SCW

NHS
South, Central and West
Commissioning Support Unit

# DRAFT INTEGRATED CARE PROVIDER (ICP) CONTRACT
# OVERVIEW AND PROPOSED CONSULTATION RESPONSE

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# CONTENTS

# 1. SUMMARY OVERVIEW

SCW have proceeded to develop a response to the ICP contract consultation that was launched by NHS England (NHSE). This paper provides background and context and an overview of the proposed contract document. It also includes the SCW response to the consultation questions which SCW submitted on its own behalf, and on behalf of many of its customers, in line with the national deadline of 26th October 2018.

Some customers chose to submit their own response to the consultation and were able to use the SCW content to inform this.

The information below is a summary of the document entitled;

Draft ICP Contract: a Consultation, gateway reference, 07883 and is available via the address below:

www.engage.england.nhs.uk/consultation/proposed-contracting-arrangements-for-icps

# 2. PURPOSE OF THE CONSULTATION

The consultation was launched in order to:

- Explain what the ICP contract is for
- When it might be used
- Dispel misconceptions about what integrated care models might mean for the NHS and people's care.

The High Court has now decided the two recent judicial reviews in NHS England's favour. The Health and Social Care Committee has also published its report on integrated care, in which it expressed some support for ICP development. Following these developments, NHSE are now consulting on lead provider integrated care models and on the draft ICP Contract. Following the consultation, they will decide whether to issue the ICP Contract as a formal alternative to the NHS Standard Contract. If they 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.

There are no plans to replace existing contract forms simply to provide another option.

The consultation period ran to 26th October.

# 3. THE AMBITION TO INTEGRATE CARE

The NHS in England comprises a series of local organisations. 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.

A complex set of separate contracts, organisations and funding streams can lead to duplication and lack of co-ordination, make communication between providers, clinicians and patients more difficult, and risk loss of focus on the overall needs of the person.

# 4. THE ICP CONTRACT

In some areas 'alliance agreements' have been used to supplement individual contracts and aid collaboration, but there has never before been a commissioning contract specifically to promote an integrated service model including primary care, wider NHS and some local authority services.

The opportunity with the ICP contract is to ensure that contracting, funding and organisational structures help rather than hinder staff to do the right things and define more clearly who has overall responsibility for integrating and co-ordinating care.

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 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
- A population based payment approach, allowing flexible redeployment of resources to best meet needs
- Aligned incentives across all teams and services.

ICPs are not new types of legal entity, but rather provider organisations which have been awarded ICP contracts.

# 5. STRUCTURE OF ICP CONTRACT

The structure of the ICP contract follows that of the generic NHS Standard Contract, and is in three parts:

- **Particulars**, which the parties of 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 contact
- **Service Conditions**, setting out the core national requirements in clinical and service terms any ICP will be required to deliver
- **General Conditions**, setting out the necessary contract management processes and standard, legal 'boilerplate' requirements.

Much of the content of the ICP Contract is identical to the NHS Standard Contract, however, additional requirements have been incorporated to allow integrated services, including primary medical services to be brought in with the same contract rather than through different contracts.

NHSE have worked with the Department of Health and Social Care to develop a new set of 'Directions' for primary medical services within the ICP Contract (these are not subject to this consultation). If the ICP contract is introduced the Directions will initially be made available on a case by case basis for specific areas.

In developing the ICP Contract, changes to regulation are needed. The most significant is to allow GPs to suspend their GMS or PMS contracts should they decide to become 'fully integrated' with the ICP. These are yet to be laid before Parliament.

# 6. CORE REQUIREMENTS OF AN INTEGRATED WHOLE POPULATION CARE MODEL

The draft ICP Contract includes core requirement of a provider in delivering an integrated care model for example:

- Requires providers to consider how they can address health inequalities, supporting the CCG's discharge of its own statutory duties in this respect
- Adds a requirement for the provider to conduct risk stratification to identify people who are more likely to require care in the future
- 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
- Includes an obligation to develop shared electronic patient records.

# 7. USING THE DRAFT ICP CONTRACT

### Contract duration
The duration of the contract is for local determination, however, in drafting the contract it is anticipated that they will be awarded for a longer term typically 10 years.

### Service specification
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.

### The integrated budget
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 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 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.

Although most of the money available to the ICP will be through the WPAP, there will additionally be an incentive scheme for ICPs 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.

