

GP participation in an Integrated Care Provider

NHS England and NHS Improvement



GP participation in an Integrated Care Provider:

ICP Contract Package

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Executive Summary

Integrated Care Providers (ICPs)

- 1 'Integrated Care Provider' ('ICP') is a term we use to describe a provider that is responsible for the integrated provision of general practice, wider NHS and potentially local authority services, which enters into an ICP Contract with the commissioner(s) of those services.
- 2 The ICP (which is sometimes referred to as a 'multispecialty provider' or 'integrated services provider' in different parts of the country) would be a 'lead' provider organisation, and so would be contractually responsible for delivering integrated services for local people.

GP involvement in an ICP

- 3 GPs are at the heart of the NHS, and their participation is vital to deliver integrated care. Without it, we will not be able to deliver the full potential of the population-based models developed through the New Care Models programme. The ICP Contract is specifically designed to aid the integration of primary medical services with other local health and care services. Along with improving people's care, this integration is 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 to underpin the ongoing delivery of primary medical services.
- 4 GP participation in an ICP is voluntary and local ICP proposals will not be able to move forward without support from general practice. Recognising that in areas where proposals are being taken forward GPs may wish to work with an ICP in different ways to deliver an improved service for patients, we have developed the ICP Contract to provide for two distinct means by which they could participate:
 - a. Where the contract is used to commission a package of services excluding essential primary medical services, with GMS/PMS contracts continuing to be in place as they are currently, this is called a 'partially integrated' ICP. Practices would enter into an agreement with the ICP (the 'Integration Agreement'), setting out how they and the ICP will work closely together.
 - b. Where the contract is used to commission a package of services including, by agreement, the essential primary medical services currently provided individually by practices under GMS/PMS contracts, this is called a 'fully integrated' ICP.

What do these options mean for GP practices?

- 5 When creating a partially integrated ICP via an Integration Agreement – expected to be the most likely route chosen by participating practices – existing contracts for core primary medical services will remain operational. An Integration Agreement is designed to allow the agreement of shared objectives between GPs and the ICP, and to bring greater clarity around how GPs and colleagues in the ICP will work together to oversee service delivery and improvements. It will also support greater consistency of care across the whole population, achieved through shared clinical protocols and common ways of working.

- 6 A more significant change will occur where a practice wishes to become fully integrated. In a fully integrated model, GP practices would choose to terminate or, more likely, suspend their GMS/PMS contracts (in accordance with the process introduced via changes to GMS and PMS regulations), providing the partners with the option to work for the ICP directly as salaried employees, leading and contributing to blended clinical teams within the same organisation. The ICP Contract requires that where GPs are employed by ICPs, they will be offered terms at least as favourable as the BMA and NHS Confederation's model salaried GP terms and conditions. A practice may also choose to become fully integrated where it wishes to continue to be an independent organisation, but considers that a closer formal relationship with the ICP would be beneficial. This would be achieved through suspending the GMS/PMS contract as before, and becoming a subcontractor to the ICP, on terms agreed up front prior to the ICP Contract commencing.
- 7 Whilst for partially integrated practices existing contracts for core primary medical services will remain operational, for those wishing to suspend contracts, the more significant changes associated with a fully integrated model will require careful consideration and advice. NHS England has committed to make further information available to aid those going through this process, and this document starts this process by describing the different options and the implications for practices.

Introduction to integrated care models and ICPs

- 8 This document is designed to support GP practices as they consider what participating in an ICP might mean for them. GPs should read this document in conjunction with other documents in the [ICP Contract package](#).
- 9 In January 2019, the [NHS Long Term Plan](#) highlighted the intention to ‘dissolve the historic divide between primary and community health services’. It also explains that ICPs allow, for the first time, the integration of primary medical services with other services through a single commissioning contract, creating greater flexibility to achieve full integration of care.
- 10 The participation of GP practices in ICPs is of critical importance to the success of integrated care models and contracts. Most people commonly access healthcare through their GP, and therefore GP participation with integrated care models is the foundation of a population-based approach. GP participation within integrated care models will help improve patient care, as the approach will improve access to services, enable people to tell their story once, and receive more consistent, joined-up care.
- 11 NHSE has previously produced a [series of videos](#) which seek to portray what it is like to be a GP in a multispecialty community provider (a type of care model that could be facilitated by the ICP Contract), and which also highlight how GP participation in such models can benefit patients.

