



Draft ICP Contract: a Consultation

**Draft Integrated Care Provider (ICP) Contract -
consultation package**

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Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Our consultation - purpose of this document

- 1 This document has been published in support of NHS England's consultation on the proposed Integrated Care Provider (ICP) Contract.¹ It provides detail about how the ICP Contract would underpin integration between services, how it differs from existing NHS contracts, how ICPs fit into the broader commissioning system, and which organisations could hold the ICP Contract.
- 2 This consultation includes a series of questions on which NHS England welcomes feedback. A summary of these questions, next steps, and details of how to respond are set out at the end of this document. Further documents have also been published as part of the consultation package. The package includes:
 - The draft ICP Contract and explanatory notes
 - Frequently asked questions
 - An overview of integrated budgets
 - A document describing the incentives framework for ICPs
 - A draft template Integration Agreement and frequently asked questions
 - Guidance on CCG roles where ICPs are established
 - A draft equality and health inequalities analysis
- 3 Our initial intention had been to consult formally on the draft ICP Contract in accordance with NHS England's legal duties,² but to do so once it had been tested and further developed, working with commissioners in the context of their local procurements.
- 4 Earlier this year we committed to bringing our consultation forward to take the opportunity to explain what the ICP Contract is for and when it might be used, and to dispel misconceptions about what integrated care models might mean for the NHS and people's care.
- 5 The High Court has now decided the two recent judicial reviews in NHS England's favour.³ The Health and Social Care Committee has also published its report on integrated care, in which it expressed some support for ICP development.⁴ Following these developments, we are now consulting on lead provider integrated care models and on the draft ICP Contract. Following the consultation, we will decide whether to issue the ICP Contract as a formal alternative to the NHS Standard Contract. If we do, it would then be available for use by commissioners wishing to commission an integrated model of care for their population, subject to their proposals being reviewed by NHS England and NHS Improvement through the Integrated Support and Assurance Process (ISAP) and enabling Directions being made the Secretary of State.

1 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.

2 Legal duties under Regulation 18 of the Standing Rules Regulations can be found on the Government website: <http://www.legislation.gov.uk/uk/si/2012/2996/regulation/18/made> (Information accessed 25 July 2018)

3 R (on the application of Hutchinson & Anor) v Secretary of State for Health and Social Care and NHS England [2018] EWHC 1698 (Admin); and R (on the application of Jennifer Shepherd (On behalf of 999 Call for the NHS) v NHS England [2018] EWHC 1067 (Admin), [2018] WLR(D) 295.

4 The House of Commons Health and Social Care Committee Integrated care: organisations, partnerships and systems Seventh Report of Session 2017-19 [p39] can be found on the Government website: <https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/inquiry4/>

- 6 Regardless of the outcome of this consultation, NHS England has no plans to replace existing contract forms (the generic NHS Standard Contract, and GMS, PMS and APMS contracts for primary medical services), which we anticipate will remain appropriate in most circumstances. It will be for local commissioners to determine which form of contract would best suit their particular population's health needs.

The ambition to integrate care

- 7 The NHS in England comprises a series of local organisations, bound by a common philosophy and set of standards. These organisations are either 'commissioning' (purchasing) healthcare (NHS England and local Clinical Commissioning Groups (CCGs)), or providing it. There are, for example, 229 NHS trusts and foundation trusts providing a variety of services and approximately 7400 GP practices, as well as numerous other independent and third sector provider organisations. Social care is bought separately by local authorities, usually from another set of providers. Between the providers and commissioners contracts are agreed, setting the services required by commissioners and the terms on which they are to be provided.

- 8 A person with complex needs may have contact with their GP, their local hospital, a community services provider, a mental health services provider, as well as the care home in which they live. Accordingly, there is a (long-recognised) need for health and social care services to be better integrated,⁵ improving people's experience of the care they receive and offering opportunities to improve outcomes and efficiency. As the Care Quality Commission put it in its [2016/17 State of Care report](#):

'People should be able to expect good, safe care when they need it, regardless of how this care is delivered... It's clear that where care providers, professionals and local stakeholders have been able to do this – where they have stopped thinking in terms of 'health care' and 'social care' (or specialities within these) and instead focused their combined efforts around the needs of people – there is improvement in the quality of care that people receive. To deliver good, safe care that is sustainable into the future, providers will have to think beyond their traditional boundaries to reflect the experience of the people they support.'⁶

- 9 The most recent mandate given by the Government to NHS England includes increasing integration with social care so that care is more joined up to meet physical health, mental health and social care needs. This aim is also reflected in previous versions of the mandate.⁷
- 10 More recently, the House of Commons Health and Social Care Committee has expressed its support for improving integration of care, highlighting its potential to improve patient experience.⁸

5 An example of this, the Integrated Care and Support: Our Shared Commitment (2013) report, can be found on the Government website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf (Information accessed 25 July 2018).

6 The CQC State of Care report 2016/17 [p36], can be found on the CQC website: https://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf (Information accessed 25 July 2018)

7 See for example, NHS mandate 2018 to 2019 which can be found on the Government website: <https://www.gov.uk/government/publications/nhs-mandate-2018-to-2019> (Information accessed 24 July 2018)

8 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)

- 11 NHS England's policy goals in relation to this area have been clear for some time. NHS England's ambition to transform the delivery of care in this spirit was first described in 2014's [Five Year Forward View](#) (FYFV):

'The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.'

- 12 The FYFV proposed two 'new care models' through which collaborative care redesign could deliver integration of services for whole populations. These were referred to as the Multispecialty Community Provider (MCP) and the Integrated Primary and Acute Care System (PACS).⁹ Since then, the [Next Steps on the Five Year Forward View](#) further articulated the ambition 'to make the biggest national move to integrated care of any major western country'.¹⁰
- 13 To achieve this, across England, steps are already being taken to improve collaboration between commissioners and providers and to deliver better care for patients. In some parts of the country, organisations are coming together to form 'integrated care systems' (ICSs), where 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. The first wave of 'shadow ICSs' were announced in June 2017 with four more announced in 2018. Other collaborations will take place at a number of different levels in the system, including through provider partnerships, such as networks of primary care providers.

Why do contracts matter?

- 14 Care redesign and integration are the absolute priority in order to improve patient services; any wider changes should only serve to support that. However, as Appendix A describes in more detail, the health and care services provided to an individual or population are currently bought via a series of different contracts, with 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 on another type of contract, often separately from each other. 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.
- 15 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

9 The Multispecialty Community Provider (MCP) emerging care model and contract framework can be found on the NHS England website: <https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf> (Information accessed 25 July 2018). The Primary and Acute Care Systems (PACS) – describing the care model and the business model can be found on the NHS England website: <https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf> (Information accessed 26 July 2018).

10 The Next Steps on the Five Year Forward View [p.31] can be found on the NHS England website: <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf> (information accessed 28 July 2018)

agreement'), supplementing the providers' individual contracts with the commissioner and formalising their collaboration. This agreement can describe 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.

- 16 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. Commissioners want the opportunity to use a contract of this type to ensure that 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.

What is the draft ICP Contract?

- 17 The development of the draft ICP Contract responds to the demand in some areas for a single contract through which general practice, wider NHS and in some cases, some local authority services can be commissioned from a 'lead' provider organisation, responsible for delivering integration of services. Such a provider can be known as an 'Integrated Care Provider' (ICP). The draft ICP Contract provides for:
 - a consistent objective to deliver integrated, population based care
 - 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
 - a population based payment approach, allowing flexible redeployment of resources to best meet needs and encourages a stronger focus on overall health, rather than simply paying for tightly defined activities
 - aligned incentives across all teams and services.
- 18 The ICP Contract is intended to promote an environment in which different teams and services can come together in a coordinated way, incentivising organisations to focus on delivering better patient care and improving the health of the population as a whole. The contract is designed to allow this to be achieved in a transparent way, ensuring consistency with all national NHS standards and requirements, whilst establishing clear accountability through a lead provider. The long term health and care outcomes for the population are the priority, and the prevention of ill health which the contract seeks to incentivise is vital to achieving improvement in those outcomes.

- 19 This form of commissioning, in the way that we understand clinicians and staff want to see it, can ensure the sustainability of care redesign that can in the first instance usually be established through collaboration. It can ensure that these benefits 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.
- 20 In this context, it is important to understand that ICPs are not new types of legal entity, but rather provider organisations which have been awarded ICP contracts. The area that is at the forefront and may choose to use the draft ICP Contract (subject to the outcome of this consultation exercise) is Dudley. The bid for this proposal is led by an NHS body, and has the support of local GPs.

