NHS England

Contracting arrangements for integrated care providers – response to consultation

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Contracting arrangements for integrated care providers: response to consultation

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1 Context and development

1.1 What is the ICP Contract?

1. There is a long-recognised need for health and care services to be better integrated to improve people's care, reinforced recently by the House of Commons Health and Social Care Committee's support for improving integration of care.[1] In January 2019, the NHS Long Term Plan highlighted the intention to 'dissolve the historic divide between primary and community health services' and further stated:

   'The NHS will be more joined-up and coordinated in its care. Breaking down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care'.

2. The NHS Long Term Plan sets out the centrality of integrated care systems (ICSs) to achieving this goal. In ICSs, commissioners and providers of NHS services, in partnership with local authorities and others, voluntarily take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve. Collaborations will also take place at different levels in the system, including through provider partnerships, such as networks of primary care providers. The NHS Long Term Plan committed to new investment of at least £4.5 billion over the next five years in primary medical and community services to deliver stronger integration and out of hospital care. This will support, for example, expanded community multidisciplinary teams aligned with new primary care networks, and a new offer of urgent community response and recovery support.

3. The health and care services provided to an individual or population are currently arranged via a series of different contracts, awarded by NHS and local authority commissioners to a range of different providers. For example, each GP practice holds a contract of one sort for primary medical services, whilst hospital, mental health or community NHS services are bought using another type of contract, usually independently from each other. In addition, many public health and social care services are delivered by local authorities themselves. A complex set of separate contracts, organisations and funding streams can lead to duplication and lack of coordination, make communication between providers, clinicians and patients more difficult, and risk loss of focus on the overall needs of the person. This affects how people receive their care from the various health and care services across the system, and could adversely affect those services.

4. For this reason, in some areas, commissioners and providers have found it helpful to put in place an overlaying agreement (which can be known as an 'alliance agreement'), supplementing the providers' individual contracts with the commissioner and formalising their collaboration. This agreement can describe

[1] The House of Commons Health and Social Care Committee Integrated care: organisations, partnerships and systems Seventh Report of Session 2017-19 [p17] can be found on the Government website: https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/inquiry4/ (Information accessed 25 July 2018)

shared processes, goals and incentives, and set up a joint forum for discussion of what is best for the population and for the achievement of the defined goals, and how budgets and resources can best be used to those ends. In these collaborations there can be a sense of shared system accountability for managing separate organisations' resources, quality improvement and population health in a more aligned way.

5. Despite the longstanding aim of improving integration there has never before been a commissioning contract designed specifically to promote an integrated service model including primary care, wider NHS and some local authority services. Though contracts alone do not deliver integration, commissioners want the opportunity to use a contract of this type to ensure contracting, funding and organisational structures all help rather than hinder staff to do the right thing and to define more clearly who has overall responsibility for integrating and co-ordinating care.

6. The development of the NHS Standard Contract (Integrated Care Provider) Contract ('ICP Contract') responds to the demand from some commissioners and providers for a single contract through which general practice, wider NHS services, and in some cases some local authority-funded services, may be commissioned from a single 'lead' provider organisation, responsible for delivering those services in an integrated fashion. We call such a provider an 'Integrated Care Provider' (ICP). ICPs are not new types of legal entity, but rather provider organisations (such as NHS foundation trusts) which have been awarded ICP contracts.

7. The ICP Contract is largely based on the generic NHS Standard Contract, and includes additional provisions specifically designed to:
   - ensure the ICP is required to deliver integrated, population-based care
   - ensure, as far as possible, consistency in terms and conditions in relation to different services, reducing the risk of conflicting priorities or requirements getting in the way of clinicians and care workers doing the right thing for people in their care
   - accommodate a population-based payment approach, allowing flexible deployment of resources to best meet needs and encouraging a stronger focus on overall health and prevention of ill-health, rather than simply paying for activity delivered
   - accommodate aligned incentives across all teams and services.

8. Commissioning services in this way, as we understand many clinicians and staff want to see it, can ensure the sustainability of care redesign – perhaps cementing developments already achieved through looser models of collaboration. It can ensure the benefits of collaboration are not lost over time. In particular, the new contract is designed to facilitate a stronger role for providers of primary medical services, allowing GPs to work at the heart of the system and with colleagues to take an operational, clinical leadership role in co-ordinating the care that is delivered to their patients, treating them in the most appropriate setting, close to home.

1.2 History of publication and development

9. Engagement on what is now the draft ICP Contract began with six 'vanguard' areas working towards implementation of the Multispecialty Community Provider (MCP) care model. A contract development group was established in 2015 which brought together interested clinical commissioning groups (CCGs) with wider stakeholders such as the Royal College of General Practice (RCGP), the British Medical Association (BMA), and the National Association of Primary Care (NAPC). This early co-development period led to a publication of a draft 'MCP Contract Package' in December 2016, which began an engagement period in which feedback was invited on the draft.

10. Following its publication, it became clear to NHS England that the draft MCP Contract could in fact have a broader application. The next version of the draft contract was re-named to reflect this and published in August 2017. We published alongside it a summary of the engagement received earlier in the year on its first iteration as the draft MCP Contract.[2,3]

11. Our initial intention had been to consult formally on the draft ICP Contract following testing with early commissioners and providers. In early 2018 however, we committed to bringing our consultation forward to take the opportunity to explain our proposals in more detail, and to dispel misconceptions about what integrated care models might mean for the NHS in England and for the people who rely on it.

12. The consultation began once the High Court had decided two judicial reviews in NHS England's favour:
    - *R (oao Jennifer Shepherd) v NHS England* [2018] EWHC 1067 (Admin)[4], which concerned the lawfulness of the payment approach contemplated by the draft ICP Contract, the whole population annual payment.[5]
    - *R (oao Hutchinson & others) v SSHSC and NHS England* [2018] EWHC 1698 (Admin)[6], which concerned, in general terms, the lawfulness of the ICP model and the manner of its introduction.[7]

[2] The full draft Contract package published in August 2017, including a summary of the feedback previously received, can be found on the NHS England website: https://www.england.nhs.uk/new-business-models/publications/. This package of documents may be further updated.

[3] The previous iteration of this draft ICP Contract was referred to as the draft Accountable Care Organisation (ACO) Contract. At that point in time, we described ICPs as accountable care organisations or ACOs. We have changed our terminology in recognition that, as reported by the House of Commons Health and Social Care Committee, use of the term 'accountable care' has generated unwarranted misunderstanding about what is being proposed. We believe that the terms 'Integrated Care Provider' and 'Integrated Care Model' better describe our proposals – to promote integrated service provision through a contract to be held by a single lead provider.

[4] The judgment can be viewed here: https://www.bailii.org/ew/cases/EWHC/Admin/2018/1067.html

[5] The Claimants in the other judicial review challenge did not seek permission to appeal the High Court's judgment.

[6] The judgment can be viewed here: https://www.bailii.org/ew/cases/EWHC/Admin/2018/1698.html

[7] Note that following the start of the consultation, the Appellant in the Jennifer Shepherd judicial review challenge sought to overturn the decision of the High Court in an appeal to the Court of Appeal. Her appeal was unsuccessful in respect of all seven of her pleaded grounds and, for eleven reasons, the decision of the High Court was upheld by the Court of Appeal in its judgment dated 20 December 2018 (citation number: [2018] EWCA Civ 2849). The judgment can be viewed here: https://www.bailii.org/ew/cases/EWCA/Civ/2018/2849.html.

1.3 Summary of consultation approach

13. The consultation ran over a period of 12 weeks, from 3 August-26 October 2018.

14. In support of the consultation, we published a consultation document setting out our proposals (along with an easy read version), the draft ICP Contract and other supporting materials. These were available on the NHS England website and were available in hard copy format by request. We worked with voluntary sector organisations, patient groups and networks in a variety of ways to raise awareness about the proposals.

15. We held engagement events, open to those who expressed interest in attending, in London, Leeds, Exeter and Birmingham. At each location there were sessions for members of the public and for NHS and other stakeholders. A further event was held specifically for local authority representatives.

16. There were various options for people to give written feedback to the consultation. These included an online survey based on the questions outlined below, and postal responses. We also received a number of responses via email and made available an easy read questionnaire.

17. The consultation document set out 12 questions for feedback. These related to:
    - whether people supported the option of a single contract that promotes the integration of services
    - proposed content in the draft contract aimed at promoting integration
    - the balance between national and local content in the draft content
    - whether an 'integrated budget' offers a useful flexibility for commissioners
    - the proposed contractual safeguards about service quality, patient choice, transparency and financial management
    - GP participation in an ICP
    - local authority participation in an ICP
    - proposed contractual safeguards about commissioners' statutory duties
    - proposed contractual provisions about public accountability
    - proposed contractual provisions about value, quality and effectiveness
    - additional suggestions for the draft ICP Contract
    - the equality and health inequalities impact of the proposed national provisions in the draft ICP Contract.

2 Who responded to the consultation?

18. In total, we received 3,806 written responses to the consultation. These included:
    - 466 responses to our online survey
    - 67 responses to the easy read version of the survey
    - 3,273 responses received by email and post.

19. Of the 3,806 total written responses, we judged that 3,276 (86%) were part of organised campaigns, identified through their use of common response templates repeating key themes and phrases. Three separate template responses were identified – with 3,161 responses on the first,106 on the second and ten on the third[8].