Integrated care models

- 12 There is a long-recognised need for health and care services to be better integrated to improve people’s care. In January 2019, the [NHS Long Term Plan](#) (LTP) committed:

‘The NHS will be more joined-up and coordinated in its care. Breaking down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected ‘episode’ of care’.
- 13 The LTP sets out the centrality of integrated care systems (ICSs) to achieving this goal. In ICSs, commissioners and providers of NHS services, in partnership with local authorities and others, voluntarily take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.
- 14 General practice is centrally important to delivering integration of services, and the LTP signalled the national development of primary care networks (PCNs) as a fundamental building block for ICSs, with more details set out in the [Five-year framework for GP Contract reform](#) published in January 2019. The LTP committed to new investment of at least £4.5 billion over the next five years in primary medical and community services to deliver stronger integration and out of hospital care. This will support, for example, expanded community multidisciplinary teams aligned with networks, and a new offer of urgent community response and recovery support.
- 15 One way of achieving collaboration between providers of services in an ICS is by putting in place an overlaying agreement (which can be known as an ‘alliance

agreement'), supplementing the individual contracts which each will hold with their commissioners. This collaborative 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 The ICP Contract is another way of helping to underpin some of the strong relationships needed within each 'place' to deliver integration. It responds to the demand from some commissioners and providers for a single contract through which general practice, wider NHS services, and in some cases some local authority-funded services, may be commissioned from a 'lead' provider organisation, responsible for delivering those services in an integrated fashion.
- 17 The ICP model is consistent with the emergence of PCNs, which make sense regardless of whether ICPs occur locally. PCNs are a natural development of the localities at the heart of whole population care models.

What is an ICP?

- 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 long-term health and care outcomes for the population are the priority, and the prevention which the contract seeks to incentivise is vital to achieving improvement in those outcomes. The ICP Contract therefore helps to facilitate whole population-based care models that aim to improve the physical, mental and social health and wellbeing of the local population.
- 19 ICPs are not new types of legal entity, but rather provider organisations (such as NHS foundation trusts) which have been awarded ICP Contracts. We expect ICP Contracts would be held by public statutory providers.
- 20 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.
- 21 In some cases, it may be difficult for commissioners to identify an existing organisation that could take on responsibility for a contract of this kind. If, for instance, a group of local GP practices and a provider of community, mental health and/or hospital services wished to come together to become an integrated care provider, they might wish to establish a new NHS organisation that exists solely for the purposes of providing integrated care. The existing legislative framework does not, however, lend itself to these circumstances. We have therefore proposed that the law should be clarified so that the Secretary of State can set up new NHS trusts to deliver integrated care across a given area. If this proposal is progressed and legislative changes are made, this 'integrated care trust' could hold the ICP Contract.
- 22 To allow for the contracting and provision of primary medical services (until now only possible under GMS, PMS or APMS) and other health services (which must be commissioned using the NHS Standard Contract) together, the ICP Contract is a variant of the NHS Standard Contract and a contract which is legally appropriate

for the commissioning of primary medical services. We have therefore worked with the Department of Health and Social Care to create new Directions applying to ICP Contracts. These are based on the current APMS Directions and provide for streamlined and simplified requirements in relation to primary medical services. The DHSC plans to publish Directions (which were the subject of a consultation during Autumn 2018) later this year.

- 23** Importantly, the ICP Contract must be a contract that both commissioners and providers would be willing to sign. With this in mind, we have worked closely with GP stakeholders and others to shape the contract. The ICP Contract balances the desire to be as clear and streamlined as possible with the need for a legally robust contract that will safeguard patient safety and service quality.

How could GPs participate in an ICP?