Question 1:

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.

Case study: Dudley CCG

Dudley is a large metropolitan borough in the Black Country, nine miles west of Birmingham. The borough has a population of 316,000, with great variation of affluence and poverty and health outcomes. The gap in life expectancy between the least and most deprived areas of Dudley is 9.6 years for men and 7.3 years for women, and the proportion of Dudley residents aged 65 and over is 18.6%, higher than the national average of 16.3%. The proportion of older people in the area is increasing, and age brings with it a range of physical and mental ailments. The structure of the NHS and related local authority services, in which organisations are designed around types of treatment rather than around people, is not optimal for managing the increasingly complex health and social care needs of people living longer with multiple conditions.

In 2015, health and care organisations from across Dudley gave new energy to improving how they work together to meet people's changing needs, as explained in this public [video here](#). This resulted in (amongst other things) different staff groups from a range of health care and voluntary sector organisations joining with GPs to establish multi-disciplinary teams that work in the community with more vulnerable patients with multiple complex needs, to take a shared responsibility for better co-ordinating their care – giving people clear credible alternatives to hospital.

In addition, better continuity of care is achieved for individuals with long-term conditions by bringing together specialists with GPs to work to the same shared outcome objectives which are often co-produced with their patients.

Dudley CCG considers that the new more integrated model has been a success; people in Dudley now enjoy services that cover their medical and social needs in one place, link more closely with the voluntary sector and empower them to stay healthier for longer at home. They report that this 'has made a huge difference to [their] life'; 'has given [their] confidence back'; and that 'the service is fantastic'. In addition, staff involved in this work report that this 'provides easier access to a variety of professionals'; that it 'has improved efficiency greatly and led to a service improvement for people who use services and their carers' and that 'integration has re-energised team members and the enthusiasm of key professionals in the service has encouraged more staff to want to become involved'.

Dudley CCG undertook a [public consultation](#) in 2016 on making the new care model a permanent feature of the local care landscape. Three themes emerged from the consultation in terms of the public's expectations of services – access to a service, continuity of care from a service and co-ordination and communication between services. A video from the consultation explaining the proposals can be found [here](#).

It is theoretically possible to deliver such a model by establishing and maintaining the synchronisation of all existing contracts, but Dudley CCG believes that practically, this would be extremely difficult. Health and care organisations in Dudley are managed under 170 contracts and agreements, with each covering different types of care and resulting in each organisation having its own focus. This is a typical situation.

Dudley CCG believes that putting in place a new single ICP Contract instead for the integrated care model will make it easier to bring services together and also help Dudley commissioners and residents hold the new lead organisation to account for improving the health of the local population as measured by a single set of population health outcomes, described [here](#), and some of its income will be linked to these measures. Through this, Dudley would ensure that the system has an incentive to improve the health of the local population, rather than simply treat its illnesses. A ten-year contract would be awarded to support this, allowing providers to invest in changes to improve long-term population health.

How have we created the draft ICP Contract?

- 21 We have developed the draft ICP Contract from existing NHS contracts, further informed by joint working with stakeholders within and outside the NHS.

Collaborative development of the draft ICP Contract

- 22 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 CCGs with wider stakeholders such as the Royal College of General Practice, the 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.
- 23 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 as the draft NHS Standard Contract (Accountable Care Models) ('the draft ACO Contract'). We published alongside it a [summary of the engagement](#) received earlier in the year on its first iteration as the draft MCP Contract.¹¹ As part of our engagement process, we have continued to develop the draft Contract with CCGs intending to use an ICP model in their local areas. We have also had discussions with a group of local authorities, facilitated by the Local Government Association. The purpose of these discussions was to ensure that the draft ICP Contract is fit for purpose for commissioning social care and public health services as an integrated package with health care services where commissioners locally wish to adopt this approach. These discussions have been productive and have resulted in a number of changes to the draft Contract. This contract, as further developed, is now known as the draft NHS Standard Contract (Integrated Care Provider) ('the draft ICP Contract').

Structure of draft ICP Contract and inclusion of requirements relating to primary medical services

- 24 The structure of the draft ICP Contract follows that of the generic NHS Standard Contract with which most NHS services are commissioned. It is in three parts:
- i. **Particulars**, which the parties to the contract sign, and which record the signature of the contract and contain all the locally-agreed details and requirements – i.e. what is 'particular' to the specific arrangement between the parties to each local contract
 - ii. **Service Conditions**, setting out the core national requirements in clinical and service terms which any ICP will be required to deliver
 - iii. **General Conditions**, setting out the necessary contract management processes and standard, legal 'boilerplate' requirements.

11 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 subject to the outcomes of the consultation. (Information accessed 25 July 2018)

- 25** As with the structure, much of the content of the draft ICP Contract is identical to that of the generic NHS Standard Contract. This is because although the draft ICP Contract aims to support a new approach to service delivery, the regulatory and policy requirements which underpin and safeguard the delivery of NHS services – for example the [fundamental standards of care](#) and the [NHS Constitution](#), along with contracting safeguards – remain the same. Any provider which holds an ICP Contract would therefore be subject to those same requirements.
- 26** However, additional requirements needed to be incorporated into the draft ICP Contract to allow integrated services, including primary medical services (such as care provided by GP practices), to be bought with the same contract rather than through different contracts.
- 27** 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; GP participation is therefore essential to the success of the care and contractual models. The draft ICP Contract is specifically designed to aid the integration of primary medical services with other local health and care services – and along with improving people’s care, this is also intended to ensure the sustainability of general practice, support a future of strengthened relationships between GPs and the rest of the system, and offer the scale and infrastructure with which to underpin the ongoing delivery of primary medical services.
- 28** For primary medical services to be commissioned as part of an integrated package we have ensured that the draft ICP Contract complies with statutory requirements already applicable to primary medical services. However, we also wanted to ensure that the contract is as streamlined as possible. We have therefore worked with the Department of Health and Social Care (DHSC) to develop a set of new ‘Directions’, a type of legislation which will underpin the specific primary medical services requirements within the ICP Contract, and are designed specifically for a contract for integrated services. We are not inviting specific comments on the draft Directions at this stage, and they remain subject to change, but the Department of Health and Social Care will be undertaking a separate consultation that asks for specific views on the Directions themselves. If NHS England introduces the ICP Contract for use following this consultation, then (subject to the outcome of the Department’s own consultation on the Directions), the Directions will initially only be made available on a case by case basis for specific areas after they are signed off through the Integrated Support and Assurance Process, satisfying Government scrutiny requirements.

Inclusion of core requirements of an integrated whole population care model

- 29** The draft ICP Contract includes core requirements of a provider delivering an integrated care model, developed through work with commissioners and providers participating in the vanguard programme (2015 onwards).

30 For example, the draft ICP Contract:

- a. requires providers to consider how they can address health inequalities, supporting the CCG's discharge of its own statutory duties in this respect
- b. adds a requirement for the provider to conduct risk stratification to identify people who are more likely to require care in the future
- c. includes a requirement for the provider to provide analysis of population health needs and to develop strategies to improve the health and wellbeing of the population, supporting the CCG's discharge of its own duties in this respect
- d. includes an obligation to develop shared electronic patient records.

Amendments to regulations

- In developing the draft ICP Contract NHS England and DHSC have identified the need for various changes to existing Regulations. The most significant of these changes are to allow GPs to suspend their General Medical Services (GMS) or Personal Medical Services (PMS) Contracts should they decide to become 'fully integrated' with the ICP (see further details at paragraph 73): essentially, to allow primary medical services to be commissioned via the ICP Contract while maintaining for GPs the security of their General Medical Services or Personal Medical Services contracts. In addition there are a number of smaller technical changes which are generally designed to ensure current rules will apply to holders of the ICP Contract in the same way as to other providers of similar services. These regulations, if and when laid before Parliament, will not require the creation of ICPs, nor mandate what form they will take.
- Between 11th September and 3rd November 2017 the Department of Health and Social Care ran a public consultation on the proposed amendments to the identified regulations. This consultation [Accountable Care Organisations: Consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract \(Accountable Care Models\)](#), specifically asked consultees to consider whether the draft regulations delivered the policy objective of the introduction of a model contract for an integrated care model. The Department of Health and Social Care has published its response to that consultation which can be found [here](#).
- The Department of Health and Social Care has also separately previously consulted on proposed amendments to pensions scheme rules so that work which is currently pensionable under the NHS Pension Scheme remains so for those delivering NHS services under a contract for an integrated care model or a subcontract to it.