20. The table below breaks down the responses by different types of respondent, based on categories available for selection through the Citizenspace survey[9]:

Respondent Type	Number of responses
Member of the public	**3,595**
Other	**57**
NHS provider organisation	**23**
Clinical Commissioning Group (CCG)	**23**
Voluntary organisation or charity	**17**
Clinician	**14**
Local authority	**15**
GP organisation/individual GP	**11**
Patient representative organisation	**15**
Professional representative body	**22**
Not Answered	**6**
Other healthcare organisation	**6**
Academic	**2**
	3,806

21. In addition, a petition addressed to NHS England received 31,870 signatures. Its content was similar to that of the most common template campaign response.

22. Approximately 250 people attended our engagement events. Those attending included members of the public and representatives from provider organisations, commissioners, GPs, local authorities, professional representative bodies and charities.

[8] One response was identified as using text from two of the campaign templates.

[9] Respondents to the Citizenspace survey self-identified their respondent category. We have identified the respondent category responses received by post and email, and for the easy read survey.

3 Summary of feedback and response

3.1 Summary of feedback

23. Responses varied considerably across the different types of respondent. NHS providers and commissioners were generally supportive of introducing the ICP Contract as an option for local systems to enable integration. They acknowledged and confirmed the proposed benefits of such a contract, whilst recognising that considerable engagement and strong relationships would be required locally before considering its use. The benefits identified included, for example, the opportunity an ICP would have in removing organisational and other barriers between different parts of the health and social care system, which may currently lead to duplication of work and confusion for patients. It was noted that the contract should provide the flexibility to enable staff and teams to work differently, and enable a stronger focus on preventing ill-health. For example, NHS Clinical Commissioners (a representative body for CCGs) stated:

> *'A key potential benefit of the ICP Contract is that it is designed to promote an integrated service model, affording the opportunity to commission primary care alongside wider NHS services, public health and social care provision. This has the potential to further integration and the delivery of person-centred care.'*

24. An NHS provider stated:

> *'It is clear that there is a need to move to a new way of working which enables integration of services to be delivered irrespective of provider organisation. The current contracting arrangements make this hard to achieve as organisational barriers will always get in the way of enabling integration of services to occur.'*

25. Responses from the small number of individual GPs who responded were mixed. Responses from GP representative bodies (particularly the BMA and the RCGP) raised various issues in their responses, including their concerns about what they refer to as the *'potential marketisation of the NHS'* through competition for contracts, and that the likely scale of an ICP would mean only large organisations would be capable of holding the contract, limiting the opportunity for GPs to have leadership opportunities and autonomy. The RCGP and BMA welcomed the aim to deliver greater integration of services, for example the RCGP stated:

> *'It is widely agreed that there is a need for greater integration of care to improve patient experience, quality of care and outcomes. It is hoped that integration will help address current unsustainable pressures within the NHS and social care, and as the challenge of caring for an ageing population with multiple co-morbidities grows, represent an opportunity to collaborate and improve the patient journey. In order for there to be widespread change, there must be joint working between primary care, secondary care, mental health, social care and the voluntary sector.'*

However, these representative bodies raised specific issues about the effectiveness and widespread viability of options proposed to enable GP

integration in an ICP – including around the complexity and viability of elements of the 'fully integrated' option, where GPs would be given the option of suspending their current primary medical services contracts for a period of time in order to become an employee or sub-contractor of the ICP. For example, the BMA highlighted that they *'retain serious doubts about the practicality of the "right of return" proposals, open to practices should they agree to suspend their respective GMS/PMS contract and integrate fully into an ICP.'* The BMA also highlighted their view that collaboration is already occurring effectively through local agreements which do not require new contracts. A small number of responses also queried how emerging forms of collaboration such as primary care networks would relate to ICPs.

26. Local authority responses (including a joint response from the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS)) were generally supportive of the option of a contract to support health and social care integration, but raised general questions about how adequately the current version provides for integration of local authority services with healthcare. They also expressed concern about potential barriers to a local authority itself holding an ICP Contract, and we heard some wider views about potential challenges of local authority participation in an ICP model.

27. A significant majority of responses from members of the public, including those related to organised campaigns, were opposed. A widely-held concern expressed in these responses related to the potential for private sector bodies to hold an ICP Contract, and there was considerable support for preventing non-statutory bodies from holding an ICP Contract altogether. Specific related concerns included whether the performance of an independent sector ICP would be sufficiently open to public scrutiny. For example, the petition and responses associated with one campaign stated:

    'This would mean that profit-making companies – who have often failed our NHS – could be responsible for the care of whole areas of the country, even though they're not a statutory part of the NHS.'

    Some associated concerns were raised in the consultation that private providers may prioritise profit which could result in reduced quality of care or access to services, or local or regional monopolistic providers could emerge. Many respondents rejected in general the principle of contracting as the basis for service provision in the NHS.

28. A number of other themes and specific comments were received across the consultation feedback, including:
    - Concerns the potential role for sub-contractors in delivering services commissioned through an ICP Contract may lead to duplication between commissioners and the ICP in carrying out provider / contract management activities, which might limit the extent to which an ICP would achieve a meaningful and effective transformation in care
    - Concerns about how a CCG would effectively hold an ICP to account
    - Whether a provider organisation would have the necessary skills and capability to successfully meet the requirements of an ICP Contract, such as to deliver a population-based approach

- A consensus among many respondents, consistent with statements we had made in the consultation pack, that the ICP Contract should not be presented as the only option for local systems, but as one of a number of different approaches to integration available to commissioners and providers.

29. Further detail about the feedback we received in response to each specific consultation question is contained in Annex A.[10]

3.2 Our response

30. We have analysed and considered in detail the feedback received throughout the consultation. There is support across NHS commissioners and providers for making the ICP Contract available as an option for local systems, and widespread agreement with the proposal set out in the consultation pack that, if adopted, its use should be voluntary, recognising the range of options available to systems. Many respondents agreed that an ICP Contract has the potential to underpin integration of primary medical services and other health and care services. We therefore consider that the rationale for asking a lead provider to take responsibility for this integration remains strong where the necessary local conditions are in place, including buy-in from local GP practices and the wider system.

31. We address below three broad themes which arose from the consultation responses. The first of these, expressed in particular by members of the public through the campaign-related responses, relates to the potential for an independent sector organisation to be awarded an ICP Contract. We then discuss the ability for the ICP to achieve successful integration of primary medical services and local authority-commissioned services and finally the feedback relating to the changes to commissioner and provider roles where an ICP is commissioned.

32. More detailed feedback and responses for each consultation question is provided in Annex A.

3.2.1 The benefits of a statutory body holding the ICP Contract

33. The experience of CCGs who have been exploring the possibility of an ICP Contract for their area supports the view that a statutory provider is likely to be identified as the most capable organisation to hold such a contract. Statutory bodies have been selected as preferred bidders in the ongoing procurement in Dudley, the area where the first ICP Contract may be awarded. This likelihood reflects the need for any organisation which would wish to become an ICP to demonstrate wider sign-up and strong relationships with different providers across the system, in addition to assuring commissioners that it had the experience, resilience and capability to deliver the required services to a high standard.

[10] In some cases, similar themes were raised in response to multiple consultation questions. In summarising consultation feedback for this report, we have generally sought to ensure that the comments for specific themes are included in the summary for one question only in order to reduce duplication.

34. However, it should be understood that current NHS law and EU and domestic procurement law prohibits CCGs or NHS England from taking steps, whether through evaluation criteria used in a procurement or otherwise, to disqualify certain categories of provider (e.g. independent sector providers) from bidding for or being awarded commissioning contracts. It is with these rules in mind that we included in the draft ICP Contract package a range of financial safeguards, over and above those already in the generic NHS Standard Contract, that would apply to provide additional assurance to commissioners and the public in the unlikely event that a non-statutory provider should be awarded an ICP Contract. These safeguards have been proposed specifically to recognise the anticipated broader scope and scale of ICP Contracts in comparison with existing NHS commissioning contracts, and to provide security to patients and the public that services will be protected. These safeguards include, as examples:
    - requirements to maintain a minimum level of assets
    - a restriction on carrying out any business other than that required by the ICP Contract
    - a prohibition on distribution of funds unless a range of quality standards and financial conditions have been met
    - the expectation that the ICP will secure a guarantee from its parent organisation or a third party, providing financial security for the ICP's performance of the ICP Contract.

35. In order to provide further assurance regarding financial stability, transparency and accountability we will take the following steps before the ICP Contract is republished:
    - We will provide guidance as to the further contractual protection and stringent capitalisation and financial standing and security requirements that an ICP will be required to satisfy, constituting an important safeguard for ongoing delivery of services.
    - We will include in the ICP Contract new standards more explicitly requiring ICPs to act in an open and accountable way. These will include:
        - requirements to hold board meetings in public
        - additional transparency standards requiring performance and financial information to be published and made available directly to patients and the public
        - more explicit requirements, in response to specific suggestions in the consultation, for the ICP to work directly with local Healthwatch and other supervisory bodies.