- 24** Before deciding to procure an ICP Contract, commissioners will need to engage with GPs, other providers and other stakeholders to develop the clinical model and different contractual models that might be implemented to deliver it. Different systems will only wish to consider moving to an ICP model where there is strong support in place across all providers, including GPs.
- 25** General practice is fundamental to integrated models of care, but GP participation in an ICP is voluntary. To support GPs to take a more central role in the health and care system, we have developed the ICP Contract to provide for two distinct means by which general practitioners can participate in an ICP model and therefore work more closely with other teams to join up pathways and deliver an improved service for patients:
- a.** One way is where practices simply agree to work in a consistent way with the ICP and describe, in a separate agreement, how all parties will collectively oversee and deliver services for the population. This is known as the ‘partially integrated’ option. Importantly this option doesn’t require any changes to GMS/PMS contracts. The crucial contribution of practices will instead be described via an ‘Integration Agreement’. A template GP Integration Agreement and further information can be found on the NHS England [website](#).
 - b.** The second option is where GPs wish to work more directly with or within the ICP (for example, a NHS trust or FT), normally by becoming employed in it and working alongside the other teams delivering wider primary and community services directly. This is known as the ‘fully integrated’ option. In this model the ICP would be responsible for directly providing primary medical services itself, with the consent of those GPs working in or with it. This decision needs therefore to be taken on a practice by practice basis. In order for the ICP to be responsible for delivering primary medical services, practices need to be released from their current obligations under GMS/PMS arrangements. Where practices decide they would like to do this, it is important that they have the option of returning to their GMS/PMS contracts in the future. In order to allow GP practices to choose this option temporarily, we have created a new right, known as ‘suspension’, which ensures any existing GMS/PMS contract continues to exist whilst the GPs are employed or

contracted to the ICP. GP practices would have a right to 'reactivate' their GMS/PMS contract at fixed points.

- 26 Each approach could deliver the outcomes envisaged for an integrated care model. Some areas may choose to focus on GP integration through the partially integrated model, whilst others will prefer to move towards fuller integration. What is important is that the chosen model works for the local system. Local areas will need to work through the trade-offs between:
 - a. the degree of formal integration they want to achieve
 - b. their appetite for change and the pace at which they are able to proceed.
- 27 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 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. In all organisational models we would expect GPs to play a leading role in shaping the clinical approach. 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.

ICP funding

- 28 The ICP Contract envisages commissioners paying for the entire bundle of in-scope services (excluding partially-integrated primary medical services, which would continue to be paid for via ongoing GMS/PMS contracts) as a package by way of an integrated budget, rather than on a service-by-service basis. The integrated budget is designed to incentivise providers to work together towards outcomes. The ICP Contract provides for a Whole Population Annual Payment (WPAP) integrated budget approach, paid in monthly instalments, which will represent the majority of the funding available to the ICP under the contract.
- 29 The commissioner would decide how much funding to set aside for an ICP. This could be up to all of its available funding as the ICP could conceivably be responsible for most of the care provided to patients.
- 30 The amount of money made available through the ICP Contract will not affect the funding of GMS/PMS contracts in any way. It will only be if GP practices choose to become fully integrated that their current contracts will be affected.
- 31 Where GP practices are fully integrated in an ICP, it is expected that funds flowing to the ICP would incorporate the practice's previous funding, in most cases mirroring arrangements from GMS/PMS contracts. This means for example that payments previously made to a GMS practice as a global sum would form part of the ICP's WPAP, and the ICP would earn activity-based payments in the same way as the practices would have previously, for example, payments relating to vaccines and immunisations.

- 32 Further details about funding arrangements for ICPs are provided in the Integrated Budgets Overview in the [ICP Contract Package](#).

What does this mean for me?

- 33 This chapter looks in detail at how the ICP organisation and contract could impact GPs' working lives. We have worked with GPs and representative bodies to understand their motivations and listened to their concerns. Given the complexity of the topic, we have broken the content down into subsections: my patients, my role, my practice and my contract.

My patients

- 34 The ICP model is designed to improve patients' experience of care across the local system, not just in one particular service. The ICP aims to both improve population health outcomes and to deliver care centred around the holistic needs of individuals.

Will continuity of care be protected?

- 35 One of the great strengths of the general practice model is the relationship between GPs and their patients. The ICP Contract enables the system to draw on other professionals and economies of scale to give GPs the time to deliver high-quality, personalised, primary care that is founded upon the relationships they have with their patients, their families and carers.
- 36 As part of an ICP model, GPs can ensure continuity of care across different pathways and services. ICPs are expected to adopt fully interoperable records, align the system to one set of outcomes and improve communications at the interface between services, meaning that patients should only have to tell their story once. GPs will be core members of the multidisciplinary team, bringing in-depth knowledge of the patient's circumstances. Care coordinators feed into the MDT providing dedicated support to patients and carers who have multiple interactions with different care settings. The effect is coordinated care, delivered by professionals who communicate regularly and collectively to agree the best way forward for the individual.

