviewed. All interviews were conducted face to face at the interviewees place of work.

Table 1 – Interviews by case study site

Case study	Type of contract	No. of interviewees – first stage	No. of interviewees - second stage	Total interviewees
A	Alliance agreement	7	1	8
B	Alliance agreement	7	3	10
C	Joint venture agreement	6	4	10

Review of empirical evidence relating to use of alliance contracting and lead provider contracting in relation to the provision of health services

SANDERSON, M., ALLEN, P. OSIPOVIC, D., MORAN, V. 2019. New Models of Contracting in the NHS. PRUHSSC. new-models-of-contracting-final-report-1-.pdf

The literature review took the form of a 'narrative review' to enable flexibility in search procedures encompassing a large and diverse evidence base (Dixon-Woods et al., 2004). Literature was selected according to relevance as opposed to a fixed set of methodological criteria. We adopted a pragmatic approach in our literature search strategy. First, we identified relevant literature from the review of the wider literature (see above) which related to the use of alliance and lead provider contracting in the provision of health services. This search was followed by a Google search using a wide range of terms such as: 'alliance contract', 'prime provider contract', 'lead provider contract' combined with 'health' or 'NHS'. We did not restrict our search to specific dates. The search was conducted in 2018. Titles and abstracts were reviewed, extended to rapid scans of articles where necessary. We focused on qualitative published studies written in English. Because of the wide range of search terms required this search was extensive but not exhaustive. Through 'snowballing' of references we identified further relevant studies. Additionally we conducted a review of news articles in the Health Service Journal, following similar search terms. This literature review was updated on 2026, and the additional literature included in this review of the evidence.