36. Alongside the publication of the ICP Contract, we have considered further legislative steps, part of a package outlined in the NHS Long Term Plan, which if enacted would support commissioners and providers in developing and carrying forward proposals to put in place an ICP more quickly and with less bureaucracy than is possible currently. The proposals have accordingly been designed to facilitate local discussions to identify a suitable public body where this consensus has been reached. The two related proposals:
    - provide for the creation of new statutory bodies ('integrated care trusts') which would be fit-for-purpose organisations to perform the role of integrated care provider for a defined population; and
    - allow NHS commissioners to decide the circumstances in which they should use procurement, subject to a 'best value' test to secure the best outcomes for

patients and the taxpayer – which would enable local commissioners to award a service contract to an appropriate statutory provider organisation without the need to undertake a process as required by current procurement rules.

37. The agreement of these proposals by Parliament is, at best, some years off. However, if progressed they would support CCGs to act more freely in delivering improved outcomes and integration for patients, and so we will continue to advocate for these changes as we learn from early adoption of the ICP Contract.

3.2.2 The inclusion of GP and local authority funded services

38. We agree with the many respondents, such as the RCGP, who told us the inclusion of primary medical services is vitally important to the delivery of a whole population model of care, given the central role of general practice in every health system. We will continue, in response to concerns raised particularly by the RCGP and the BMA, to reassure GP practices that whether and how they participate in an ICP model is entirely voluntary, noting respondents' views that the availability of a range of options is important.

39. While GPs would be able to choose whether and how they wish to participate in an ICP, GP responses demonstrate that some are concerned about how reactivation of suspended General Medical Services (GMS)/Personal Medical Services (PMS) contracts (the mechanism for which remains subject to changes in regulations developed through discussions with the BMA and was previously consulted upon by the Department of Health and Social Care in 2017[11]) will operate in practice for 'fully integrated' models. No specific suggestions for further refinement of this mechanism were made by respondents however, we also recognise the potential benefits and opportunities for GPs and other partners in working in closer collaboration within a fully integrated ICP, and are committed to making this an attractive option locally for those GPs who choose it.

40. It will be necessary for us to share learning from ongoing procurements where GPs have demonstrated strong support for the model, and we will further develop the template integration agreement between GPs and the ICP, for use where GPs choose the 'partially integrated' option.

41. In addition to the options for individual practices, both the Long Term Plan and subsequent five year framework for GP Contract reform set out the ambition to support the Primary Care Network (PCN) development across the country, enabled by a new PCN Contract from 1 July 2019. PCNs make sense regardless of whether ICPs occur locally. PCNs are a natural development of the localities at the heart of whole population care models. Where practices are partially integrated with an ICP and retain their GMS or PMS contract, an ICP will be in a position to integrate its services with those delivered through networks, in line with expectations of other community providers. Where GPs decide to participate as fully integrated practices, they will similarly be supported to work more effectively

[11] The Department of Health and Social Care's consultation and response are available at https://www.gov.uk/government/consultations/accountable-care-models-contract-proposed-changes-to-regulations (accessed 12 January 2019).

at scale within an ICP, enabled through the infrastructure and support it will be able to provide.

42. While local authority responses in general welcomed the goal of integration we are seeking to enable through the ICP Contract, responses have demonstrated that barriers remain to the integration of local authority-funded services with healthcare services through an ICP Contract. Although the joint response from the LGA and ADASS highlighted and welcomed changes that we had made to the ICP Contract following engagement with them, many respondents pointed out that the different statutory frameworks underpinning the NHS and local authorities are likely to continue to act as barriers to integration unless and until those frameworks are aligned. We will continue to engage closely with local authority representatives to ensure we both learn from experiences elsewhere where health and social care integration has been successful, and in developing the ICP Contract further in due course to reflect new learning that arises out of its early use and to facilitate integration as far as current legislation allows.

3.2.3 The role of an ICP will require it to take on greater responsibility for some activities such as sub-contracting and population health management

43. The ICP proposals envisage that in order to perform this role properly, the ICP will itself need to take on responsibility for the coordination and management of a wide range of services in the system. In a complementary way, the ICP Contract specifically sets out new standards requiring the ICP to consider more thoroughly the health needs of the population, and ensure it is developing longer term strategies to meet those needs.

44. It is true that the ICP Contract envisages the ICP taking a different role in the system compared to the more traditional role that a provider may currently play in the system, for example where an existing provider may only be responsible for a specific portion of the services to be delivered to any one patient. While many providers already use subcontractors, the ICP Contract represents an attempt to allow a lead provider greater flexibility to join up a wider range of services which any one patient may be required to use over the course of their life. It is unlikely that any single organisation will ever be able deliver all of the services that a population requires. However, it is important that whilst not delivering all services, the provider is held to account properly for their collective delivery, as this provides the incentive for it to think more carefully about the best way to improve quality. Alongside this responsibility, it must have flexibility to achieve this, including through the power to contract with other providers in the system to deliver the desired integration. This is an important power, and complements the payment approach in the ICP Contract, which aims to offer flexibility to the provider holding the ICP Contract to use its available funding to respond to areas of poor performance or target longer term improvements in health outcomes.

45. Whilst we believe these new flexibilities and powers are important to effectively perform the role of an ICP, we also acknowledge that the expanded role of a provider holding this contract necessitates a range of new checks and balances to be in place, supporting any ICP to deliver this role. For example:

- Through appropriate national oversight we will ask whether a potential provider of this type of contract – such as an existing NHS foundation trust – has the capability and capacity to deliver services required under the contract to the highest possible standard. This includes testing through the Integrated Support and Assurance Process (ISAP) [12] that the provider has good relationships with other partners in the system so they have a shared and coherent vision of how to integrate and improve services, or that they have demonstrated sufficient rigour in their approach to health analytics prior to commencing delivery, that there can be confidence they will be able to deliver this role properly and plan carefully to meet the current and future needs of the population.
- Similarly, through ISAP, we will seek assurance from the responsible commissioners that any proposals protect the long-term sustainability of high quality services, irrespective of where and how they are currently provided. This assurance – alongside the engagement and testing which CCGs will already be carrying out – will test whether the ICP will itself take an active role in the delivery of services.
- As outlined in the consultation document, we have given commissioners the ability to intervene effectively in the delivery of an ICP Contract, should this be required. For example, the commissioners have the power to suspend or terminate individual parts of the contract where the provider is not meeting important service requirements, so it can if necessary change how those services are delivered or require their delivery by other providers. A commissioner also has the power to enter into direct agreements with any subcontractors that the ICP has put in place, complementing existing rights to approve such subcontracts in advance, and prevent their alteration without agreement.

46. All of these protections are in place specifically to ensure that a CCG is always able to carry out its role effectively in arranging delivery of services and holding providers to account across the system for their quality and performance.

47. Finally, other national support is being developed, in part through proposals outlined in the NHS Long Term Plan, which will help to develop capability and knowledge that will enable providers to more effectively deliver an ICP Contract. For example, all services will benefit from the ongoing investment in improving population health management techniques, helping systems to identify the greatest areas of unmet need. In addition, the new commitments on tackling health inequalities will lead to a greater awareness and ability to respond to and manage inequalities across different pathways such as cancer, maternity, and long-term conditions, with ICPs and other providers able to benefit from the increased national focus and investment.

[12] ISAP provides a co-ordinated approach by NHS England and NHS Improvement to supporting and assuring the procurement and transactions related to complex contracts. Further details can be found in the ISAP documents on the NHS England website: https://www.england.nhs.uk/publication/integrated-support-and-assurance-process/ (Information accessed 12 January 2019)

4 Next steps

48. In response to the feedback received, and including the important steps outlined above to put additional controls in place over ICPs and improve transparency and accountability, we will make a number of changes to the ICP Contract before it can be used by any commissioners.

49. Following these improvements, the ICP Contract will be made available in a controlled and incremental way, conditional on successful completion of NHS England and NHS Improvement assurance through the ISAP, and initially focusing on those commissioners which have already taken steps towards using an ICP Contract prior to our consultation. This incremental approach is in line with the recommendation of the House of Commons Health and Social Care Committee.[13]

50. Recognising that much engagement and consultation has taken place in those early frontrunner areas, we intend to publish a revised version of the ICP Contract in due course to support those processes. This will follow the publication of, and reflect, the generic NHS Standard Contract 2019/20. We will ensure the use of the ICP Contract is controlled by making it available only by specific exception to the general mandate to use the generic NHS Standard Contract to commission non-primary care healthcare services. The ICP Contract will continue to develop through a process of co-production with early adopter commissioners and other stakeholders, and further iterations will be published when appropriate. We will also continue to provide guidance to support commissioners and providers that wish to use it.

51. The DHSC will publish Directions (which were subject to a separate consultation during Autumn 2018) later this year. Following the decision to make the ICP Contract available the DHSC laid regulations in Parliament, following the consultation process undertaken in 2017, in support of the ICP Contract on 13 February 2019.

[13] Seventh Report of Session 2017-19 [p41] can be found on the Government website: https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/inquiry4/ (Information accessed 18 January 2019)

5 Annex A – Overview of responses by question

5.1 Question 1: Option of single contract

We asked…

Should local commissioners and providers have the option of a contract that promotes the integration of the full range of health and, where appropriate, care services? Yes/No/unsure; and please explain your response.