The whole population budget will need to be adjusted periodically for population changes, or scope of services changes, or to ensure affordability with CCG allocations.

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. The CCG retains statutory responsibility to arrange the provision of services for people for whom it has responsibility.

### Incentives
CQUIN and QOF national schemes will be included dependant on the scope of services.

Additional incentive schemes could be included subject to a national assurance process before the contract was awarded to ensure the balance of risk for the provider was suitable.

### Subcontractors
Subcontracting is envisaged as it is unlikely that one provider will be able to deliver the full range of services and obligations. The ICP remains accountable to the commissioner for the delivery, integration and management of its 'supply chain' of subcontractors.

# 8. SAFEGUARDS INCLUDED IN THE DRAFT ICP CONTRACT

### Safeguards

There are a number of new safeguards with the aim of ensuring that the contract is used as intended to improve the overall health and care of the relevant population. These include:

- Ensuring the ICP is financially resilient, and its budget is used appropriately to deliver service continuity. The ICP will need to manage its budget over the duration of the contract and manage demand and demonstrate transparently how it is doing so; measures include:
    - Provide an independently audited financial business plan to the commissioner before the start of each contract year
    - Operate 'open book' accounting
    - Submit annual audited accounts
    - Be transparent about remuneration of senior staff.

### Protecting patient choice

The draft ICP Contract contains requirements to ensure that existing patient rights are protected. These requirements may be supplemented by local requirements as commissioners think appropriate.

# 9. WHAT KIND OF ORGANISATIONS COULD HOLD ICP CONTRACTS, AND HOW WOULD THEY BE SELECTED?

### How would an organisation be chosen to hold an ICP contract?

The usual procurement rules and procedures would be followed. 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.

The award of ICP contracts will be subject to an assurance process known as ISAP (Integrated Support and Assurance Process), where NHSE and NHSI conduct a coordinated review of the proposals.

### GP Participation

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. There are currently two options for participation;

**Partial integration:** hold GMS and PMS, but enter into an Integration Agreement setting out how they will work more closely. 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:** allows for the usual GP services being commissioned with other services under a single ICP Contract. Practices would have the option to reactivate their suspended GMS and PMS contracts at different points throughout the lifetime of the contract and this would happen by default when the contract ends.

# **10.** HOW WOULD ICPs FIT INTO THE NHS COMMISSIONING SYSTEM AND WIDER HEALTH CARE SYSTEM?

### Commissioner duties and responsibilities

The draft ICP Contract does not change the statutory duties of commissioners.

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.

### Public accountability and involvement

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.

This consultation engages on those proposals already included in the ICP Contract and to develop as necessary further measures for inclusion. 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.

### Involvement of local authorities

NHSE have worked with local authorities and the LGA to ensure that the draft ICP contract is a suitable vehicle for the commissioning of public health and/or social care services alongside NHS services, provisions include:

- 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 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.

# 11. SCW CONSULTATION RESPONSES

## Integrated Care Provider (ICP) Contract Consultation - Questions and proposed responses:

**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:

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

System maturity happens at different times and at different paces therefore having a generic framework will help achieve consistency of approach over time, although it is recognised that the presence of a contractual document alone will not achieve integration and that the importance of stakeholder relationships is vital and will underpin transformational change.

It is recognised that the proposed contract is not mandated and is just an option therefore simplifying the system through shared mechanism of payments and rewards is entirely logical. It is very early to be trying to understand if the complexities of the draft presented will meet the particular needs of the Health Communities and Commissioners drawn to using it. Variations should therefore be anticipated once use of ICP contract becomes more commonplace.

We should be encouraging integration across the STP boundary, especially where co-terminus with social care and other services that need to be part of a wider integration agenda. This is in line with the national integration agenda and broadly the NHSE strategic direction for more holistic, high quality services that are financially sustainable.

It is important to note that the financial incentive for non NHS providers to become involved may differ to NHS providers and therefore this needs to be considered fully in order to mitigate potential material outflow of NHS funds for profit rather than system re-investment.

**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 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:

The value of the whole Population Budget spend is specified at the starting point, but a cost basis would potentially be more equitable and reduce issues as the discussions progress. Establishing the costs would encourage more open relationships and would potentially give scope for the realisation of more efficiencies in total spend by Commissioners.

Overall, whilst the elements of paragraph 30 are desirable it is important to ensure it is not perceived as the Commissioners divesting themselves of accountability for key indicators of future success.