How will patient choice be maintained?

- 37 Patient choice is at the centre of many of the initiatives in the NHS Long Term Plan and is enshrined in legislation. The ICP Contract has been designed to make sure the commissioning of multiple services through a single contract does not restrict or in any way adversely affect the options people have about how and where they receive care. The ICP Contract not only requires the ICP to ensure the rights of choice people have under the NHS Constitution are respected, but also to offer further choice as to when, where and how people can receive the services they need wherever practicable.
- 38 Where all services, including core primary medical services, are being delivered through a fully integrated ICP, the contract ensures that the ICP offers patients a

choice of location from which to receive primary medical services and a preference for a named GP.

- 39 Where a GP practice is considering whether and how they may wish to participate in an ICP model, it will be important that they engage with their patients as part of their decision-making process.
- 40 If a GP practice decides to become fully integrated in an ICP, the patients on their list will be formally notified of this by the commissioner. This means that they would have an opportunity to register with an alternative GP practice, rather than becoming a patient of the ICP, if they prefer to do so. Patients would also be notified if a GP practice subsequently decides that they no longer wish to be fully integrated, so would have an opportunity to choose whether to maintain their registration with the ICP, return to the reactivated practice, or register elsewhere.

How will the ICP improve patient access?

- 41 For a long time, many practices have been struggling to meet demand. ICPs support the NHS England ambition to link extended access with the vision for general practice at scale, working as part of a wider set of integrated services.
- 42 ICPs will offer sufficient pre-bookable and same-day GP appointments, including online 'digital' GP consultations, to meet the needs of the population, including during evenings and at weekends. The ICP Contract already includes extended hours for primary medical services, and we will be considering how it may need to be updated to reflect the access review to be undertaken in 2019.
- 43 Enhanced primary care will bring a broader skill mix into the primary care team. GPs will be able to pull in expertise to meet patient needs without the delays and poor patient experience often associated with referring out to separate services.

How can the ICP help me to improve the health of my local population?

- 44 GPs working with an ICP will be able to support people to look after their own health. For example, an ICP may harness community assets and build in social prescribing so that GPs can refer to local voluntary sector services, for example befriending services, sports clubs, and community groups, to maintain the health and wellbeing of their local population.
- 45 ICPs deliver place-based models of care, meaning they support the whole local population, including people who are currently healthy. At one end of the spectrum of need ICPs could deliver health education to support people to stay healthy and promote wellbeing. At the other end of the spectrum they would identify high-risk patients and deliver proactive, personalised care to prevent avoidable episodes for people with the highest needs.
- 46 ICP leaders will need to understand the needs of their population, then analyse the quality, equity and efficiency of the care that is being provided, before identifying opportunities for improvement. In the partially integrated ICP model, we expect that GPs practices will agree via the Integration Agreement to participate in a stratification approach and how this will be applied at practice level.
- 47 ICP services will benefit from the ongoing investment in improving population health management techniques, helping systems to identify the greatest areas of unmet need. In addition, the new commitments on tackling health inequalities will lead to a greater awareness and ability to respond to and manage inequalities across different pathways such as cancer, maternity, and long-term conditions,

with ICPs and other providers able to benefit from the increased national focus and investment.

My role

- 48** Many GPs have told us their workload is unsustainable. The LTP recognises that general practice faces multiple challenges with insufficient staff and capacity to meet rising patient need and complexity. It makes a commitment to ease the pressure on GP practices, funding them to work together and extend the range of convenient local services, creating truly integrated teams of GPs, community health and social care staff.
- 49** GPs participating in an ICP model will be supported by a diverse team from across health and social care, with the flexibilities in terms of resources and time that a larger scale model can offer. Those who take a leadership role in the ICP will have significant influence over resource allocation, population health and service design.



Image: Ten High Impact Actions, General Practice Forward View

How will this improve my work life balance?