Using the draft ICP Contract

31 While the draft ICP Contract provides a framework for commissioning integrated care, and dictates some core national requirements and processes, it does not dictate matters for specification locally, by commissioners, on the basis of their assessment of what is required to best meet the needs of their local population in accordance with their statutory duties.

- 32** The duration of any ICP Contract, as for current local arrangements under the generic NHS Standard Contract, is not determined nationally, but is for local commissioners to decide, based on the model that they think would work best for their population. Where commissioners use the ICP Contract, they may consider it appropriate to award a contract for a term of up to 10 years (as could in principle occur with existing contracts) – recognising that the details of the contract will need to be monitored by commissioners and revisited regularly by commissioners and providers to ensure the contract continues to reflect changing circumstances. An important idea behind the draft 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 people’s health and conditions, 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.
- 33** The following paragraphs set out details about how the ICP Contract would be used. Further details are available in the draft ICP Contract and explanatory notes.

The service specification

- 34** As far as healthcare services are concerned, the area served by an ICP will be defined by commissioners, usually by reference to the practice areas of the GP practices integrated with it. For any public health services and adult social care services, the area served by the ICP is likely to be the area of the relevant local authority. Where the ICP is commissioned to provide core GP services, all permanent and temporary residents of its area will have the right to register with it. The ICP may also accept people onto its list of registered patients people who are not permanently or temporarily resident in that area. The ICP will then be required to provide those core GP services for everyone who has registered with it. The ICP must provide all other healthcare services specified by its commissioners for everyone registered as a patient with the ICP or with one of the practices integrated with it, and for everyone permanently or temporarily resident in its area and not registered with a GP practice elsewhere, as required to meet their individual needs. For everyone for whom the ICP is to provide services, it will be responsible for delivering on the proposed core national requirements set out in paragraph 30 above. But although these go some way to describing how services are to be delivered in a generic sense, they do not describe:
- a. the range of services for which any specific ICP will be responsible
 - b. how, where, and by whom those services are to be delivered
 - c. with which other services those ICP services are to be integrated, and how.
- 35** The population health management, outcomes-driven approach envisaged by the draft ICP Contract differs from the service/activity-based model on which most existing commissioning contracts are based. Existing contracts are often prescriptive as to the types of services to be delivered and how they are to be delivered.

- 36** In an ICP context, a focus on the broader needs of the population and on improving health and care outcomes demands a different approach. While it is for local commissioners to decide what and how to commission services, if commissioners are overly prescriptive the ICP will not have the flexibility and discretion to allocate resources, deploy health and care professionals and alter the provision of services on an ongoing basis to best meet the changing needs of local people, reflecting up-to-date best practice and a focus on prevention. But – understandably – commissioners will be concerned to ensure that a full range of high quality services is maintained in accordance with their commissioning strategies, and that any changes to the way in which services are delivered are well managed, and appropriately consulted upon. The key is to achieve the right balance between prescription and a more outcomes-based approach to service specifications. Finding this balance is consistent with the CCG’s duty to arrange for the provision of health care services.
- 37** Given the ICP’s focus on population health management, prevention and improvement of health and care outcomes, it is inevitable that over the course of an ICP contract it will consider altering the way in which it provides services to best meet these objectives. However, it will be for local commissioners to determine (by how prescriptive or otherwise they are in specifying the services in their Contract) the scope the ICP will have to do this without the commissioners’ consent. And, in any event, the ICP would be subject to the same rules and requirements as any other provider of NHS services when considering service change. Further details are outlined at paragraph 91.

The integrated budget

- 38** Providers of NHS services are paid in a number of different ways. For NHS services other than most primary care, payment is subject to the National Tariff Payment System (NTPS). For some services, such as community services or mental health services, commissioners and providers can choose their local payment arrangements, subject to the national tariff’s rules, and will usually be paid via a fixed payment. This payment method is typically known as a ‘block contract’ and is reported by the National Audit Office,¹² to account for over a third of all NHS contracts in 2017/18. Block contracts are normally paid in advance of the service being undertaken and the value of the contract is usually separate to the actual number of patients treated or the amount of activity undertaken. For primary care services, GPs are generally paid on the basis of a capitated payment related to the number of registered patients on a practice list, alongside a range of other payment streams. For many hospital based services, the tariff’s national currencies¹³ and prices apply, so providers are paid on the basis of the amount of activity provided. The fragmented nature and misaligned financial incentives of the current payment system can inhibit the delivery of more integrated and better co-ordinated care centred around the patient.
- 39** The draft ICP Contract envisages commissioners paying for the entire bundle of in-scope services as a package by way of an integrated budget, rather than on a service-by-service basis. The draft ICP Contract thus accommodates this by providing for a

¹² The National Audit Office’s publication *Sustainability and transformation in the NHS* (2018) [section 3.17], can be found on the National Audit Office’s website: <https://www.nao.org.uk/wp-content/uploads/2018/01/Sustainability-and-transformation-in-the-NHS.pdf> (Information accessed 25 July 2018)

¹³ A currency is a unit of healthcare for which payment is made. Under the national tariff system, a currency is a specification of a particular service or activity which may then be used as the basis for specific price to be paid for that activity.

Whole Population Annual Payment (WPAP), paid in monthly instalments, which will represent the majority of the funding available to the ICP under the contract. The initial baseline budget by reference to which the commissioners will determine the WPAP (and other payments to which the ICP may be entitled under the ICP Contract) is likely to be set by commissioners by reference to their current spend on the in-scope services. It is intended that the WPAP will provide flexibility for the ICP to manage care more effectively across different settings and invest in services designed to improve the longer term health outcomes of the population. The integrated budget approach has been developed to encourage the promotion of whole population management, prevention, self-care and a focus on outcomes rather than inputs or units of activity delivered.

- 40** Although most of the money available to the ICP will be through the WPAP, there will additionally be an incentive scheme for ICPs (see paragraphs 44-46) and may be additional payments to the provider for the small number of services where rules still require the payment to be made following delivery of specific activities. For example, this may apply in relation to the provision of vaccinations and immunisations. The WPAP applicable to any ICP Contract will need to be adjusted periodically to reflect changes to the size and profile of the population served by the ICP. It may also need to be adjusted from time to time to reflect agreement between the commissioners and the ICP as to the scope of services to be delivered. These adjustments will ensure that the ICP's funding can change in a controlled way over the lifetime of the contract, and will for example be required where an ICP budget is no longer sufficient to provide the full range of in-scope services to its population. Separately, periodic adjustments may be required to ensure that payments will continue to be affordable within CCGs' allocations.
- 41** The WPAP approach would be implemented using the existing flexibilities available to commissioners and providers of NHS services pursuant to the NTPS. A WPAP is entirely consistent with the statutory framework.¹⁴ Block payments of this nature may be agreed under the national tariff. In particular, if the WPAP includes nationally priced services, the commissioner and provider would agree 'local variations' to the specifications and prices of the relevant services, in accordance with NTPS rules, so as to combine them into a single package of services (along with other locally priced services) for which a single price is paid.
- 42** The commissioning of an ICP Contract on the basis of a WPAP will mean that the ICP becomes responsible for managing changes in the demand for services that are within scope of the ICP's contract. There are significant benefits of this approach, as the ICP is incentivised to focus on the causes of ill health and the management of conditions across its population; however the draft ICP Contract also introduces a number of additional safeguards to ensure that the ICP's budget is managed appropriately. These are set out at paragraphs 54-58. The CCG retains statutory responsibility to arrange the provision of services for people for whom it has responsibility.
- 43** For more information on the integrated whole population payment approach please see the [Integrated Budget Overview](#), published alongside this consultation.

¹⁴ See the judgment of the Court in R (on the application of Jennifer Shepherd (On behalf of 999 Call for the NHS) v NHS England [2018] EWHC 1067 (Admin), [2018] WLR(D) 295.