Recognising that it is ultimately for local health system agreement, it is recommended that further consideration and guidance is given to defining and measuring outcomes across component elements by which an ICP could be deemed to be achieving.

**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:

Encourage and support NHS trusts to take over and manage primary care where this enables integration in systems where GP numbers are not stable. This could bring resilience to systems where trusts can promote rotation of doctors into community settings when needed to avoid acute escalation into secondary care.

**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 element 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 context 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:

SCW input – The proposed ICP contract offers a useful framework that allows the commissioners to introduce local flexibility and innovations. The standard NHS contract offers opportunities for flexibility but it is recognised that this facilitates additional opportunities to integrate primary care and Local Authorities within a sound legal basis and it helps with the structuring of considerations determining what elements are required to be included.

It is important to ensure that enough flexibility is ultimately given to ICPs over SDIP, DQIP, service specifications and pathway design to ensure that they have enough control to make being an ICP an attractive proposition for them to want to enter in to, confident that over a long period they can safely make the required investments. If the balance is not correct then it may be an unattractive proposition for potential ICPs either at formal bid stage or as part of other collaborative discussions within a health system. It will be important to ensure that the ISAP process reviews this aspect to ensure that an appropriate balance has been proposed.

It is correct that ultimately the services within scope has been left for local determination as Commissioners are best placed to determine the appropriate scope to ensure enough of an incentive for providers to participate. For example, it might be difficult to address prevention of admissions to hospital and maintenance of frail complex patients without the inclusion of primary care , community providers or elements of social care. However, mandated currencies, minimum data sets for specific pathways of care and a minimum set of services in scope to kick start integration where there are multiple providers/specifications and clinical models across an STP footprint should be considered. To put this in context, an STP could have x200 contracts with providers across all CCGs and each contract will have multiple specifications and KPIs. To simplify this 'puzzle', a prescriptive start for community services, MH services and acute services would help enormously.

Prescribing a 'minimum' for the service list to be included in an integrated position would also set the right tone and start point for each system. For example, all integrated systems must have a minimum of, MH, community, primary care, and social care services to qualify itself as a truly integrated system. Excluding any one of these creates a gap before it has even started. A key factor will be the management of the transfer of utilisation risk from Commissioner to Provider and it is crucial that the details regarding this as assessed via the ISAP process.

It is important to ensure that the collaboration and ICS style of working that has been encouraged through the suspension of certain fines and penalties within the National Standard contract is not unwound within this contract. This could be an unintended consequence that impedes what the ICP contract is trying to achieve overall as due to the increased autonomy that ICP providers may have and the increased risk to the health economy of failure, additional assurances and governance have been proposed but if this is too restrictive and punitive it may discourage a culture of openness and collaboration.

**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:

SCW input – It is good to give flexibilities to providers but it must be clear what tasks and accountabilities CCGs are passing over to the providers e.g "utilisation risk". CCGs retain statutory responsibilities but to facilitate integration and make it attractive enough to a potential provider market you have to give enough control and flexibility to the providers to be able to control and shape the pathways to be able to drive efficiency and integration.

Incentives need to be appropriate to encourage appropriate provider behaviour but they must have the flexibility to execute that appropriate behaviour.

There needs to be a huge amount of upfront work by providers to develop the appropriate approaches and assurances to each other via sub contract arrangements and it is possible that this may lead to a proliferation of sub contracts replacing a proliferation of existing contracts. This may create on-going complexity and require providers to procure capacity and capability to manage such sub contracts effectively that they may not already have within their provider organisations.

To use the flexibility effectively, suitable governance arrangements will need to be put in place and any potential impact on statutory obligations will need to be considered and understood by all parties. All provider parties of the ICP would need to work to one single budget therefore open book accounting and transparency is required. The relationships should be such that if one area fails all fail – this promotes collaborative incentives and working.

It could enable flexible deployment of resources between providers but that could have both positive and negative consequences in terms of sustainability and will need to be modelled to understand the risks associated.

The contract is potentially long term – 10yrs but future provider delivery will be dependent on the level of funding awarded to the various funding streams (NHS/Social Care) to in turn be passed on to the provider. If the overall quantum is insufficient then despite increased flexibility that may not be able to be operationalised effectively to deliver improved outcomes for the population. This risk will have to be carefully modelled in provider risk assessments within their ICP proposals and may also need to be explored fully before this as part of the ISAP process to ensure that potential providers are being given a financial envelope that enables a high chance of successful delivery.