Respondents said…

52. Stakeholders such as NHS commissioners, NHS providers and local authorities generally supported the option of a single contract to promote the integration of services. They saw the potential benefits of such a contract – for example, in offering opportunities to improve alignment and break down organisational barriers, allowing space to work differently, addressing perverse incentives in the current system and enabling a stronger focus on preventing ill-health. For example, NHS Clinical Commissioners (a representative body for CCGs) stated:

    'A key potential benefit of the ICP Contract is that it is designed to promote an integrated service model, affording the opportunity to commission primary care alongside wider NHS services, public health and social care provision. This has the potential to further integration and the delivery of person-centred care.'

53. Most individual public respondents, including through the campaigns and petition, opposed the proposed ICP Contract, often on the basis of fears that it would lead to privatisation of NHS services and lack of accountability to the public.

54. Some associated concerns were that private providers could result in reduced quality of care or access to services, or that local or regional monopolistic providers could emerge. Many respondents rejected in general the principle of contracting as the basis for service provision in the NHS.

55. Respondents also raised other concerns – including expressing a view that the ICP Contract would not address perceived existing problems in the system such as funding and staffing levels, and that the likelihood of subcontracting of services in an ICP model means it would not truly achieve integration of services.

56. There was recognition from many respondents that a contract in itself would not be enough to achieve integrated care, with a strong emphasis on the importance of relationships and culture. Some questioned whether a new form of contract is necessary given the existence of other options for integration, such as alliances and integrated care systems, and noted the importance of 'system maturity' – with a view that many areas would not yet be ready to pursue a contractual route to achieve integration. On the other hand, there were some strong views to the contrary, for example, one CCG stated:

    'The option of having a contract which is aligned with the national, regional and local ambition for the transformation of services to meet the needs of local populations would be welcomed by the CCG. It is recognised that health

systems are encouraged to integrate and that despite the presence of alliance arrangements where provider and commissioning organisations have chosen to integrate further, the presence of multiple contracts and other agreements can be challenging. As a result a contractual vehicle that is dedicated to eliminating such complexity and duplication is welcomed even if in some cases it is a way of codifying existing agreements and relationships.'

57. There was a strong view that, as proposed during the consultation, if the contract is made available it should be as an option for local commissioners, rather than mandatory.

58. Many respondents suggested the ICP model should be debated in Parliament before being introduced, and if such a model is to be introduced ICPs should be statutory bodies.

Our response…

59. We welcome the support of NHS commissioners, NHS providers and local authorities for our making available a form of contract to encourage the integration of services. This approach has the potential to bring a range of benefits that will better enable organisations to provide more integrated care to people and their families – including, as highlighted in consultation feedback, by providing incentives that are more aligned towards integrated working, breaking down organisational barriers, encouraging a stronger focus on preventing ill-health and managing long-term conditions.

60. We accept that a statutory provider is considered by many as the most suitable vehicle to perform the role of an ICP.

61. We acknowledge the objections expressed by some to the principle of contracting as the basis of service provision in the NHS. The wider structure of the NHS is outside the scope of this consultation.

62. Subcontracting is already an important and widespread part of NHS service delivery. Smaller providers, for example from the voluntary sector, will continue to play a vital role in delivery where an ICP is in place, as they did beforehand. The ability to bring together a range of providers, and deploy flexibly its budget to develop a coordinated set of services, is an important power which an ICP will require to give it the opportunity to achieve better outcomes for its population. This flexibility will in addition be an important safeguard for personalisation of services. Furthermore, it is important to note that while an ICP may not itself deliver all services which are in scope under its contract, it will, under that contract, be held to account for their collective delivery: this provides the incentive for it to think carefully about the best way to improve quality.

63. Various respondents emphasised that the ICP Contract should be made available as one option amongst others available to local system, rather than being mandatory. This remains the position. The ICP Contract should only be used where commissioners decide, following appropriate engagement with providers, staff and local people, that the appropriate conditions (including strong relationships) are in place to do so successfully. Other options to achieve

integration between different providers, such as alliances, will continue to be most suitable in many areas. However, some commissioners, such as in Dudley, believe using the ICP Contract would allow them to go further in fulfilling their ambitions to provide better, more integrated care for people than they have already been able to achieve using existing approaches.

5.2 Question 2: Content to promote integration

We asked…

The draft ICP Contract contains new content aimed at promoting integration, including:

- *Incorporation of proposed regulatory requirements applicable to primary medical services, included in a streamlined way within the draft ICP Contract*
- *Descriptions of important features of a whole population care model, as summarised in paragraph 30 (of the consultation document)*

a) Should these specific elements be amended and if so how exactly? Yes/no/unsure; and please explain your response.
b) Are there any additional requirements which should be included in the national content of the draft ICP Contract to promote integration of services? Yes/no/unsure; and please explain your response.

Respondents said…

64. Throughout the consultation there was generally support for integration of services, and many respondents welcomed the inclusion of care model content in the ICP Contract. For example, one CCG employee stated:

    'Health inequalities, provider risk stratification, analysis of population health needs and obligations to develop shared electronic patient records are each features where an ICP provider can play a significant role.'

    Some respondents were supportive of the existing content, while others offered suggestions for how it could be further developed.

65. Some respondents – particularly providers and commissioners – also noted the importance of ensuring that providers which would become an ICP had the skills and resources necessary to deliver requirements of a whole population care model. For example, NHS Clinical Commissioners stated:

    'Support will need to be given to enable lead providers to fulfil a new role within an ICP... Many providers will not yet be well equipped to deliver population health management and risk stratification functions that will be delivered by the provider under an ICP – consideration needs to be given as to how best to support the transfer or development of this skill set.'

66. Many responses sought further clarity on the population that would be served by an ICP. Some noted the potential challenges (should local authority-funded services be in-scope for an ICP) where CCG and local authority boundaries are

not coterminous. Others sought information on how people such as out of area patients, travellers and people who are homeless, along with those accessing digital GP services, would be able to access ICP services.

67. Some respondents commented specifically on the contract requirements relating to primary medical services, largely derived from the draft Directions published alongside the consultation. Among these, the BMA, had concerns about the proposals but agreed that ICPs providing primary medical services should be bound by the same regulatory requirements as existing GP practices, and therefore welcomed the consistency between the proposed requirements for ICPs (as set out in draft Directions, and reflected in the draft Contract) and requirements under existing primary medical services contracts.

68. Some respondents, particularly campaign responses, also expressed a concern that the integration of GP services in an ICP could lead to larger-scale less personal primary care provision.

69. We also received suggestions on other matters, including in relation to the importance of:
    - voluntary sector involvement in ICPs
    - data and how it is shared.

Our response…

70. No substantive suggestions were received through the consultation on the drafting of the population health content within the ICP Contract, so we do not at this stage propose making material changes to the existing content in this respect, though the whole contract will be kept under review. It will be for local commissioners and their chosen providers to set out in their locally-developed service specifications what is required of their population health model and how it will be delivered locally.

71. We agree it is important for providers to have the right skills and capabilities in place, and ISAP has been designed to seek assurance from the responsible commissioners and the prospective ICP that it would be able to meet the population health requirements that it will be commissioned to deliver through the ICP Contract. In support of this, we expect local commissioners and providers to also consider the extent to which it may be appropriate to transfer resource from the CCG to an ICP to support these requirements. We also recognise that local systems will want to move to a more outcomes based approach to support a whole population care model, and in light of this feedback, we will consider what further support we can provide to ICSs to help them, and the health and care organisations within them including ICPs, develop the necessary capabilities. This will be in addition to the national programmes identified in the NHS Long Term Plan to raise levels of awareness and capability more generally in relation to tackling health inequalities and undertaking population health analysis.

72. The contract's definition of the population to be served by an ICP is designed to ensure the ICP has wide responsibilities for providing care to the whole population:
    - For NHS-funded services, the population served will comprise everyone registered with that ICP (or with a GP practice partially-integrated with the ICP) wherever they live, and everyone permanently or temporarily resident within the

ICP's area, unless they are registered with a GP practice which is not part of the ICP

- The ICP would therefore be responsible for providing care for homeless people, travellers and others who live within its area
- If local authority-funded services are within scope for the ICP, the population served by the ICP for those services will be defined so as to cover the population for which the local authority is legally responsible.

73. We welcome the comments from the BMA that the requirements for primary medical services being provided under an ICP Contract should be consistent with those of other GP contracts, whilst recognising other responses about integration dealt with separately under question 6. Most requirements of the ICP Contract relating to primary medical services are linked to the draft Directions developed with the DHSC. Those Directions may be revised as a consequence of the feedback DHSC has received in response to their own recent consultation, and we will update the corresponding provisions of the ICP Contract accordingly as necessary.

74. We agree that the voluntary sector should play a key role in delivering a population-based model of care, focused on the needs and wishes of individuals, which the ICP Contract is designed to support. Voluntary sector organisations bring important and unique expertise, and can enhance the opportunities for patient choice and personalisation. We anticipate that commissioners will require bidders for any ICP Contract to demonstrate how they will involve and work closely with local voluntary sector organisations to deliver choice and person-centred care.

75. We note that some respondents have raised a concern that provision of GP services would move to 'hubs' under an ICP Contract. This is not the intention. The ICP Contract includes a requirement that the ICP must ensure people have a choice of readily-accessible locations at which to receive primary medical care services. In addition, the ICP Contract allows local commissioners to specify, should they choose, the locations of premises from which primary medical (or any other) services must be delivered.