The incentives framework for ICPs

- 44** The draft ICP Contract, like all other NHS contracts, is designed to accommodate an incentive payment scheme. This means that a proportion of the contract value will be paid to the ICP only on achievement of certain goals. This is intended to improve the quality of service provision. There are two existing national incentive schemes, which will be reflected in the draft ICP Contract depending on the scope of services included, as follows:
- **Commissioning for Quality and Innovation (CQUIN) scheme** which contains a number of different indicators, chosen from a nationally developed set and currently constituting 2.5% of the available budget for most NHS services (except primary care)
 - **Quality and Outcomes Framework (QOF):** QOF sets out an entitlement for holders of primary medical services contracts to additional funding on achievement of a range of different process and clinical indicators. Where GPs have decided to join the ICP in a fully integrated way (see paragraph 73) core primary medical services will be included in the ICP Contract for that portion of the population. In this case the associated QOF payments for the relevant registered list will be available to the ICP on achievement of the national requirements, as they are to practices. We are currently exploring how there might be changes to future QOF arrangements to better support collaborative working in an integrated care environment as part of the QOF review. NHS England has recently published a [review of QOF](#), and discussions about its implementation are proceeding in parallel.
- 45** When using the ICP Contract, as with the generic NHS Standard Contract, commissioners would have the option to add additional indicators to the existing national schemes. This could for example change the balance of funding available through the WPAP and incentive scheme respectively. Any additional money at risk in this way would however be subject to a national assurance process before the contract was awarded, to ensure the balance of financial risk for the provider was sustainable.
- 46** For more information on the [Incentives Framework for ICPs](#), please see the guidance published alongside this consultation.

Role of subcontractors

- 47** Subcontracting by providers of NHS services is common; indeed many NHS and independent providers use subcontractors in support of fulfilling their obligations under their commissioning contract. Subcontracting can enable patient choice and diversity of provision, and allow ICP models to accommodate the invaluable contributions of smaller providers, such as those from the voluntary sector and social enterprises.
- 48** It is anticipated that at the outset, subcontracting elements of the package of services commissioned under an ICP Contract may be required to enable delivery of the desired care model. This is because it is unlikely that any one single provider will initially have all the staff, skills, capabilities, and/or assets to deliver the full range of services and obligations required under the ICP Contract.

- 49** It is important to note that subcontracting does not in any way relieve the ICP of its responsibility to the commissioner for the delivery and quality of any subcontracted service. The ICP, as lead provider, remains accountable to the commissioner for the delivery and integration and management of its 'supply chain' of subcontractors.
- 50** The draft ICP Contract therefore includes a range of provisions which set out obligations on the ICP and the commissioners as to the extent to which they may transfer, assign or subcontract to other bodies their rights and obligations under the contract. This includes:
- requiring that the decision by the ICP to let a subcontract is subject to commissioner approval
 - setting out that, as a condition of approval, the subcontractor may be required to sign a Direct Agreement with the commissioners (under which the commissioners can automatically become the direct commissioners of the subcontracted services, thus protecting service continuity)
 - allowing the commissioners to require a subcontractor to be appointed, removed or replaced in specific circumstances.

Question 2:

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
- 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.

Question 3:

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.

Question 4:

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.

Safeguards included in the draft ICP Contract

- 51** Alongside incorporating existing safeguards from the generic NHS Standard Contract, we have included a number of new safeguards into the draft ICP Contract, with the aim of ensuring that the contract is used as intended to improve the overall health and care of the relevant local population. These are set out below.
- 52** In addition we have included safeguards to prevent any unlawful delegation of CCG functions to an ICP.
- 53** These are outlined at paragraph 83.

Ensuring the ICP is financially resilient, and its budget is used appropriately to deliver service continuity

- 54** Many of the services which may be included in ICP models will already, under existing commissioning arrangements, be paid for on a 'block' basis. But the scale of an ICP model and the ICP's systemic importance makes it particularly important that commissioners will have assurance that the ICP budget is used appropriately, for the maximum short and longer-term benefit to all local people, that necessary services will continue to be delivered, and that the ICP will remain on a sound financial footing. It will be crucially important that providers do not avoid potentially more complex and costly treatments where these are clinically indicated. Commissioners will always need to ensure that the way the contract is used locally provides for a full range of services to be available to the entire population, and ensures quality or safety of care is protected. It may, for example, wish to specify certain services which must always be available to particular patient groups, or impose additional quality standards (supplementing those imposed by the mandatory elements of the Contract) which must always be maintained.
- 55** An ICP will have to manage any increases in the demand for services it delivers by the population, as the ICP itself would be responsible for delivering the extra services required. Commissioners would therefore require the ICP to think through how best to improve the health and care of its population as a whole to manage demand by keeping people well. This requires an ICP to ensure it manages its budget appropriately over the duration of the contract and to demonstrate transparently how it is doing so.
- 56** We have included a range of new provisions in the draft ICP Contract, to ensure financial accountability, transparency and service continuity. These include requirements on the ICP:
- to provide an independently audited financial business plan to the commissioner before the start of each contract year for review and comment
 - to operate "open book" accounting
 - to submit annual audited accounts
 - to be transparent about remuneration of senior staff.

57 Safeguards have been incorporated into the draft ICP Contract replicating and in some cases strengthening, those that exist under the generic NHS Standard Contract. These safeguards envisage an active and substantial continuing role for commissioners in contract management and oversight throughout the life of the contract:

- rights to terminate the ICP Contract, or the provision of individual services to some or all of the population, for a range of defaults on the part of the ICP, including in relation to service quality, or when there are concerns as to the ICP's financial viability concerns
- rights to suspend individual services
- rights to require the ICP to terminate subcontracts, and/or appoint new subcontractors
- a requirement for key subcontractors to enter into direct agreements with the commissioners, giving the commissioners assurance of service continuity in the event that the ICP contract, or any service under it, is terminated or suspended, pending recommissioning of services
- the ability for the commissioners to set periods of notice for termination by the ICP – whether of the whole ICP Contract or of specific services – of sufficient length to enable managed recommissioning and transition planning
- the expectation that the commissioners and the ICP will agree and include in their Contract detailed exit arrangements, to take effect pending and on termination and covering both a managed transition of services to new providers and financial consequences of termination
- a requirement that, regardless of any other agreed financial consequences, where termination of the ICP Contract or a service is as a result of the ICP's default, the ICP will compensate the commissioners for the costs they incur as a result, including the cost of recommissioning.

58 The ICP Contract is presented in a form which best demonstrates how it will look (subject to the outcome of this consultation and to population of Particulars locally) if and when used by the proposed early adopter site, where an NHS provider is expected to be the ICP. In the event that an ICP Contract is awarded other than to a statutory body, we believe that it would be appropriate to include additional provisions (at General Conditions 18 – 20 and 23, and associated definitions) to provide further assurance to commissioners and the population they serve (these are set out in the Appendix to the Explanatory Notes to the draft ICP Contract). These include requirements on the ICP:

- to ensure that it maintains an agreed minimum net worth and current assets to current liabilities ratio
- not to carry out any business other than as contemplated by the ICP Contract (in other words, the ICP must be a 'single purpose entity')
- not to use the assets used for delivery of services as collateral without the prior approval of the commissioner
- not to distribute funds unless a range of quality standards and financial conditions have been met
- (where required by the commissioners) to secure a guarantee from its parent organisation or a third party, providing financial security for the ICP's performance of the Contract.

Protecting patient choice

59 We have been conscious to make sure that the bringing together of services into a single contract does not restrict the choices available to people about how and where they receive care. NHS England and CCGs are under a legal duty to promote patient choice and to give effect to the legal rights to choice patients have under the NHS Constitution, and these legal requirements will continue to apply.^{15,16} Accordingly, the draft ICP Contract contains requirements to ensure that existing patient rights are protected. 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.

These requirements may be supplemented by local requirements as commissioners think appropriate for their local needs.

Question 5:

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.**

15 The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (PART 8) can be found on the Government website: <http://www.legislation.gov.uk/ukxi/2012/2996/part/8/made> (Information accessed 25 July 2018)

16 The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 can be found on the Government website: <https://www.legislation.gov.uk/ukxi/2013/500/contents/made> (Information accessed 25 July 2018)

What kind of organisations could hold ICP Contracts, and how would they be selected?

60 Commissioners would select an ICP based on their assessment of the most capable organisation to hold the contract. This section explains how they would be selected, the assurance process that they would go through and the types of organisations that may hold an ICP Contract.

How would an organisation be chosen to hold an ICP Contract?