It is also essential that that accompanying this increased flexibility for providers is very robust data in terms of cost and activity to underpin the in-scope services budget allocation – The accuracy of this must be assessed and understood to ensure that all parties understand the risks that they are accepting, which may need to be underpinned by actuarial analysis.

Ultimately, the flexibility is a positive thing as it will enable a better platform for remuneration on an outcomes focussed pathway, across current boundaries.

**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:

SCW input - It is very helpful that the safeguards within the NHS Standard contract have been extended due to the increased length of contracts and increased level of funding involved. Whilst these developments bring integration opportunities and the opportunity to drive change and innovation they also bring increased risk, therefore it is important to have wide-ranging requirements and safeguards that can provide assurance to Commissioning organisations and appropriate contractual levers for Commissioning organisations in the event of concerns or issues.

A key consideration is the degree to which patient choice has been safeguard and there could be more in the contract and associated guidance regarding how that will be assured and if needs be enforced. For example, ensuring that GPs in a partially integrated ICP still offer choice to patients, e.g to use a provider outside the ICP.

Quality and continuity is of course desirable, however continuity may not always be possible or desirable if transformative change is needed to limit the breadth of provision currently available. Consolidation might be more important to drive quality and clinical standards and sustainability inside system control financial totals.

The requirement for open book accounting needs to be further defined, especially in respect of the requirements that will be placed upon non NHS providers.

It is important to ensure that the contract allows for clear public transparency over any gain share arrangements in return for successful delivery so that the ratio of baseline payment and incentive payments is understood.

**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:

SCW input - A suggestion is where there is a requirement to move beyond governance and assurance and more towards actively managing risk and issues. Do provisions reflect the ability to step in. There is a requirement for clear and strong break clauses and it would be good to have more on practical dispute resolution e.g if things go bad and clauses are used, is it clear how any disputes around this get resolved e.g the process, timelines, binding pendulum agreement etc. This could be within technical guidance to bring the contractual clause practically to life. A good example is the dispute resolution guidance issued in recent years where there has been failure to agree a new National Standard contract.

Another consideration is recognition of the potential need for some flexibility around choice. If transformational change is to be safe and financially sustainable at some stage choice may be affected if it is no longer affordable. For example, larger 'single site scale' for cohorts of procedures and specialties might be preferable to drive quality and efficiency in an ICP across an STP footprint.

Consideration could also be given to requiring an independent party to be a cost accountant to do the reconciliation and accounting.

**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:

This additional option is supported as it could be material in securing the level of Primary Care engagement and commitment that is recognised as being essential to the successful delivery of ICPs.

As GP contracts (GMS/PMS) are 'in perpetuity' any change in their primary care contracts may require the transition to an APMS contract – this would not be palatable for most GMS/PMS contract holders therefore this would have to be mitigated as part of the development of an additional option for GPs to engage within ICPs, whilst still continuing to operate under their existing primary care contracts. It is recognised that there are emerging models of Federations or 'Super' practices holding the contract on behalf of individual practices and that there are also emerging models of Provider Trusts taking over the running of practices in some areas around the country.

If the commitment of general practice is required then it must be achievable without handing over existing contractual arrangements , it is noted that there is reference to the ability to suspend a contract during the lifetime of the ICP contract but it needs to go further.

**b. If yes, how exactly do you think we should create this?**

Is it possible to consider allowing them to be a sub-contractor to the Lead Provider, still utilising a form of integration agreement but without the need for them to suspend their current contracts?

GPs may need a guaranteed income for a fixed period of time to allow them to adapt. GPs could receive the same income through a defined transitional time period but recognise this may change and increase as the scope of what they can do changes though pathway transformation and integration with others partners in the system.

The concept of an ICP holding individual contracts with individual primary care contract holders would be prohibitive from the perspective of contract management. The nature of primary care at individual practice level is that there is significant variation in approach / methods used for service delivery (and in some cases quality of services). At an ICP level any unwarranted variation may cause challenges in the delivery of strategic goals and objectives.

In order to mitigate this, the suggestion would be for GP integration with ICPs through 'at scale contracts' whether that is through limited companies such as Federations or through the development of super practices (one partnership arrangement with several GMS/PMS contracts beneath this).

It is acknowledged that not all practices would want to work in this style – however given the alternative of not being engaged in the developing health and care landscape they may well choose to participate when they see the benefits.