76. We have already included in the ICP Contract requirements to ensure data in respect of service users is collected, managed and used appropriately and lawfully. These include the necessary controls required to protect personal data, to maintain patient health records in systems that enable legitimate sharing between providers for direct care, and to have in place robust and lawful data processing arrangements to enable secondary uses (e.g. risk stratification, targeting of care interventions). NHS England is developing an information governance framework to support integrated care. This will incorporate a data governance tool to help care systems with the lawful, and accessible use of de-identified patient data for these secondary uses.

5.3 Question 3: Balance between national and local content

We asked…

The draft ICP Contract is designed to be used as a national framework, incorporating core requirements and processes. It is for local commissioners to determine matters such as:

- *The services within scope for the ICP*
- *The funding they choose to make available through the contract, within their overall budgets*
- *Local health and care priorities which they wish to incentivise, either through the locally determined elements of the financial incentive scheme or through additional reporting requirements set out in the contract*

Have we struck the right balance in the draft ICP Contract between the national content setting out requirements for providers, and the content about providers' obligations to be determined by local commissioners? Yes/no/unsure; and please explain your response.

Respondents said…

77. Some respondents were supportive of the need to ensure local commissioners have some flexibility to determine the requirements that best meet the needs of their local population. A view was expressed, for example, that a one size fits all approach will not work for all communities and there must be recognition of differences in the way services are delivered across urban and rural populations. Some respondents saw the benefit in the contract providing a consistent national perspective while also enabling local priorities to be identified, while a number of organisations requested greater flexibility to meet local population needs. For example, we heard:

    'The best combination and relationship to deliver national priorities within a specific national context should be left to local commissioners. The structure of a national contract is very useful, the detailed content must be predominantly local.' (a CCG)

    and

    'The Trust would endorse fuller flexibility in contracting arrangements (supported by nationally consistent contract templates) to support new and innovative integrated models of care. We recognise that the release of this contract sends an important signal to enable system-wide working, however believe there is still some way to go before it lands. We feel the contract needs to maintain a suitable degree of flexibility to ensure it can work for all partners in the system.' (an NHS foundation trust)

78. However, others expressed a view that further standardised content is required, based partly on concerns that local decision-making could lead to access variations between different areas. A few respondents suggested additional national guidance that could be developed or changes that could be made to the ICP Contract, such as:
    - the development of a template sub-contract to accompany the ICP Contract

- a minimum set of required services and further national standards or quality requirements – for example, the inclusion of the national e-referral standard.

79. Many respondents supported having local flexibility in determining their financial incentive scheme as part of the contracting arrangements – this includes flexibility to set the reward quantum against local population health outcome priorities in a way that is achievable and sustainable for local delivery partners. It was suggested that a wide range of partners should be involved in developing the measures that would be incentivised including local authorities and the voluntary sector. Some respondents would like to see practical examples of how the theory of a financial incentive scheme, including risk sharing arrangements, would translate into practice and to use that learning to help develop and implement suitable arrangements for their localities.

80. Some respondents commented further on specific issues. For example:
    - We heard suggestions about the importance of certain types of services being included within the scope of ICP Contracts – such as urgent care services, mental health services, and primary care services (in addition to general practice). Some respondents also queried how specialised services commissioned by NHS England would relate to the scope of an ICP Contract.
    - Different views were expressed about potential contract duration – while some agreed that up to ten years is appropriate, some respondents thought this potential term was too long and a counter-view was also expressed that it was too short.

Our response…

81. The ICP Contract does not change the broad discretion commissioners already have about what services to commission to ensure they can meet the needs of their communities. The structure of the ICP Contract is based on that of the generic NHS Standard Contract. Most of its mandatory content is derived from the generic NHS Standard Contract or the Directions, and so reflects established national requirements for in-scope services. We agree that it is important to avoid a one size fits all approach, by ensuring local commissioners are able to determine a lot of the content of their local contracts, supplementing consistent mandatory requirements in such a way as to best meet local requirements.

82. With regard to suggestions for national guidance, we will continue to keep this area under review and we may choose to make additional resources available in due course, in addition to those already published, for example a template sub-contract. We will consider on an ongoing basis what further guidance could usefully be developed, particularly building on learning from early users of the ICP Contract.

83. There was support for local flexibility in determining the financial incentive schemes to be incorporated into the contracting arrangements. We agree with those who suggested that a wide range of partners should be involved in determining behaviours to be incentivised locally and in developing metrics against which performance will be assessed. We also agree with those respondents who expressed caution and stressed the importance of using financial incentives in a proportionate and sustainable way, including the need for incentives and their use

being properly thought through to help mitigate unintended consequences. Whilst the nature of the feedback did not suggest that any material changes were needed to the Incentives Framework for Integrated Care Providers published alongside our consultation, the feedback will inform our thinking and future policy development around CQUIN and the use of financial incentives frameworks and schemes more generally.

84. All relevant national standards and requirements applicable from time to time to providers of particular services under the generic NHS Standard Contract and/or GP contracts will apply to providers of equivalent services under an ICP model, and will be reflected in the ICP Contract as appropriate. For example, requirements in relation to use of the NHS e-referral system, as updated in the generic NHS Standard Contract for 2019/20, will be reflected in the ICP Contract.

85. We maintain the view that both the duration of local contracts, and the range of services to be commissioned under them, are matters best left for local commissioners to determine, informed by local engagements and based on the needs of their local population and desired care model. We therefore do not propose to set out a minimum set of required in-scope services for ICP Contracts but service scope (and any anticipated extension of that scope during the term of the contract) will be a key element to be considered and assured through ISAP.

86. However, as set out in the consultation materials, where commissioners use the ICP Contract, we anticipate that they may agree a contract term of up to ten years (as could in principle occur with existing contracts). An important idea behind the ICP Contract is that by giving one organisation responsibility for providing health and care services for the whole local population, it will be able to shape services around what really works best. A longer-term contract offers the stability needed to incentivise the provider to improve longer-term outcomes by investing in services to manage and improve treatment and prevent deteriorations in health, rather than being focused solely on meeting short-term targets. It will inevitably take some time for the impact of any new care model to emerge and for the new provider to be able to show improvements in population health outcomes.

5.4 Question 4: Option of single budget

We asked…

Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers? Yes/No/unsure; and please explain your response

Respondents said…

87. The proposal for an integrated budget/whole population annual payment (WPAP) was supported by most providers, commissioners and local authorities. For example, one such respondent thought that it would provide *'more flexibility for innovation'*. Another welcomed the proposed whole population annual payment, stating:

    'It is essential that the contract incentivises investment in prevention and conservative treatment options. Without giving a provider the opportunity to look

at whole pathways, through control of population budgets, this cannot happen to the optimum level.'

88. While there was much support for the integrated budget, some respondents commented on how it would work in practice. For example, some respondents raised concerns about how much funding would be available to the ICP, and how it would be determined by the commissioner. This included some queries about how the budget could respond to changing demands and local demographics over a contract term of up to ten years. A number of stakeholders also commented specifically on how the budget would be managed by an ICP which included comments about:
    - how it would be impacted deficits in parts of the local health and care system and whether a flexible budget might effectively be used to 'plug gaps'
    - how the budget would be allocated to different types of services, with some expressing support for 'ring-fencing' funding for particular types of service
    - relatedly, whether combining funding streams into a single budget might also consolidate financial risk in one organisation.

89. Many individual public respondents expressed concerns about an integrated budget approach. Among these – particularly in campaign responses that specifically responded to this question – there was a view that the proposed integrated budget offered a 'flexibility' that would mean ICPs would not be accountable for their decisions, and that a single funding stream flowing through the ICP could create risk and uncertainty for existing local NHS providers. We also heard a concern that managing the budget within financial constraints might lead to rationing of treatment or services to patients. However, some expressed support for a single budget – for example, that it '*would hopefully allow them to see the bigger picture in allocating funding to a whole local plan and avoid further fragmentation.*'

Our response…

90. We note the support expressed in many responses for the flexibility that the whole population budget is designed to offer. It is a key part of the proposals in allowing the provider the ability to design care around the needs of the population. Flexibility in how funding is used is a core feature of the whole-population approach.

91. However, we also note concerns about the ability that an ICP would have to make decisions about resource allocation. Any provider has to operate within the budget it is allocated, and this will continue to be true of a provider holding the ICP Contract. However, given the flexibility which the budgeting approach is designed to enable, we recognise the importance of ensuring all local organisations and services are fully engaged in the development of any ICP model. This engagement will be tested through ISAP, and assurance sought that the wider implications of the proposals have been considered, including the delivery costs of the services to be delivered under the proposed model, to ensure the assumptions are properly tested by partners and have taken into account long term sustainability of services. As set out in our consultation document, we have also included in the ICP Contract a range of safeguards to ensure financial accountability, transparency and service continuity.

92. We also acknowledge the point about whether an integrated budget might mean that financial risk is consolidated in one place. This is why new financial controls have been developed for the ICP Contract, and oversight and assurance over ICPs will be important. However, a consolidated budget for a whole population is a critical part of the rationale in delivering this model effectively, and is part of a wider national move towards greater accountability for delivering whole population healthcare within each system. As outlined in the NHS Long Term Plan, the move to system control totals is designed to enable organisations to jointly manage resources to deliver the best possible care for their population, whilst the system as a whole is held to account for achieving this. This principle is aligned to the ICP proposals, which allow one provider to be held to account directly for the effective management of services, whilst ensuring the oversight and scrutiny provided by the system and national regulators can be more focused and effective.