- 50** Through access to a broader team, new consultation methods, streamlined and efficient workflows and support for self-care, we expect ICPs to build on the 'Ten High Impact Actions' to release capacity previously described in the General Practice Forward View.
- 51** An ICP model will involve a broad multidisciplinary team providing primary care services, which might include Advanced Nurse Practitioners, physician associates, district nurses, pharmacists and paramedics, and community-facing specialists. This will mean patients can be directed to the most appropriate professional, reducing urgent workload for GPs and allowing GPs to spend more time doing what only they can do. Working with community-facing specialists, GPs will have greater access to timely clinical advice without unnecessary referrals, facilitating joint decision-making and making follow-ups easier.
- 52** A focus on prevention, self-care and social prescribing will support patients to manage their own health and wellbeing, which should reduce the number of unscheduled visits to GPs.

Will this increase my job satisfaction?

- 53** ICPs can provide GPs with more influence, whatever their preferred way of working, and the opportunity to develop their clinical and managerial interests.
- 54** ICPs may shift demand away from hospitals, moving parts of, or at times, the whole patient pathway into the primary care setting, with the accompanying resources. This offers new opportunities for GPs to develop clinical skills and deliver interventions that would traditionally be provided by hospital-based colleagues.
- 55** GPs will have a strong voice in both the partially and fully integrated models. Depending on the organisational form of the ICP, there are a range of ways in which the GP voice might be represented in an ICP, for example as members of the executive or non-executive board. Some organisational forms have more scope for individual GP representation at board level than others. In the partially integrated model the Integration Agreement can describe the approach to GP involvement in decision making.

Will this open up new career opportunities for me?

- 56** The ICP will provide flexibility for GPs to carve out a career that suits them. Some may choose to join the ICP as an employee, giving them time to focus on their clinical work and the possibility of flexible working patterns. With care pathways increasingly delivered in primary care settings and operational integration of services, there will be greater exposure to advice from consultants and training opportunities for GPs with Special Interests (GPwSIs). Some outpatient clinics, for example dermatology, could be delivered by GPwSIs. Similarly, integration with mental health and social care services will present opportunities for GPwSI roles in specialities such as dementia, learning disabilities, and safeguarding children and young people.
- 57** Many GPs choose to develop a portfolio career. ICPs can offer GPs the chance to take on leadership roles in a large, integrated organisation. GPs may choose to take on managerial roles within the ICP itself, or they may choose to use the improved flexibility to work outside of the ICP.
- 58** As ICPs can provide opportunities for GPs and other professionals to contribute to the strategic direction of the ICP, ICPs and practitioners need to be mindful of potential conflicts of interest that may arise and ensure to mitigate against them.

My practice

- 59** For the majority of early ICPs, in which we expect practices are most likely to choose to participate via an Integration Agreement, there may be no significant change to the way in which a practice is run. We are, however, keen to ensure that any transition to an ICP is as smooth as possible, retaining the best of the previous system but with new flexibilities and advantages for practices through integration with the ICP.

How will my practice be regulated?

- 60** The CQC is committed to working with and learning alongside new ICPs as they emerge. Within its existing legal powers, the CQC will be able to register an organisation holding an ICP Contract. This will enable the CQC to regulate the

ICP overall, as well as its constituent regulated services. Where a sub-contractor carries on an activity that is regulated by the CQC then they would need to register with the CQC.

- 61 Existing providers need to ensure that they have made any necessary changes to their registration and statement of purpose to reflect changes to the way they are organised or the care they are providing. CQC recommends that you talk to them early during the development of the care model to facilitate a smooth registration process. To discuss CQC's work on new models of care and the implications for your practice, please contact [this email](#).
- 62 As signalled in [CQC's strategy](#), inspections will be intelligence driven and when relevant they will include an assessment of 'well led' at provider level. Sampling of locations across the ICP will be dependent upon intelligence.
- 63 The nature of a GP practice's participation in an ICP will influence whether they need to be registered with CQC, separately from the ICP:
 - Partially integrated practices will need to continue to be separately registered in their own right, as they will continue to be directly responsible for providing regulated activities.
 - Where GP practices become part of a fully integrated ICP via a sub-contracting arrangement, they will also need to maintain a separate CQC registration.
 - Where GP practices become fully integrated and the GPs and staff join the ICP as employees, leading to the practice no longer holding an active contract for services, the practice would not need to be separately registered with CQC. However, the locations at which primary medical services are provided would need to be listed as conditions of the ICP's registration.
- 64 Where new providers apply to be registered or existing providers need to make changes to their registration, there is currently no separate charge for these applications. The annual fee that providers pay will be as set out in the CQC fees scheme. The CQC will closely monitor the costs of regulating new types of service provision and ensure that changes to its fees scheme reflect this.
- 65 When inspecting providers in transition, CQC will expect that providers are able to demonstrate how they meet the regulations and mitigate risks to quality associated with the changes that are taking place.