- 61** Commissioners of health and social care in England (i.e. NHS England, CCGs and local authorities) are public bodies. This means that they must comply with certain legal requirements before awarding contracts for goods and services. In the context of health and social care services, they must usually advertise their intention to award a contract and must run a clear, transparent and fair process for selection of an appropriate organisation to hold that contract.¹⁷
- 62** Before embarking on any procurement exercise, and throughout the procurement process, commissioners must comply with their legal duties to engage with the public. This means talking to local service users, staff, providers, local authorities and other representative bodies to decide on the right care model to address local health and care needs.
- 63** As part of an open and transparent process, we would expect them to test, amongst other things:
- how they will improve the quality and efficiency of services, and meet the needs of the population
 - how much experience any bidding organisation has in delivering the full range of services in scope of the contract
 - whether the bidder has a proven track record of providing the type of services in the scope of the contract
 - the robustness of delivery model proposed by the bidder
 - the bidder's ability to work effectively with local GPs to provider integrated services to people and deliver the proposed model of care, and clarity around how GPs will relate to the ICP (e.g. whether GPs have committed to full or partial integration with the proposed ICP)
 - whether they will be able to deliver value for money and have the financial standing required to hold the contract
 - whether they have sufficient capability and capacity, for example through use of technology, workforce and estates, to deliver the long term improvements in outcomes which are required by the commissioner.
- 64** Although commissioners are required to advertise their intention to award a new contract, this does not necessarily mean that there will be a competitive procurement involving multiple bidders. In some local areas, the response to the advertisement may result in the commissioners engaging in dialogue with a single bidder.

¹⁷ The Public Contracts Regulations 2015 can be found on the Government website: <http://www.legislation.gov.uk/uksi/2015/102/contents/made> (Information accessed 25 July 2018)

National assurance over the award of an ICP Contract

- 65** The award of ICP Contracts will be subject to an assurance process known as the Integrated Support and Assurance Process (ISAP). ISAP is designed to operate as an additional safeguard over the award of ICP Contracts, recognising that ICPs could be of greater systemic importance than existing providers in the system holding contracts with a longer duration.
- 66** Under ISAP, NHS England and NHS Improvement conduct a coordinated review of the proposals, at specific key critical points of the procurement process. ISAP's objectives are to:
- ensure the proposals are in the interests of service users and the public
 - take a system view of the potential consequences of the proposal, potential contract award and implementation
 - ensure potential risks presented by the approach and the contract are identified and understood and that appropriate measures are in place to mitigate
 - improve efficiency and reduce duplication in the work of NHS England and NHS Improvement, increasing the speed of the national assurance for complex contracts.¹⁸
- 67** Each CCG is accountable for its decisions when carrying out its statutory functions and the ISAP is not a substitute for their governance and assurance processes.

What type of organisations would hold an ICP Contract?

- 68** As noted previously, ICPs are not new types of legal entity. An ICP would be simply an organisation which has entered into an ICP Contract with commissioners. Nothing about the ICP Contract inherently alters who may offer to provide NHS-funded services.
- 69** Statutory organisations are likely to hold the ICP Contract, but for example ICPs based on primary and community services (similar to the multispecialty community provider concept) could be led by a GP federation. It is for would-be providers to decide the organisational form which they believe will be best suited to deliver the ICP Contract which the commissioner wishes to award, and for the commissioner to assess the suitability of that organisation against its advertised criteria.
- 70** The draft ICP Contract is not intended to, and does not, promote or encourage privatisation of NHS services or outsourcing of NHS services to private sector organisations. Indeed to do so would be unlawful.¹⁹
- 71** In local procurement processes to date, NHS statutory providers have been able to demonstrate relevant experience and the ability to convene key partners, particularly GPs, to integrate care as the ICP Contract envisages. The area that is at the forefront and may choose to use the draft ICP Contract (subject to the outcome of this consultation exercise) is Dudley. The bid for this proposal is led by an NHS body, and has the support of local GPs.

¹⁸ 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 25 July 2018)

¹⁹ See section 13P of the National Health Service Act 2006 (NHS Act 2006). This is available at <http://www.legislation.gov.uk/ukpga/2012/7/section/23/enacted> (Information accessed 25 July 2018)

How could GPs participate in an ICP?

- 72** The active participation of GPs is critical to the successful delivery of integrated care models. But the participation of any individual practice or GP is entirely voluntary, and the manner in which they integrate with an ICP will be for them to decide.
- 73** In addition to the possibility of a GP-led organisation holding the contract itself, the draft ICP Contract envisages two alternative approaches to GP involvement and integration with an ICP:
- Under what we have called a partially-integrated approach GP practices would continue to deliver usual GP services to their patients under their existing GMS or PMS arrangements.²⁰ The ICP would be responsible for delivery of a package of other services. The ICP will be required by the ICP Contract to ensure integration of its services with the primary medical services delivered by the practices, in pursuit of locally-defined 'integration goals'. The main difference for each GP practice is that they will enter into an [Integration Agreement](#) with the ICP,²¹ setting out how they will work more closely together, for example through establishing common approaches to multi-disciplinary teams, agreeing to share information in line with information governance rules, and establishing joint decision making structures across the system. The Integration Agreement may provide for GP practices to be remunerated for playing their part in closer integration by sharing in incentive payments flowed through from the ICP Contract.
 - Full integration involves usual GP services being commissioned with other services under a single ICP Contract. The draft contract has been created to enable this, by including terms and conditions applicable to primary medical services (see paragraphs 24-28 above). But in order that usual services can be commissioned under such a contract, existing GMS and PMS arrangements in relation to those services must be set aside, whether permanently (by ending their existing contract) or for the life of the ICP Contract. As noted earlier in this document, changes to secondary legislation have been proposed by the Department of Health and Social Care which would provide that, where a GP practice decides that it wishes to become fully integrated with an ICP, it may suspend its current contract, allowing the primary medical services to be commissioned through the ICP Contract. GPs would then become either salaried GPs of the ICP or subcontractors. Practices would have the option to reactivate their suspended GMS and PMS contracts at different points throughout the lifetime of the ICP Contract, and this reactivation would otherwise happen by default following the expiry or termination of the ICP Contract.
- 74** The opportunities for GPs to be involved in the direction and leadership of the ICP will be central to their engagement and to the success of the care model and contract. Any successful provider will have to demonstrate that it can work closely with general practice providers to offer a joined up set of services to their population. For their part, GPs will wish to take the opportunities presented by integrated care models to play a greater role in population-focused decision-making.

²⁰ An explanation of primary medical services contracts, including GMS contracts and PMS agreements, is provided in the Glossary.

²¹ NHS England has also published a [FAQ](#) for the draft template Integration Agreement.

- 75** The options for GPs to become involved in the decision making of the ICP itself will depend on the organisational form chosen by the bidding providers. In particular, NHS trusts and foundation trusts are public sector organisations whose governance is subject to legislation. Within the current statutory framework, GPs could take up a variety of roles at executive and non-executive level alongside opportunities to become a salaried GP, subcontractor or local stakeholder. These flexibilities and options could enable governance and operational arrangements that fully align to delivering an integrated service model and enable GPs to exert strategic influence over decision making and operational delivery.
- 76** We have previously produced a series of videos about what it is like to be a GP working to develop an integrated care model and to support GPs to learn more about these models. These videos are based on real GPs' own views and site experiences, and are available at <https://www.england.nhs.uk/new-business-models/publications/gp-participation-in-a-multispecialty-community-provider-mcp/>.

Question 6:

- 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.**

How would ICPs fit into the NHS commissioning system and wider health care system?

- 77** The draft ICP Contract does not change the statutory duties of commissioners and supports better integration of care in the way which primary legislation currently allows.²²

Commissioner duties, functions and activities

- 78** Commissioners of NHS services have duties and powers imposed on them by law. Statutory duties are the "must dos" that commissioners are responsible for delivering. Statutory powers are the things that commissioners may do (i.e. they have some discretion in deciding whether to do these things to help fulfil their statutory duties). In this section, we use the term 'function' to describe these statutory duties and powers.

²² In this context, it is important to note that the High Court has, in determining that the ICP model is lawful, held that the integration of health and social care via a single provider of care (an ICP) where that provider has a substantial degree of autonomy over health care choices 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.

See R (on the application of Hutchinson & Anor) v Secretary of State for Health and Social Care and NHS England [2018] EWHC 1698 (Admin).

79 CCGs' functions²³ include:

- commissioning, i.e. making arrangements for the provision of services to meet the reasonable needs of people for whom the CCG has responsibility
- preparing joint strategic needs assessments and joint health and wellbeing strategies with local authorities
- promoting the NHS Constitution
- having regard to the need to reduce inequalities between patients with respect to the outcomes achieved for them
- promoting patient choice
- promoting integration, with a view to securing that health services are provided in an integrated way.

80 Within the existing legislative framework, CCGs have considerable flexibility to carry out their functions in collaboration with other CCGs, NHS England, and/or local authorities. Most CCGs also purchase external commissioning support (for example, from commissioning support units and/or private providers of commissioning support services).

81 CCGs may also, through the generic NHS Standard Contract, require providers to undertake activities to help them exercise their own functions, for example by requiring the provider to do things that have the aim of reducing inequalities or ensure patient choice. However, a CCG will always retain legal responsibility for their functions. This can never be delegated to a provider. The draft ICP Contract does not change this position: it maintains a statutory boundary between commissioners and providers of NHS services.