93. Neither the use of an ICP Contract as the vehicle for commissioning services, nor the proposed WPAP approach under such a contract, will have any bearing on the level of funding allocated to CCGs by NHS England to commission services. The two matters – funding and the choice of contract – are distinct. In determining the proportion of its allocation a CCG would use to fund payments under an ICP Contract (were it to choose to commission services using one) the CCG would need to consider the funding required to safely and effectively deliver the services to be in-scope under that ICP Contract. ISAP requires that local governing bodies and boards provide an effective first line of assurance. Therefore, commissioners and providers should ensure their governing body/board is kept fully informed and given the opportunity to scrutinise, test and challenge the proposals in depth at each stage, including having first-hand access to advisers' conclusions and recommendations. Funding will be subject to ongoing review at various points throughout the lifetime of the ICP Contract.

94. We will keep under review how we can update our guidance on integrated budgets to provide additional clarity in response to consultation feedback.

95. Finally, we note that the Court of Appeal has confirmed the lawfulness of the WPAP under the ICP Contract. As noted above, in R (oao Jennifer Shepherd) v NHS England [2018] EWCA Civ 2849 the Appellant sought to argue that the pricing mechanism under the contract, the WPAP, was contrary to the relevant provisions of the Health and Social Care Act 2012. In its judgment dated 20 December 2018, all seven of the Appellant's grounds of appeal were dismissed for eleven reasons. This judgment confirms that the WPAP is lawful under the 2012 Act.[14]

[14] As at the date of publication, the Appellant has sought permission from the Supreme Court to appeal the Court of Appeal's decision. The Supreme Court has not yet made a decision on this matter.

5.5 Question 5: Safeguards about service quality, patient choice, transparency and financial management

We asked…

We have set out how the ICP Contract contains provisions to:

- *guarantee service quality and continuity*
- *safeguard existing patient rights to choice*
- *ensure transparency*
- *ensure good financial management by the ICP of its resources.*

a) Do you agree or disagree with our proposal that these specific safeguards should be included? Agree/ Disagree/unsure; and please explain your response
b) Do you have any specific suggestions for additional requirements, consistent with the current legal framework, and if so what are they? Yes/No/unsure; and please explain your response.

Respondents said…

96. The proposals were supported by most commissioners, NHS provider organisations, local authorities and GPs who responded. For example, a local authority Health Scrutiny Committee stated *'It is important these safeguards are included to ensure that high quality services are provided to communities*.' Responses from members of the public were mixed, although the vast majority of those who disagreed seemed to do so primarily on the basis of their wider concerns about the proposed ICP Contract. Some members of the public who agreed with the inclusion of the safeguards also expressed their wider objections to ICPs, or doubt about whether the safeguards offer sufficient protection. A number of respondents offered suggestions for additional requirements that could be included.

97. There was a strong view, particularly among individual respondents, about the importance of transparency about the performance and finances of ICPs – not only to commissioners, but also to the public. Some respondents offered suggestions about how the transparency provisions in the ICP Contract could be enhanced, while others suggested that commercial confidentiality should not be a reason to *'deny the public access to information'*. However, different views were expressed about the proposed requirements for ICPs to operate 'open book accounting' with some commissioners and providers requesting greater clarity about the requirements, or expressing concerns that the proposed requirements may be too burdensome or impact commercial confidentiality. A number of respondents also commented on public accountability, which is covered in further detail later in this document.

98. There was some concern about the impact on choice for patients who do not wish to register with the GP services offered by an ICP, for example where their current GP practice chooses to join an ICP. In addition, some respondents questioned whether being registered to a practice fully or partially integrated with the ICP may affect the places to which they would be referred by a GP. A range of comments were also made about patient choice and access which were not specific to an

ICP Contract, most significantly seeking assurance that the proposals would not affect the existing legal requirements establishing the free availability of NHS services.

Our response…

99. We acknowledge the support for transparency about the finances and performance of ICPs and will include in the ICP Contract additional transparency standards requiring performance and financial information to be published and made available directly to patients and the public.

100. While we acknowledge that some respondents raised concerns about the potential administrative burden of making more detail available (particularly through the proposed requirement for open book accounting), it remains our view that this and other financial reporting requirements are important to ensure financial accountability, transparency and service continuity.

101. These additions would complement the information we would already anticipate being made available, both through the existing draft contractual requirements and more widely – for example, the Care Quality Commission (CQC) would, as part of its regulation of an ICP and its constituent services, publish reports about the quality of care these provide.

102. While some concerns have been raised about preservation of patient choice, we are confident patient choice will be preserved and do not consider that further amendments to the ICP Contract are needed at this time. The ICP Contract has been designed to make sure the commissioning of multiple services through a single contract does not restrict or in any way adversely affect the options people have about how and where they receive care. The ICP Contract not only requires the ICP to ensure the rights of choice people have under the NHS Constitution are respected, but also to offer further choices as to when, where and how people can receive the services they need wherever practicable. As set out in the consultation document, it includes, for example, the requirements that:

- local people are offered choice in where, how and by whom services are delivered to them, wherever possible
- the ICP adheres to the rights of patient choice in respect of secondary and tertiary care services, as set out in the NHS Constitution
- NHS users are offered a choice of GP from those employed or engaged by the ICP
- NHS users have a choice of readily-accessible locations at which to receive GP services
- the ICP offers sufficient pre-bookable and same-day GP appointments to meet the needs of the population, including during evenings and at weekends (we will also consider how the ICP Contract may need to be updated to reflect the Access Review to be undertaken in 2019, as announced in the recent Five-year framework for GP contract reform to implement The NHS Long Term Plan).

These requirements may be supplemented by local requirements as commissioners think appropriate for their local needs. Where a GP practice decides to join an ICP on a 'fully integrated' basis, we would expect this to be informed by engagement with their registered patients and patients would also be able to

choose whether they wish to receive primary medical services from the ICP or to register with a different GP practice.

103. With respect to the concern about whether health care services would remain free at the point of use, nothing about the ICP model or the ICP Contract in any way affects the position that, subject to certain exceptions[15] determined by law, NHS services are to be provided free at the point of use by an ICP and their sub-contractors just as they are by current providers of NHS services. This will be the case regardless of the type of organisation that holds an ICP Contract or sub-contract, and whether or not it is responsible for social care services alongside NHS services.

5.6 Question 6: GP participation in an ICP

We asked…

a) Should we create a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts? Yes/No/unsure; and please explain your response.
b) If yes, how exactly do you think we should create this?
c) Are there any specific features of the proposed options for GP participation in ICPs that could be improved? Yes/No/unsure; and please explain your response.

Respondents said…

104. There was support from many respondents for primary medical services to be included within any ICP model, given the important role that general practice should play in an integrated health and care system. Most CCGs and NHS provider organisations who responded were supportive of creating a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts. For example, a social enterprise stated:

> *'Given its pivotal role within NHS care in determining both health outcomes and in optimising the use of NHS system resources, it is critical that primary care remains front and centre. Under integrated care arrangements, NHSE therefore, has no choice but to create a compelling proposition to GPs to integrate their services with ICPs.'*

105. Most responses from GPs also agreed with different options being available, but wanted NHS England to confirm that no one approach would be mandatory. For example, the BMA noted the importance of GPs having options as to how they might participate, despite reservations in general about the need for the contract. A small number of responses also queried how emerging forms of collaboration such as primary care networks (PCNs) would relate to ICPs.

106. In relation to the proposed option for 'full integration' (whereby GP practices could, subject to proposed regulatory changes on which DHSC has consulted, choose to suspend their existing GMS or PMS contract to participate in an ICP as

[15]Those exceptions being, for example, in relation to NHS charges for overseas visitors under the NHS (Charges to Overseas Visitors) Regulations 2015, statutory charges for prescribed medicines, charges for issue of certain certificates.

an employee or subcontractor), there was some concern from several respondents, including some GP representative bodies, about the complexity and practical mechanisms by which GP practices could reactivate their GMS or PMS contract if they wished to withdraw from full integration with the ICP. For example, we heard about potential uncertainties regarding the return of the patient list, estates, and workforce. We also heard a concern about ensuring patients would have sufficient notice where their GP practice wished to join an ICP, to enable them to make a choice about whether they wished to receive primary medical services from the ICP or register with a different GP practice.

107. There was a desire for more information about the partially integrated option, under which GP practices could maintain their existing contracts but agree to integrate their services with those delivered under the ICP Contract via an 'Integration Agreement'. Stakeholders including the BMA and Royal College of Psychiatrists gave some specific comments on the current draft Integration Agreement that was published as part of the consultation package.

108. Most individual respondents who responded to this question did not agree that we should create a means for GPs to integrate their services with ICPs, often on the basis of their wider objection to the ICP model. Some also expressed a view that GPs should maintain their independence, and the belief (as mentioned earlier) that GP participation in an ICP could lead to less personalised care.

Our response…

109. People most commonly access health care through their GP, and integrated care models therefore rely on GP registered lists as the foundation of a population-based approach. We continue to believe that wholehearted voluntary GP participation is fundamental to the success of the care and contractual models.