What will happen to my premises?

- 66 How GPs handle their practice premises when moving into or integrating with an ICP will depend on their personal circumstances (for example, do they own or lease their current estate), and whether they wish to fully or partially integrate.
- 67 In the context of a partially integrated ICP, no changes to ownership or formal leasing of estate will be required. The Integration Agreement will provide for a local estates strategy that would be, voluntarily agreed between the practices and ICP, in accordance with the broader estates strategy of the ICS/STP. This could set out how certain community services could be provided directly from primary care premises, or how community premises could be made available for a wider range of GP-led services.
- 68 In a fully integrated model we would expect that the use of existing estate across primary and community care would be managed and coordinated by the ICP in consultation with its partner organisations. GPs, in discussions prior to the commencement of the contract, and through leadership roles assumed in the ICP, will expect to influence these discussions. Through this process, GPs may find

that this provides them with options, depending on their personal situation and preferences. For example:

- a. Where a practice leases its premises there may be options to sub-let to the ICP. Local advice will be required to work this through, and the options available will depend on current ownership, terms of existing leases, and local negotiation between the ICP, GPs and the landlord.
 - b. For GPs who wish to sell their premises to the ICP there may be opportunities to do so. This would only occur where the ICP has the capital to buy the property and there is clear value for money for the ICP in doing so. GPs should also be mindful of how this sale could impact their ability to successfully reactivate their GMS/PMS contract if they wish to leave the ICP at a future date.
 - c. Where GPs own their estate they may prefer to keep ownership of their premises but lease them to the ICP.
- 69** In the event that a practice enters into a fully integrated ICP, estates funding will mirror current GMS/PMS arrangements. Funding for estates is generally provided as financial assistance in respect of rates, water, clinical waste and rent to GMS (and, where local agreement has been reached, for PMS) contractors under the Premises Costs Directions (PCDs). Premises payments would flow to the fully integrated ICP as the provider of primary medical services and GPs will agree with the ICP the terms on which these payments will be passed on, reflecting who is actually bearing the costs these payments are intended to cover. GPs should seek legal advice on this as part of supporting a broader agreement with the ICP in advance of suspending their contract with the commissioner.
- 70** The General Practice Premises Policy Review heard that complex reimbursement arrangements can sometimes be a barrier to mixed use of space across services within a local area. One of the policy conclusions put forward in the review's recently published report recommends piloting and evaluating alternative premises reimbursement arrangements to support integrated working; both at network level, to give networks greater autonomy to manage and minimise their costs relating to estate across their premises, and in multi-use new build premises where the NHS would directly bear the cost of premises, to remove the need for bureaucratic premises reimbursement systems and to promote integration of service delivery and optimal use of space.

What are the implications for IT and data?

- 71** ICPs must facilitate the digital transformation of the NHS outlined in the NHS Long Term Plan. They will harness technology to improve patient experience and streamline communications and administration for clinicians. Ultimately there should be a single patient record for each patient, available to and contributed to by all clinicians. All staff would have access to the appropriate information about the patients in their care, in real time (or as close to real time as is necessary) and where appropriate this would include the ability to update the records and share this with everyone involved in their care, including patients and carers.
- 72** Given the desire for improved integration, participating practices will need to agree with the ICP how they create the appropriate integration of IT systems. In the partially integrated model, the Integration Agreement will set out requirements for practices which will likely include data quality requirements, agreement from practices to make their booking system accessible to the ICP under agreed

protocols, agreements to supply business intelligence and a commitment to a data sharing agreement. In both the partially and fully integrated models, ultimately, the ambition should be for all systems to be linked and compatible and to have the ability to receive information from others, removing the need for multiple logins and reduce time wasted on manual communication.

How will this affect my staff?