82 It would be for local commissioners to determine what they want to commission an ICP to do, and to specify that in the contract with that ICP. As they already do under existing NHS contracts, commissioners may through their ICP Contract give the ICP the scope to take decisions about resource allocation and the design of care, with the aim – among other things – of improving integration and service quality.

83 We are aware that the range of services which might be integrated under an ICP Contract is potentially extensive. To ensure that a commissioner cannot unlawfully delegate its statutory functions to an ICP, we have included the following safeguards in the draft ICP Contract:

- Service Condition 1.8 of the draft ICP Contract expressly prohibits an ICP from doing anything that would put the Commissioner in breach of its statutory duties or amount to an unlawful delegation. The full text is set out in the below footnote,²⁴ and further information is also included in the accompanying document [Contract package: Questions and answers](#).

23 A list of CCG functions from 2013 can be found on the NHS England website: <https://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf> (Information accessed 25 July 2018)

24 The Provider may, within the scope provided by this Contract, use and allocate its resources and deliver the Services in such a manner as it determines will best service the needs of the Population, provided that it does not do or fail to do anything which would:

- 1.8.1 place any Commissioner in breach of any statutory duty in relation to the Population;
- 1.8.2 render any Commissioner liable to challenge under the Public Contracts Regulations 2015 or otherwise; or
- 1.8.3 constitute an unlawful delegation of any function by any Commissioner.

- Service Conditions 1.4 and 1.5 of the draft ICP Contract impose obligations on the ICP and the commissioner to perform all their obligations under the contract in accordance with, amongst other things, the terms of the contract and (within the meaning of the contract) “the Law”.²⁵ This includes adhering to the division in commissioning responsibilities between commissioners and providers, under the NHS Act 2006.
 - The draft ICP Contract includes provisions (see General Condition 17) to deal with breaches of the contract, including a breach of Service Condition 1.8 referred to above. These could be used as means of redress if a provider overstepped the statutory boundary between commissioning and provision of services. Commissioners could also vary the contract where an ICP has failed to meet its contractual obligations, or terminate, with immediate effect, the contract where the ICP has breached any of its obligations in any material respect or persistently.
- 84** As noted above, the draft ICP Contract is based on the generic NHS Standard Contract. In relation to the statutory division between commissioners and providers of NHS services, the draft ICP Contract is similar to the NHS Standard Contract in these ways:
- As under the NHS Standard Contract, the draft ICP Contract requires the commissioner to outline and define the scope of services which it requires the ICP to deliver. In both cases the contract provides a framework for decisions then made by the provider. Both the draft ICP Contract and the NHS Standard Contract therefore give a provider, within set contractual limits, discretion to make decisions and use its judgment about the allocation of resources. The draft ICP Contract is not therefore new in this respect.
 - An NHS Standard Contract between a CCG and a provider for the delivery of acute and specialist health services to patients already requires the provider to allocate its clinical and management resources for those services in the way it determines will best meet the needs of its patients, as long as it is able to meet the core operational standards and quality requirements for the services in question. This is already expected of providers, which respond to normal pressures in the health care system. The draft ICP Contract will not change this.
- 85** Neither the existing NHS Standard Contract, nor the draft ICP Contract, require funds to be spent by the provider in any particular way on the services provided. The key requirement is to deliver the services in the contract, to the level of quality it requires. It is for the provider to decide how best to spend its funds to meet those requirements.
- 86** Commissioners of ICP Contracts must continue to assure themselves that they are fulfilling their statutory functions, even where the ICP is required by the contract to undertake activities in support of the commissioners’ functions. Alongside the safeguards in the draft ICP Contract, which envisages a continuing and active role of a commissioner throughout the lifetime of an ICP contract, a thorough procurement process for the award of an ICP Contract will be important. Through ISAP, NHS England and NHS Improvement will seek assurance that (amongst other things) before the contract is awarded the CCG has taken legal advice on its ability to continue to carry out its statutory functions.

²⁵ Meaning, in the language of the draft ICP Contract, “(i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (ii) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; (iv) Guidance; and (v) any applicable code, in each case in force in England and Wales”.

- 87** As for all other contracts commissioners will continue to be responsible for managing performance of the ICP. CCGs will continue to be responsible for the development of the service specification, desired outcomes, standards and outputs by which performance will be measured, contract management and quality monitoring, alongside oversight of risk and reward mechanisms. This would include holding the ICP to account for the performance of the entire ICP Contract, including those aspects subcontracted to other providers.
- 88** We have developed [CCG roles where ICPs are established](#), which sets out more detailed guidance about the implications that commissioning an ICP may have for CCGs. It is available alongside this consultation document.

Public accountability and involvement

- 89** As leading systems testing new approaches to accelerated improvement, holders of ICP contracts will be held to a higher standard of transparency on value, quality, and reduction of inappropriate clinical variation. This will aid continuous improvement, monitoring and evaluation, and the spread of best practice across the NHS. We are using this consultation to engage on those proposals already included in the ICP Contract and to develop as necessary further measures for inclusion (see consultation Question 10). The incorporation of this suite of additional transparency requirements, included as a template within each ICP Contract would, once agreed, be a condition of using the contract, enforced through the ISAP approval process.
- 90** The draft ICP Contract does nothing to change the existing statutory obligations of both commissioners or providers of NHS services regarding public accountability. Commissioners are required to make arrangements to involve the public in commissioning, including consulting their local populations when proposing significant service change. This is explained in [statutory guidance](#). Where use of the ICP Contract is currently being considered, activity has included engagement events and the involvement of people who use services and public groups.
- 91** We have previously noted that within the parameters of the contract an ICP would undertake some improvements to and redesign of the provision of services. Changes to service provision would need to be carefully considered, and would be a matter on which both commissioners and the ICP will need to engage with local people, staff and affected organisations. The ICP Contract requires the ICP to support commissioners in performing their duty to involve the public on such changes, and in some cases this engagement and involvement activity may actually be led by the provider, in line with current practice. For larger proposed changes, the existing rules on service reconfigurations will also apply. These are set out in guidance²⁶ published by NHS England, which sets out the steps that commissioners and providers should follow to give effect to major NHS service changes. In particular:
- CCGs have a legal duty to involve patients and the public in proposals for service reconfiguration, to have regard to the above guidance, and must necessarily work in partnership with other bodies in developing service change proposals

²⁶ The guidance Planning, assurance and delivering service change for patients can be found on NHS England's website: <https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf> (Information accessed 24 July 2018)

- Providers, whether or not subject to similar duties under statute, will be subject to a duty to involve the public in the planning, development, consideration of and decisions upon service change proposals through contractual obligations imposed on providers under both the existing NHS Standard Contract and (in stronger terms) the draft ICP Contract.

In addition to these requirements, the draft ICP Contract allows the commissioner to specify through the Service Specification specific premises from which key services must be delivered, as is the case under the existing generic NHS Standard Contract; the ICP would not be able to depart from this without commissioner consent.

- 92** The obligations for public involvement on the ICP mirror (and in certain respects go beyond) those obligations which are imposed on any other provider under the generic NHS Standard Contract. Alongside providing support and assistance as necessary to the CCG in order to meet the commissioner's obligations, these include requirements to involve local people, staff, and voluntary and community sector organisations in considering and implementing service redesign. In addition the ICP will be required to operate the [Friends and Family Test](#), to carry out appropriate staff surveys and other surveys, and to provide assistance to commissioners in relation to the latter's statutory duty to carry out consultation on proposals for service reconfiguration. The commissioners' own statutory obligations around public involvement would remain unchanged. If the ICP is an NHS trust or foundation trust, its statutory duties in relation to public involvement will apply in addition to its obligations under the ICP Contract.
- 93** In addition to its contractual and statutory obligations as to public involvement, the ICP would be required by the ICP Contract to respond to complaints by service users, mirroring those in place for other providers holding existing NHS contracts. This includes publishing and operating appropriate complaints procedures. As with current providers under NHS Standard Contracts, the ICP must separately comply with the 'duty of candour' obligation to be open and transparent with service users and their families about any problems or incidents that arise with their care.
- 94** CQC is committed to working with and learning alongside new ICPs as they emerge. CQC is currently considering its approach to ICPs, and other new, integrated models of care. Within its existing legal powers, CQC will be able to register an organisation holding an ICP Contract where it is established as a separate legal entity. This will enable CQC to regulate the ICP overall, as well as its constituent regulated services.