**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:

Why do other primary care contractors not appear in here? Community dental services, community Pharmacy services and optometrist services could all add value in an ICP.

GP engagement – a clear definition needs to be made between GP engagement and consultation. All too often primary care is consulted with rather than engaged with. To overcome the challenge that GP participation is voluntary, true engagement in the planning (bottom Up) is essential.

Clarity on conflict of interest would also be required were GPs to be involved in the decision making – there are already examples of potential conflicts where GPs are on CCG boards and have been appointed directors in Federations – these can be mitigated; however then adding another decision making role will complicate matters further.

There is a need for more clarity on the likely systems and interoperability needs for GPs and other provider systems to operate efficiently without clinical risks. Perhaps a prescribing of a limited number of software and hardware systems that may be used and purchased that are guaranteed to work together in an ICP that would apply to all ICP parties.

**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 social care services?**

Yes / No / **Unsure**; and please explain your response:

Is Section 75 enough to facilitate change? Are there enough flexibilities within it to ensure that it can work if parties want to make it work.

Incentivising the best behaviours to meet the needs of an individual and population is key. There is the potential for shift of cost between NHS & LA to achieve true integration and therefore individual statutory duties could play in and could be a limiting factor.

Has any consideration been given to including and integrating Offender Health Care – this should certainly be considered as part of the Digital Road map for a local area?

**b. If not, what specifically do you propose?**

There will be the need to utilise NHS resource to commission and fund Social Care delivery where it is necessary to deliver the outcomes agreed. There may need to be dispensation of legislation where it exists and hinders ICPs to resource and deliver social care. This might need legislative review for both Health and social care services and national constitutions.

Where are their technical and legal limitations between for example continuing health care and social health care needs for complex patients? Where might it be prudent to spend health care funding on social care placements to reduce length of stay and health risks for an ICP with commissioner authorisation – will this need changes to the legislation and legal mandates for health and social care nationally?

**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 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:

The ISAP process is key to ensuring that statutory duties are not unlawfully delegated to an ICP as part of the initial design and implementation of an ICP. It is noted that the ISAP process requires legal input and clarity that statutory obligations are not given away therefore this should safeguard the process and ensure that obligations continue to be met by each statutory body.

Notwithstanding the above, is there a need to consider putting a governance panel in place to govern the contract as a whole, including Commissioner and provider representation. This would go beyond the contractual Contract

Review meetings and could include non-exec type parties on the panel to ensure people are working collaboratively in the right way. Some areas may want to consider the role of their Health and Wellbeing Board as part of the strategic commissioning governance.

Whilst it will not be desirable to hinder the ICPs ability to innovate, governance must protect the commissioners' oversight of the services delivered so as to enable a holistic configuration of services that will work seamlessly across a health system. ICPs that enthusiastically develop and limit services without commissioner authorisation could leave gaps in services that are unsafe or generally unacceptable when viewed at a system wide level. Contracts must state categorically that all parties must have authorisation before changing the specification and outcomes of services. This will include but not be limited to nationally mandated targets and standards.

**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
- Requirement to operate an appropriate complaints procedure
- Complying with '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:

SCW input –The NHS Standard contract is very mature and therefore mirroring its provisions is welcomed. However, it should be considered that public involvement, whilst desirable for transparency can also slow and hinder the transformative pace needed to bring together so many organisations, sites and services. We have seen many times those with vested interests delay change over years when given a public platform to resist change, and the ICP is all about a new model and way of working. With this in mind there may need to be limitations put on the need to consult on changes to services, or the delay and distractions for those involved may prove to be impracticable for some of the parties involved and limit their appetite and capacity to be involved.

Ultimately this is about creating a workable contract and not about reducing or increasing the associated accountability to the public. Whilst an ICP CQC requirement is sensible, it is important not to allow this to result in significant additional transactional activities that will strip out the potential efficiencies of this model.

**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:

With so many parties and organisations involved there will need to be guidance and templates relating to the possible 'conflict of interest' and relationship management scenarios. Existing guidance may need to be reviewed to ensure it is still robust enough for such a complex merging of people and organisations.

Foundation Trusts and Community Interest Companies / Social Enterprise Trusts, have a range of regulatory requirements therefore the contract is only one aspect of their public accountability, however, if new organisations are formed by a collaboration of trusts then it would need to be clear what their duties were e.g if Limited companies were formed then it would need to be clear what accountabilities this organisation would have or how it would affect the cost of services with regard to HMRC.