110. We acknowledge the availability of different options for participation in an ICP model is important and valued by GPs. We further recognise, in response to concerns raised particularly by the RCGP and BMA, that we should continue to make clear, as the consultation did, that participation on any basis in an ICP is entirely voluntary for practices.

111. For fully integrated models, we agree with the importance of patients being able to choose the provider from whom they receive primary medical services and have developed the draft regulations proposed to underpin the suspension and reactivation of GMS and PMS contracts with this in mind. Outside the formal requirements set out in the draft regulations, we would anticipate that GP practices will engage with their patients when deciding whether to join an ICP on a fully integrated basis.

112. On the matter of reactivation of suspended contracts, no firm proposals for how to improve this option have been identified through the consultation. However, the existing proposals – developed during previous discussions with the BMA and consulted upon by the DHSC in 2017 – will be subject to further review on the basis of experience from sites, and we remain committed to working with GP representatives to make it an attractive option locally.

113. It will be necessary for us to share learning from ongoing procurements where GPs have demonstrated strong support for the model, and we will further develop the template integration agreement between GPs and the ICP, for use where GPs choose the 'partially integrated' option.

114. PCNs will benefit patients, GPs and the NHS generally regardless of whether ICPs come into being. PCNs are a natural development of the localities at the heart of whole population care models. Where practices are partially integrated with an ICP and retain their GMS or PMS contract, an ICP will be in a position to integrate its services with those delivered through networks, in line with expectations of other community providers. Where GPs decide to participate as fully integrated practices, they will similarly be supported to work more effectively at scale within an ICP, enabled through the infrastructure and support it will be able to provide.

115. We note that some respondents raised concerns about the need to ensure GP participation does not mean less personalised care. Our view remains that GP participation in integrated care models – which the ICP model would facilitate – will improve the care patients receive by, for example, improving access to services. We have previously produced information on what it is like to be a GP in a multispecialty community provider (a type of care model that could be facilitated by the ICP Contract), and which also highlight how GP participation in such models can benefit patients. These videos are available on the NHS England website.

5.7 Question 7: Local authority participation in an ICP

We asked…

a) Do you think that the draft ICP Contract adequately provides for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services? Yes/No/unsure; and please explain your response.
b) If not, what specifically do you propose? Please explain your response.

Respondents said…

116. Many respondents were supportive of including local authority-funded services in an ICP where possible, as important to the delivery of a whole population model of care. For example, one respondent stated:

> *'As an alliance organisation that counts local authorities as key members, we feel that it is essential that the ICP Contract does provide for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services.'*

117. However, some respondents felt that the current ICP Contract is NHS-focused and could do more to provide for the inclusion of local authority services. For example, in their shared response the LGA and ADASS argue that certain requirements of the ICP Contract might restrict the ability of a local authority to be a lead provider. Another respondent noted that it is underpinned by an NHS contractual and legal framework.

118. Respondents also shared wider views about local authority participation in an ICP model, such as:
- a view that it might be more feasible to include public health services than social care services within an ICP's scope
- potential challenges due to differences in how social care and NHS services are funded, and in funding levels
- potential challenges due to differences in the governance and structures of local authorities and NHS organisations, including that local authorities may perform commissioning and provider functions, but NHS organisations may not
- comments about how the proposed ICP Contract relates to existing mechanisms for achieving integration with local authority services, including a question about how it would achieve more than arrangements under existing section 75 agreements and a concern from a small number of respondents that a section 75 agreement might still be needed alongside an ICP Contract
- technical barriers, such as VAT, where rules apply differently to local authority services and healthcare services.

119. Some responses suggested that greater clarity was required on how local authorities, including elected members, can be reflected in governance arrangements where a local authority is involved in an ICP. There were also requests for further guidance, such as practical examples of partnerships and local authority integration agreements.

120. Other comments included emphasis on the importance of engagement with local authorities, including that they should be engaged as equal and active partners in commissioning.

Our response…

121. We are committed to ensuring the ICP Contract is fit for purpose, given existing statutory constraints, for commissioning local authority-funded services should this be desired by local authorities locally. We have already worked to achieve this through extensive engagement with the LGA, and following this engagement we made a number of changes to the ICP Contract in response to local authorities' feedback, particularly as commissioners of services. In Dudley, the local authority has already chosen to commission public health services through this contract.

122. We will consider whether any further amendments can be made to the ICP Contract, within the constraints of the existing legal framework. We will make available a template integration agreement for local authority participation, which would allow local authority-funded and delivered services to be integrated with services commissioned under an ICP Contract, and consider whether any further guidance can be developed.

123. Many of the concerns raised by the LGA and ADASS relate to the implications for a local authority itself of being a potential ICP Contract-holder. We recognise that many of the perceived obstacles to a local authority holding an ICP Contract could only be overcome by legislative changes which are outside the scope of this consultation (for example, in relation to CCG membership and governing body composition), however we are committed to supporting NHS and local authority

commissioners where proposals are being developed that envisage such an outcome.

5.8 Question 8: Safeguards about commissioners' statutory duties

We asked…

The draft ICP Contract includes safeguards designed to help contracting parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP:

- *It provides a framework within which decisions can be taken by the ICP, based on a defined scope of services which the commissioners require the ICP to deliver*
- *It includes a number of specific protections, outlined in paragraph 83 (of the consultation document), which together prohibit the provider from carrying out any activity which may place commissioners in breach of their statutory duties.*

Are there any other specific safeguards we should include to help the parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP? Yes/No/unsure; and please explain your response.

Respondents said…

124. Most types of stakeholders expressed mixed views in response to this question. There was some support for the proposed safeguards. Several comments were broadly positive, viewing the safeguards proposed in the ICP Contract as adequate to ensure statutory duties are not unlawfully delegated to an ICP. For example, one healthcare partnership stated:

'The changes proposed in the draft ICP Contract are broadly positive and it provides flexibility for commissioners and providers to strike the right balance depending on the local context. The guidance document 'CCG roles where ICPs are established' is helpful in clarifying the extent that ICPs may lawfully undertake activities that are currently undertaken by CCGs, in order to manage whole pathways of care and a capitated budget.'

125. However, some respondents proposed additional safeguards or guidance, including a request for further assurance on the tasks and responsibilities CCGs would be passing over to ICPs – with some CCGs highlighting a related need to be clear on how an ICP would be expected to support the CCG in carrying out its statutory duties and how CCGs could ensure that they do not inadvertently breach requirements.

126. More widely, some respondents highlighted a concern that ICPs and commissioners may have overlapping roles. One provider organisation suggested that further consideration should be given to support greater collaboration between providers and commissioners to avoid duplication.

Our response…

127. In respect of the division of responsibilities between CCGs and providers, we note the comments that suggested the ICP Contract is clear about this distinction.

128. We acknowledge that, while statutory duties of CCGs will not change, some activities – such as population health management – undertaken in support of those duties may change under an ICP model, and indeed the ICP Contract is, in part, designed with the intention of accommodating this change. We would expect, for example, that where an ICP Contract is awarded, CCG and/or commissioning support unit teams currently involved in health analytics and informatics may support the ICP in its role in understanding and mapping population health needs.

129. As part of our consultation package, we published updated guidance on CCG roles where ICPs are established. We will consider whether this can be updated or further guidance developed in future. In particular, in due course, once a contract is commissioned, more practical examples will be made available to help those considering similar proposals.

130. We also think it is helpful to restate the findings of the High Court in one of the judicial review claims referred to above, R (oao Hutchinson) v SSHC and NHS England [2018] EWHC 1698 (Admin). In dismissing that claim, the Court found, amongst other things, that the integration of health and social care via a single provider of care (for example, an ICP), where that provider has a degree of autonomy over how care is delivered and resource allocation:

- is within the statutory powers of a CCG;
- does not represent the unlawful delegation to ICPs of non-delegable functions or preclude CCGs from fulfilling their statutory functions; and
- is not contrary to the commissioner-provider split under the National Health Service Act 2006.

131. An important lesson from the judgment is that commissioners have under the 2006 Act considerable leeway to lawfully commission provision of services in such a way that the relevant provider has a substantial degree of autonomy over how care is delivered and resource allocation. The ICP Contract does not change this. Indeed, as noted by the Court, the ICP model recognises the non-delegable nature of CCG functions and includes measures (for example, monitoring, supervision and enforcement) specifically designed to ensure that ICPs act in a manner consistent with the CCG's functions.

5.9 Question 9: Provisions about public accountability

We asked…

The draft ICP Contract includes specific provisions, replicating those contained in the generic NHS Standard Contract, aimed at ensuring public accountability, including:

- *Requirements for the involvement of the public as explained in paragraphs 89-93 (of the consultation document)*
- *Requirement to operate an appropriate complaints procedure*
- *Complying with the 'duty of candour' obligation*

a) Should we include much the same obligations in the ICP Contract on these matters as under the generic NHS Standard Contract? Yes/No/unsure; and please explain your response.

b) Do you have any additional, specific suggestions to ensure current public accountability arrangements are maintained and enhanced through an ICP Contract? Yes/No/unsure; and please explain your response.

Respondents said…

132. Most types of respondents agreed the ICP Contract should include much the same obligations as the NHS Standard Contract, with one provider organisation stating that it *'provides the necessary obligations for public accountability and is demonstrated to work effectively'*. Others thought these standards should be the minimum, with scope for them to be strengthened. Some specific suggestions included requirements to:
- hold board meetings in public
- engage with bodies such as local Health and Wellbeing Boards and local Healthwatch.