Involvement of local authorities

- 95** Local authorities have statutory responsibilities for providing public health and social care services for relevant local populations. They do so through a combination of in-house provision and commissioning of services from provider organisations.
- 96** Earlier sections of this document (see paragraphs 7-13) describe the widely-recognised importance of integration between health and social care services. Indeed, across the country over recent years NHS commissioners and local authorities have worked together collaboratively on integration initiatives such as the Better Care Fund (BCF), pooling resources to jointly tackle the needs of their population.

- 97** The benefits to be derived from the whole population approach envisaged by the ICP Contract could potentially be greater if social care and public health services were to be commissioned under it, alongside NHS services, giving one single organisation responsibility for delivering genuinely integrated health and social care services. This would likely need to be supported by a 'section 75 agreement' between NHS and local authority commissioners. Section 75 agreements (i.e. agreements made in accordance with section 75 of the NHS Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000), which are already in use, allow health bodies and local authorities to pool budgets in one or more pooled funds and to delegate the exercise of certain of their functions to the other party.
- 98** However, there are several models through which closer integration of healthcare, public health and social care services can be and is being pursued, and it will be for local health and council partners to decide the approach best suited to local circumstances. Where an ICP model is envisaged, integration between NHS and local authority services could also be achieved through separate arrangements, such as an integration agreement between the local authority (and/or the providers of services it has commissioned) and the provider holding the ICP Contract for healthcare services.
- 99** We have worked with a number of local authorities, and the Local Government Association (LGA), with a view to ensuring that the draft ICP Contract is a suitable vehicle for the commissioning of public health and/or social care services alongside NHS services, where local commissioners wish to adopt this model. In response to feedback from local authorities and the LGA to date, we have (amongst other things) ensured that the draft ICP Contract:
- allows for the population to be served by the ICP to be defined in a way which can accommodate the different statutory responsibilities of CCGs and local authorities
 - makes explicit that some provisions apply only to healthcare services, some only to public health and/or social care services, and some to all services
 - makes specific reference to regimes particular to local authorities and their staff: for example, the Local Government Pension Scheme.
- 100** When considering whether to commission social care and public health services via an ICP Contract, a local authority would of course need to consider:
- how it will design its budget for those services in scope, bearing in mind the size and demand-led nature of the adult social care budget
 - how it will continue to discharge its core statutory duties in relation to social care and public health, including strategic commissioning and shaping the market in social care
 - how the arrangements will allow elected members to continue to discharge their responsibilities to local people and for the council as an organisation
 - how links between social care and public health with other council functions will be maintained.
- 101** As they are currently, NHS services would remain free at the point of use under an ICP Contract.

Question 7:

- 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.

Question 8:

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, 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.

Question 9:

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
 - 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.

Question 10:

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.

Question 11:

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.

How might the ICP framework affect equality and health inequalities?

- 102** In developing the proposed contracting arrangements for ICPs, we have been mindful of considering any potential impact on equality and health inequalities.
- 103** Overall we anticipate that the proposed contracting approach for Integrated Care Providers 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 that 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 care such as PACS and MCPs (which the contracting framework would support) 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 the compliance to the Public Sector Equality Duty.
- 104** We have set out in our accompanying [draft Equality and Health Inequalities Analysis](#) more details about how we anticipate that the proposed national framework for ICPs may affect people with protected characteristics and those that are more likely to experience health inequalities.
- 105** We note that, subject to the outcomes of this consultation, the practical impact of this national framework would be determined by the local decisions made by 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.

Question 12:

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

How do we measure impact, and learn?

- 106** We do not yet have any ICPs in place in England. However, subject to the outcomes of this consultation, we plan to study the effects of the first ICP Contracts that come into being and share learning with others that may follow. Following its recent inquiry on integrated care, the House of Commons Health and Social Care Committee recommended that ICPs should be carefully evaluated before being implemented widely.²⁷
- 107** Dudley, the first area that might use the draft ICP Contract, has a programme of evaluation underway. We will work with the first systems using the draft ICP Contract to ensure that:
- in the near term we capture the lessons around how to improve the local processes for designing and establishing an ICP under contract, including how amending national rules could aid this
 - in the longer term there is ongoing evaluation of any improvement in population health outcomes and other measures of performance in areas served by an ICP relative to others and how these were achieved.
- 108** We would expect local areas that implement an ICP Contract to evaluate outcomes and impact against local measures.

Next steps

- 109** Following the conclusion of this consultation we will consider the feedback we receive. We plan to then publish a response to the consultation, and will decide whether to make the draft ICP Contract or an amended version of it available to CCGs as a model commissioning contract. If we decide to do so, we will:
- publish the model contract and guidance to CCGs about the circumstances in which we would allow it to be used (in line with ISAP and our powers under the Standing Rules)
 - if we consider it necessary to do so, put in place a process, aligned to ISAP, under which we may consider amendments to the model contract proposed by early CCG users during their procurements, within our discretion under those Standing Rules. We may choose to do this in recognition that integrated care models are at an early stage of development in the NHS in England, and the terms of the model contract may need adjustment to reflect those models as they are developed locally. Any amendments we consider may then be incorporated in subsequent versions of the model contract, on which we would carry out further consultation.

²⁷ The House of Commons Health and Social Care Committee's publication Integrated care: organisations, partnerships and systems inquiry Seventh Report of Session 2017-19 [p41] can be found on the House of Commons website: <https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/inquiry4/> (Information accessed 25 July 2018)

Summary of consultation questions

Question 1:

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.

Question 2:

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
- 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.

Question 3:

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.

Question 4:

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

Question 5:

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.**

Question 6:

- 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.**

Question 7:

- 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.**

Question 8:

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, 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.

Question 9:

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
 - 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.**

Question 10:

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.

Question 11:

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.

Question 12:

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.

How to give feedback

- 110 NHS England is keen to receive feedback and answer your questions on proposed contracting arrangements for ICPs. Your views will help NHS England to further shape and refine our proposals. The consultation period runs from 3 August - 26 October. We encourage you to read the full consultation document before responding.
- 111 You can respond by:
 - Online survey: the online survey can be accessed by clicking [this link](#).
 - Post: Alternatively, if you can't respond online you can post your response(s) to ICP Consultation Response team, NHS England, Skipton House, 80 London Road, London SE1 6LH.
- 112 NHS England is grateful to individuals and organisations who take the time to respond to this consultation. During the 12 week consultation period, we will work to gather views from a range of stakeholders. Following the close of the consultation period, NHS England will review, analyse and consider all responses received. A summary of the responses will be published on our website to provide an opportunity to reflect on what has been heard.

Appendix A – How is health and social care currently commissioned and provided in England?

- 113** The NHS in England is actually comprised of a series of different organisations which between them deliver a comprehensive health service in England.
- 114** These organisations fall broadly into two categories:
- Providers of health care: these are the organisations that deliver free-at-the point- of-use NHS services to patients. These mostly include GP practices (which are typically independent contractors) and statutory bodies (such as NHS trusts or NHS foundation trusts). But other types of organisation, including voluntary and independent sector organisations, also provide some services.
 - Commissioners, or purchasers, of health care: these are the bodies which have statutory duties to arrange for appropriate health care services to be provided to the people for whom they are responsible. The 195 local clinical commissioning groups (CCGs) are responsible for arranging (amongst other things) most acute services, mental health services, ambulance and community health services for local people. NHS England²⁸ has responsibility for commissioning primary medical services, dental, pharmacy, ophthalmic and certain specialised services.
- 115** CCGs have a duty to improve the health of the people for whom they hold responsibility. In doing so, they must ensure that they promote health and wellbeing, address health inequalities, and provide high quality services in line with the national standards which are set out in, for example, the [NHS Constitution for England](#).
- 116** In practice, commissioners arrange for the provision of services from health care providers by awarding contracts to them. For example, each GP practice will hold a contract awarded to it by NHS England (or the local CCG on its behalf if NHS England has delegated its commissioning responsibility to that CCG), and each NHS trust or foundation trust will hold contracts, awarded by a number of CCGs and/or by NHS England, for the delivery of health services. It is for commissioners to decide which providers they commission services from to meet their statutory duties, subject to the relevant procurement rules²⁹. Contracts awarded by NHS commissioners to providers take different forms, depending on the nature of the services to be provided by the provider in question.
- 117** Most services delivered by GP practices are commissioned by NHS England under what are known as General Medical Services (GMS) contracts or Personal Medical Services (PMS) agreements. Some GP services are also commissioned under contracts known as Alternative Provider Medical Services (APMS) contracts. Most of the terms and conditions of these contracts or agreements (including payment terms and care quality standards) are set out in legislation and/or agreed following national negotiations between NHS England and GP representatives. Contracts awarded to GP

28 Since 1 April 2013, NHS England has been the operating name for the National Health Service Commissioning Board. NHS England was established as a body corporate by the Health and Social Care Act 2012, which made amendments to the National Health Service Act 2006.