If there was a private company then consideration would have to be given to how much flexibility it is desirable to give them to trade with others and not undertake procurements versus the requirements of the contract. If there is insufficient flexibility then this could limit interest from the private sector.

As integration of the pathway is the goal, it would be good if patients received a total pathway discharge summary that identified the elements of care received and from whom (tracking their journey from initial point of contact to discharge from care and including GP, LA etc)

**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:

SCW input – To some degree this is the case as there is a requirement for open book accounting but there are nuances regarding what this means in practice therefore this needs to be defined.

The general and service conditions will need to prescribe financial and clinical audit 'open book' transparency to set a standard for all parties to comply with that will then enable the higher standards sought to be realised from the start of agreements.

**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:

Open Book Accounting – Can there be further guidance about how this will work in practice, definitions of open book accounting, clarity around required data quality and consistency to enable this?

This approach aims to drive outcomes as a greater alternative currency and this is important and to be applauded. It might help if there were a nationally mandated core set of outcomes to act as a catalyst and also to assist for example with benchmarking in the early stages of development of ICPs nationally, and to share learning from success where possible. Locally ICPs could be expected to develop or include existing outcome currencies/indicators that have been tested to add to the national core outcome dataset. This could encourage a faster start to developing outcome measures locally as well as benchmarking progress. The faster we start, the better the outcomes and delivery might be realised for patients. The alternative currencies linked to national tariff and other indicators will hinder progress if alternatives are not driven from the start and to some extent prescribed.

Transparency is key but to facilitate this can there be more specific detail regarding financial monitoring arrangements.

**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 the Contract may have?**

**Yes** / No / Unsure; and please explain your response:

SCW input - It is recognised that the Technical Guidance to the NHS National Standard contract is very extensive and a regular source of practical assistance therefore a similarly detailed technical guidance to accompany the ICP contract would be welcomed.

Can more guidance and consideration be given to the potential TUPE implications as a result of the development of ICPs? For example, the potential implications for CCG staff if material responsibility for the design of care pathways is transferred to the ICP provider.

Can more guidance be provided in respect of exit provisions and contingency planning of fall back options if, for example, an ICP provider fails and rapidly ceases service delivery whilst within a 10 year contract.

Can there be additional guidance around how to handle any underlying CCG and provider deficits as part of the transition to an ICP. Would there be an expectation that all deficits would be picked up by potential ICPs as part of the terms of the contract. If this is the case then the quantum of risk would need to be attractive enough for potential ICPs to want to take on the challenge of providing.

There could be additional focus on the details of expected data quality requirements as accurate data is a key enabler for all parties to understand the level of risk they are taking on. It would also be good to get more focus on the issue of deriving cost vs deriving current price to maximise the opportunity for Commissioners to realise financial efficiencies as part of the transition to an ICP.

Can further consideration be given to the associated legal and project management costs that would likely need to be incurred as part of a transition to an ICP. Presumably this would be an essential part of the ISAP gateway process to ensure that all associated costs were understood and accepted.

Procurement costs and challenges – more guidance would be welcomed regarding procurement requirements as the UK leaves the European Union.

Social Care and Primary Care may need additional, transitional funding to allow them to transition from existing risks and arrangements to new ways of working. This may be needed for employment, redundancy, TUPE, estates, clinical equipment leases and other existing commitments that will need the be entered into or ended to enable the integration of differing needs and ways of working for such a range of services and organisations. Local governance across STP areas would need to be put in place to be able to make cases to drawn down funding of this type when needed and the ICP parties would need to jointly sign off on such funds when clear cases are made for the benefit of the ICP.

Greater detail on how whole system outcomes could be measured/demonstrated. As stated previously, there is the potential to develop some generic national cross system KPIs.

Ultimately, legislative change might be required as an enabler to either prescribe or encourage integration where progress is not at a sufficient pace.

Commissioners will (in some cases) need to collaborate more openly with neighbouring CCGs where there are currently a range of specifications, currencies, and investment with many or sometimes the same provider that can cause unnecessary complexity. Additional guidance around this issue would be welcomed.

**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:

# SCW

Our hummingbird was chosen for more than its aesthetic appeal.

It represents determination, endurance, flexibility, adaptability, resilience and great courage. The very characteristics we will demonstrate in our work with our customers.

contact@scwcsu.nhs.uk | scwcsu.nhs.uk | @NHSscwcsu