- 73** Your workforce should find that there are opportunities for personal development and new careers for them in a larger, multidisciplinary organisation. For example, nursing staff might take on more clinical responsibilities or train to be nurse prescribers; administrators might train to deliver call and recall services.
- 74** Practice staff will be affected in different ways depending on the contractual model, and to some extent the service scope, of the ICP. If your practice continues to provide primary medical services under GMS/PMS, no changes to the employment arrangements for its staff are likely to be required. The Integration Agreement between practices and the ICP would cover how integrated teams will work together, how practice staff will work as part of a wider team to deliver the care model, and how a broader range of specialist skills will be made available to patients.
- 75** Alternatively, if your practice becomes part of the fully integrated model, your staff will almost certainly see more significant changes. The ICP would take responsibility for providing all or some of the services your practice currently provides, and your staff could well transfer to it under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE). If your practice becomes a sub-contractor to the ICP, no changes to existing staff employment are likely to be required. Under TUPE any employees that are transferred to a new employer will maintain their continuity of service and, in the majority of cases, their job role and terms and conditions of employment will remain the same.
- 76** In all cases, GP practices will have individual responsibility for engaging and consulting with their own staff regarding any possible transfer under the TUPE Regulations. There may also be an obligation to provide information about any transferring staff to the receiving organisation, which could be either the ICP or another practice.
- 77** Where GP practices are considering participating in a fully integrated ICP it is important to consider how any transfer of workforce could impact on the ability to successfully reactivate your GMS/PMS contract, should you choose to do so in the future. It may be possible for staff to transfer back to the practice, but this would of course need to be carefully worked through, both with staff (who may or may not chose to transfer back) and the ICP itself. GP practices and partners should seek legal advice if they are considering changing the way their staff are employed or engaged, or if they are considering changing their roles or terms and conditions as a result of their participation in an ICP.

Will my indemnity cover change?

- 78** The new Clinical Negligence Scheme for General Practice (CNSGP) will provide clinical negligence indemnity for everyone delivering primary medical services. This includes contract-holders, GPs, GP practice employees, locums, self-employed workers and trainees. Sub-contractors and their staff are similarly

covered. All primary medical services are automatically covered and staff do not need to enrol as individuals.

- 79** In partially integrated ICPs, where the practice remains a separate entity to the ICP, practice partners and staff will be covered for all NHS services under CNSGP. In fully integrated ICPs, we expect the package of clinical services to be covered by CNST and/or CNSGP as appropriate. Staff will need to retain membership of an MDO for non-NHS or private work, inquests, regulatory and disciplinary proceedings, employment and contractual disputes, and non-clinical liabilities such as those relating to defamation.

How will this help me to streamline back office services?

- 80** GPs working in federations, super practices and PCNs have already demonstrated how economies of scale can streamline back office services and help manage resource pressures. Working together at scale, practices can share administration and management staff, consolidate reception services and benefit from purchasing discounts when buying in bulk.
- 81** ICPs can go further, offering opportunities to invest in training back office and patient-facing services such as call handling, or to create a single business function to manage human resources, IT, finance, contracts, public engagement etc. across the ICP. The ICP will need a back office function capable of supporting a large-scale, integrated organisation – presenting opportunities to upskill staff and leading to new career opportunities.

My contract

Is it compulsory for practices to integrate with an ICP?

- 82 Participation in an ICP is entirely voluntary. GP practices can choose whether, and how, they wish to participate in an ICP model.
- 83 An ICP Contract, whether used by a commissioner to commission a partially or fully integrated ICP, is not a contract with GP practices. GP participation with the ICP would be underpinned either through an Integration Agreement in addition to the practice's existing GMS/PMS/APMS Contract in a partially integrated model, or through moving directly to work as employees of or sub-contractors in a fully integrated ICP.
- 84 The intention is to make ICPs as attractive to GPs as possible, by offering them more control and influence over their local health system. GPs will only sign up to arrangements that offer them terms and conditions that are right for them.

What happens to my GMS/PMS contract in an ICP?