133. However, many individual responses highlighted a perception that ICPs would not have a statutory duty to ensure public accountability. For example, some campaign responses stated *'As long as ICPs remain bodies with no statutory legal status, there can be no guarantees they will respect any requirement to ensure public accountability.'* Specific concerns focused on the possibility that, despite the contractual responsibilities in the ICP Contract to do so, providers would not comply with their obligations under the "duty of candour", or to operate an appropriate complaints procedure. Some respondents were also concerned about whether ICPs would be subject to freedom of information requirements.

134. Some campaign responses expressed a view that even if the ICP Contract includes the same obligations as under the generic NHS Standard Contract, public accountability would be mediated through the CCG and *'the public will have to rely on the skills and willingness of the CCGs to hold ICPs to account'*. Some respondents were concerned about whether CCGs would have the *'necessary staff, skills or willingness to rigorously and robustly manage the ICP Contracts'*, and some stressed the importance of effective monitoring and KPIs.

135. A small number of CCGs who responded agreed with the desirability of public involvement in service redesign, but did express a concern that it can *'slow and hinder the transformative pace needed to bring together so many organisations, sites and services'*.

136. We also received comments about other accountability mechanisms. There were also some questions about how ICP arrangements would be regulated by bodies such as the CQC and NHS Improvement.

Our response…

137. We are committed to ensuring an ICP can be properly held to account for its delivery. Along with the additional transparency requirements outlined in response to question 5 (including in relation to freedom of information requests), we are proposing further standards to more explicitly require ICPs to act in an open and accountable way. These will include:

- Requirements to hold board meetings in public, in line with the requirements that are already in place for statutory providers
- More explicit requirements, in response to specific suggestions in the consultation, for the ICP to work directly with local Healthwatch and other supervisory bodies.

138. It will also continue to be a requirement to ensure adequate public involvement has taken place to inform decisions about service redesign: this is a principle enshrined in legislation and guidance and reflected in the ICP Contract.

139. Whether an ICP has statutory duties, and if so what those duties are, will depend on the nature of the organisation in question. We do not consider it likely that non-statutory organisations will hold ICP Contracts. In any event CCGs are required to hold the ICP to account under their own statutory duties regardless of the type of organisation holding the contract, however the additional controls that have been developed within the ICP Contract have been designed specifically to ensure patients and the wider public can have confidence that commissioners will hold ICPs to account effectively. We believe that, alongside the new protections, the ICP Contract provides a CCG with appropriate and robust levers and performance indicators by which to hold an ICP to account. Under ISAP, a national assurance process run jointly by NHS England and NHS Improvement, it will be for the CCG to provide assurance to NHS England of the robustness of its own locally-determined performance management indicators and of its capability to manage the ICP's performance, both before any ICP is in place, and subsequently during the lifetime of the contract.

140. Alongside CCGs other system partners, including the CQC and NHS Improvement, will also have important roles in holding ICPs to account for their performance.

141. The CQC is committed to working with and learning alongside new ICPs as they emerge, and is currently considering its approach to ICPs, and other new, integrated models of care. This includes how it will regulate ICPs overall, and how its approach would take into account the different options for GP participation. Within its existing legal powers, the CQC will be able to register an organisation holding an ICP Contract where it is established as a separate legal entity. This will enable the CQC to regulate the ICP overall, as well as its constituent regulated services. Where a sub-contractor carries on an activity that is regulated by the CQC then they would need to register with the CQC.

142. Any organisation holding an ICP Contract would need to hold a licence from NHS Improvement, and so would be subject to NHS Improvement oversight.

143. The requirements on holders of ICP Contracts, for example around the duty of candour, or obligations to operate an appropriate complaints procedure, are in line with those imposed on existing providers of NHS services through their contracts with NHS commissioners. DHSC's proposed changes to complaints regulations are intended to ensure these requirements would be the same for ICPs as for other providers of similar services.

5.10 Question 10: Provisions about value, quality and effectiveness

We asked…

It is our intention to hold ICPs to a higher standard of transparency on value, quality and effectiveness, and to reduce inappropriate clinical variation. In order to achieve this the draft ICP Contract builds on existing NHS standards by incorporating additional provisions describing the core features of a whole population model of care and new requirements relating to financial control and transparency:
a) Do you think that the draft ICP Contract allows ICPs to be held to a higher standard of value, quality and effectiveness and to reduce inappropriate clinical variation? Yes/No/unsure; and please explain your response.
b) Do you have any additional, specific suggestions to secure improved value, quality and effectiveness, and reduce inappropriate clinical variation? Yes/No/unsure; and please explain your response.

Respondents said…

144. Many responses to this question generally drew on those to earlier questions, including the themes expressed in response to related questions on transparency and quality of ICP performance, and accountability – see questions 5 and 9.

145. Other feedback was mixed. A number of respondents suggested it may not be appropriate to hold ICPs to account for meeting a higher standard in the early years of an ICP Contract's duration due to the time required to develop processes and positively impact quality, efficiency and effectiveness.

146. There were some requests for further guidance – for example, for more detail on the transparency required, the types of outcomes envisaged, and how the features of a population health model would allow ICPs to be held to a higher standard.

147. More widely, some respondents shared views on whether ICPs should be held to a 'higher standard' at all: that it is not clear why a higher standard should be expected for ICPs than for other providers of the same services, with an NHS provider suggesting:

> *'This in itself could result in different standards of health provision dependent on what type of NHS contract that a provider enters into. This could almost act as a perverse incentive encouraging providers not to seek the integration of services.'*

Our response…

148. We are seeking to strengthen the controls and assurance over ICPs in a number of ways, both through the imposition of additional financial and transparency requirements, and through the requirement that any proposed award of an ICP Contract must be subject to ISAP. We have proposed elsewhere revisions we may make to the ICP Contract and related requirements to ensure the services delivered by an ICP are of the highest possible quality. We will also draw on wider developments around the availability of system-wide data and

performance metrics to ensure whole population providers can be held accountable for their wider impact on improving outcomes and integration of services.

5.11 Question 11: Additional suggestions for the draft ICP Contract

We asked…

In addition to the areas covered above, do you have any other suggestions for specific changes to the draft ICP Contract, or for avoiding, reducing or compensating for any impacts that introducing this Contract may have? Yes/No/unsure; and please explain your response.

Respondents said…

149. Alongside comments repeating themes expressed elsewhere in the consultation responses, various respondents made suggestions about the importance of ICPs having some responsibility for workforce training. This included a suggestion that the contract should include a requirement for an ICP to contribute to the future supply of trained clinicians to meet NHS needs.

Our response…

150. The ICP Contract contains provisions in relation to workforce training which largely reflect those under the generic NHS Standard Contract and current GP contracts. These include a requirement to cooperate with the LETB and Health Education England in the planning and provision of education and training for healthcare workers.

151. The ICP Contract already contains provisions around conflicts of interest, which include a requirement for the ICP to comply with existing NHS guidance on management of conflicts. We will consider whether supplementary contractual requirements or guidance are warranted. We will also consider how the contract may need to be updated to reflect commitments made in the NHS Long Term Plan.

5.12 Question 12: Equality and health inequalities impact

We asked…

Are there any specific equality and health inequalities impacts not covered by our assessment that arise from the national provisions within the draft ICP Contract? Yes/No/unsure; and please explain your response.

Respondents said…

152. There were mixed views about whether there would be any additional equality and health inequalities impacts arising from the proposed mandatory provisions that were not covered by our draft impact assessment.

153. Many NHS provider organisations and commissioners, along with some other respondents, thought our draft assessment (included with the consultation) covered the likely equality and health inequalities impacts. For example, one integrated care partnership stated:

'The assessment sets out how the draft ICP Contract, and supporting documents, could be utilised to address inequalities, and, as such, we welcome the potential these offer to support our agreed ambitions. As noted in the assessment, it will be imperative that equality and health inequality assessments are completed effectively by commissioners and providers to ensure the potential to reduce inequalities amongst the local population are realised.'

154. Amongst those respondents who disagreed, there were concerns about the impact of ICP arrangements – for example, (as highlighted earlier) about whether the homeless or travellers might be able to access care from an ICP. Others raised concerns, addressed under Question 3, that use of the ICP Contract could result in inequality of access due to a variation of care in different geographical areas.

Our response…

155. The proposed contracting approach for ICPs provides a national framework to enable the integration of care, which could have a positive impact for people with protected characteristics and those that are more likely to experience health inequalities, such as health inclusion groups. Its focus is on ensuring people receive integrated care that is focused on meeting their individual needs. At the whole population level, a key component of the new models of is that they are focused on addressing the wider determinants of health and tackle inequalities. This also complements the existing NHS England policies on equality and health inequalities, assisting in compliance with the Public Sector Equality Duty. Alongside the existing contractual provisions, we will also ensure that the ICP Contract incorporates where appropriate the new national policy and interventions to address health inequalities signalled in the NHS Long Term Plan.

156. However, as set out in our draft Equality and Health Inequalities Analysis, the practical impacts of this national framework will be determined by local commissioners in determining a care model and selecting an appropriate provider. It will be important for local commissioners and providers to undertake their own equality and health inequalities analyses to inform their decision-making, in accordance with legal and contractual requirements.