29 The Public Contract Regulations 2015 (<http://www.legislation.gov.uk/uksi/2015/102/contents/made>) and the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (<https://www.legislation.gov.uk/uksi/2013/500/contents/made>) apply to the procurement of health care services (Information accessed 25 July 2018)

practices vary in duration; GMS contracts are usually open-ended, PMS agreements may or may not be time-limited, while APMS contracts are typically for a fixed period of time.

- 118** NHS England (in accordance with powers given to it under its Standing Rules³⁰) requires CCGs (and NHS England itself), when commissioning other health care services (except pharmaceutical services, and primary care ophthalmic and dentistry services), to use what is known as the **NHS Standard Contract**. This is a template contract published by NHS England in full length and shorter forms, and revised periodically. Because this template contract is used by all commissioners and providers of these services, a consistent set of rules, standards and contract management processes is applied nationally.
- 119** The NHS Standard Contract sets out mandatory terms and conditions governing (amongst other things):
- service quality
 - compliance with the NHS Constitution and other legal requirements
 - patient safety and safeguarding
 - patient records
 - patient choice
 - how performance issues are to be managed
 - how disputes are to be resolved
 - when a contract may be terminated or suspended
 - invoicing and payment arrangements.
- 120** The NHS Standard Contract is also a framework within which commissioners must specify, on a contract-by-contract basis, matters including:
- how long the contract is to last
 - the services to be provided
 - how those services are to be provided, and to whom
 - prices for services (if there are not national prices for those services, determined by NHS Improvement, or those prices are agreed or determined not to apply), and how those prices might be varied periodically
 - local policies and processes with which the provider must comply
 - local quality standards.
- 121** These are, rightly, things to be decided locally and in respect of each individual contract, because CCGs will be best placed to determine what will best meet the needs of the people for whom they are responsible.

³⁰ The Standing Rules are contained within the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, which can be found on the Government website: <http://www.legislation.gov.uk/ukxi/2012/2996/contents/made> (Information accessed 25 July 2018). These regulations are made by the Secretary of State for Health and Social Care under powers given to him under primary legislation, including the National Health Service Act 2006.

122 Meanwhile, local authorities³¹ have statutory responsibility for arranging public health services and social care services for local people. Local authorities may provide services themselves, but they may also commission other organisations (private sector care homes, for example) to provide services for them. Although they are closely linked to NHS services, these services and the funding for them are not part of the NHS.

31 In this context, usually meaning: (a) a county council in England; (b) a county borough council in England; (c) a district council in England; (d) a London borough council; (e) the Council of the Isles of Scilly; (f) the Common Council of the City of London.

Glossary

Better Care Fund or BCF

The Better Care Fund (launched in April 2015) is a programme spanning both the NHS and local government which seeks to join-up health and care services. The BCF requires local health bodies and local authorities in each health and wellbeing board area to pool funding. In 2016/17, £5.9 billion was pooled in the BCF.

Clinical commissioning groups or CCGs

Clinical commissioning groups, established by the Health and Social Care Act 2012, are responsible for commissioning healthcare services within their geographical boundaries by assessing local needs and monitoring the quality of the care which is provided.

Commissioning

Commissioning is the term used to refer to the process of planning, purchasing and monitoring health services.

The draft ICP Contract

The draft NHS Standard Contract (Integrated Care Provider), first published under that name with this consultation package, (but based very closely on a draft contract published on 16 December 2016 as the draft NHS Standard Contract (Multi-speciality Community Services) Contract, or 'draft MCP Contract'), and on 4 August 2017 as the draft NHS Standard Contract (Accountable Care Models) is the subject of this consultation. The draft ICP Contract is made up of:

- Particulars
- Service Conditions
- General Conditions.

The draft ICP Contract is supplemented by guidance and explanatory documents. These include:

- guidance on integrated budgets
- Incentives framework for ICPs
- draft template Integration Agreement and associated overview
- guidance on CCG roles where ICPs are established.

See [here](#) for further details.

NHS Five Year Forward View or FYFV

The [NHS Five Year Forward View](#) was published in October 2014 by NHS England as a planning document. The FYFV proposed new care models, including the concepts of a Multispecialty Community Provider (MCP) and Primary and Acute Care System (PACS).

NHS Five Year Forward View Next Steps or FYFV Next Steps

In March 2017, NHS England published [Next steps on the NHS Five Year Forward View](#). This document took stock of progress at the half way point of the Five Year Forward View and set out priorities for the two years following its publication.

Integrated Care Provider or ICP

An Integrated Care Provider (ICP) is a provider organisation that is contractually responsible for providing an integrated set of services to a defined population, under a NHS Standard Contract (Integrated Care Provider) Contract. The ICP can provide services itself and/or subcontract provision of services to other organisations (such as GP practices). ICPs are not new legal entities, and there is no process by which an organisation would be 'designated' an ICP by NHS England or any other body: an organisation will be an ICP if it is awarded an ICP Contract under which it assumes that role.

Integrated Care Systems or ICSs

An ICS is an evolved version of an STP. In an ICS, commissioners and providers of NHS services, in partnership with local authorities and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

The Integrated Support and Assurance Process or ISAP

The Integrated Support and Assurance Process provides a co-ordinated approach by NHS England and NHS Improvement to supporting and assuring the procurement and transactions related to complex contracts.

Multispecialty Community Providers or MCPs

Multispecialty Community Providers (MCPs) were first announced by NHS England in the FYFV. MCPs are whole population care models which integrate primary medical services with other community-based health and care services. Further details were provided by NHS England in the [Multispecialty Community Provider Emerging Care Model and Contract Framework](#) published in July 2016. The draft ICP Contract is an evolved version of the earlier draft MCP Contract and subsequent draft ACO Contract.

The NHS Act 2006

The National Health Service Act 2006 (the NHS Act 2006) is the principal legislation governing the health service in England. The NHS Act 2006 was substantially amended by the Health and Social Care Act 2012.

NHS Constitution

The [NHS Constitution for England](#) is published by the Secretary of State under section 1 of the Health Act 2009. The NHS Constitution describes itself as follows:

'This Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.'

The Secretary of State, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required to take account of the NHS Constitution in their decisions and actions.

NHS Standard Contract

The [NHS Standard Contract](#) is the name given to the model commissioning contract currently mandated by NHS England (pursuant to its powers under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996) for use by commissioners for all of their commissioning contracts for healthcare services other than primary care. The draft ICP Contract is largely based on the NHS Standard Contract and, subject to the outcome of this consultation, may in due course be adopted (in its current form or as further amended) as a model commissioning contract – a variant of the NHS Standard Contract for use by commissioners in circumstances to be defined by NHS England.

Primary and Acute Care Systems or PACSs

Primary and Acute Care Systems are whole population care models which integrate hospital care with services including primary medical services. PACS were first outlined in a framework document published in September 2016: [Primary and Acute Care System \(PACS\) Integrated primary and acute care systems – Describing the care model and the business model](#).

Primary medical services contracts

NHS England commissions primary medical services through three types of contract: the General Medical Services (GMS) contract; the Personal Medical Services (PMS) agreement; and, the Alternative Provider Medical Services (APMS) contract. Currently, most GP practices operate under GMS contracts or PMS agreements. A small minority operate through APMS contracts.

The GMS contract is a nationally prescribed contract between NHS England and a practice. Statutory regulations require the GMS contract to contain certain contractual requirements. GMS contracts are underpinned by nationally agreed payment provisions. The duration of GMS contracts is usually open-ended.

The PMS agreement is also based on statutory regulations but enables greater local agreement on certain contractual provisions in particular the funding arrangements. PMS agreements may or may not be time-limited.

APMS contracts are typically for a fixed period of time and allow greater local tailoring of the contractual requirement.

Section 75 agreements

These are agreements made under section 75 of the National Health Service Act 2006 between a local authority and an NHS body in England. Section 75 agreements can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

The Standing Rules or the 2012 Regulations

The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996, which (among other things) empower NHS England to draft model commissioning contracts and require NHS commissioners to use them when they commission certain services.

Vanguards

'Vanguard' areas are those areas selected by NHS England in 2015 to pilot new models for integrated care.