- 85 In many ICPs, we are not expecting there to be any change to current GMS/PMS contracts, because practices are likely to predominantly choose a partially integrated option where they maintain responsibility for delivery of essential services. In this option, the commissioner would procure an ICP Contract for a package of services excluding essential primary medical services. GMS/PMS contract holders would sign an Integration Agreement with the ICP, to underpin the integration of primary medical services with other services delivered by the ICP. NHS England has published a template Integration Agreement and accompanying Frequently Asked Questions as part of the [ICP Contract Package](#).
- 86 Local commissioners will decide what the scope of the ICP Contract will be, based on their engagement with local people, GPs, other providers and stakeholders. We recognise that some GPs are concerned about the potential to lose non-core income due to additional services which they currently provide over and above essential primary medical services being commissioned from an ICP instead. It is important to recognise that any ICP proposal needs the support of practices to proceed, so no decision can be taken without consultation and agreement locally. It is likely in this situation that local partners may see some advantage in coordinating and managing the delivery of non-core services within the ICP itself to improve the delivery of care to patients, but in this case GPs will often still wish to play a role in delivery, including for example as subcontractors to ICP.
- 87 The second option is the 'fully integrated' ICP. In this option the scope of services commissioned under the ICP Contract would include core primary medical services. In order to facilitate this, practices wishing to fully integrate would need to suspend their GMS or PMS contracts, putting to one side their right and obligation to provide the services under those contracts for the duration of the ICP Contract or for as long as those practices wish to be fully integrated with the ICP (this also includes rights and requirements relating to the Network Contract Direct Enhanced Service¹). Under a suspended contract, practices would have the right

¹ Further details about the Network Contract Direct Enhanced Service are available in the Network Contract Direct Enhanced Service Specification 2019/20 on the NHS England website:

to reactivate their contracts either at the expiry or termination of the ICP Contract, or at regular two-year windows during its lifetime. The CCG would not be able to award a fully integrated contract until partners have agreed terms on which they and their employees will deliver primary medical services through the ICP, either within the ICP as an employee or as a sub-contractor to it.

- 88** We have worked with the Department of Health and Social Care to create the suspension and reactivation option for practices wishing to fully integrate with ICPs by amending the relevant legislation. As GP practices move into the ICP, either as employees or sub-contractors, their patients would automatically follow them (subject to their legal right to choose their primary medical services provider), becoming part of the ICP's registered list. The integrated budget will reflect this, channelling core primary medical services funding via the ICP.

Can GPs in the same locality choose different contractual models?

- 89** Yes. It is possible, and perhaps likely, that GPs in the same locality choose different options for participating in an ICP, resulting in a 'mixed economy'. This could be the case where some practices have chosen to suspend GMS/PMS whilst others have chosen to participate via an Integration Agreement, or not at all. It is important that individual GP practices have a choice about whether and how they participate in an ICP, and do not feel pushed into a particular model because it is preferred by the majority.
- 90** If a GP wished to move from fully integrated involvement in an ICP to partially integrated, they would need to reactivate their GMS /PMS and then sign an Integration Agreement with the ICP. Should they wish to move from a partially integrated to a fully integrated model they will need to negotiate the terms and conditions of such a move with the ICP Contract holder organisation.

If I change my mind, how would I leave the fully integrated ICP?

- 91** As explained above, suspending a GMS/PMS contract is not required if a practice enters into an Integration Agreement with the ICP; the suspension option only applies where GP practices have decided that they would benefit from working within or as sub-contractors to, the fully integrated ICP organisation to deliver primary medical services. The 'suspension' option we have developed for practices is designed to offer GP practices the opportunity to integrate fully with the ICP without sacrificing the long-term security of their GMS/PMS contract. In summary, it allows practices to suspend their GMS/PMS contract in order to participate in an ICP, with the option of reactivating their contract at two-year intervals throughout the life of the ICP Contract, or on expiry or termination of the ICP Contract.

How would reactivation work in practice?

- 92** As outlined above, GP practices can reactivate their GMS/PMS at two-year intervals or at the termination or expiry of the ICP Contract. This is subject to the condition that the commissioner is satisfied that during the period of suspension, the practice did not act in a manner that would have given rise to the commissioner's right to terminate the GMS/PMS contract, as continues to apply to any provider of primary medical services. The reason for the two-year time frame is to balance the need to provide regular windows for practices to leave the ICP, whilst providing some stability for the ICP so that its registered list is not constantly fluctuating, and the means by which services for affected patients are integrated are frequently having to change, as practices join or leave. The decision to reactivate can be made using the agreed decision-making approach of the practice.
- 93** Upon reactivation, GP practices would return to the GMS or PMS contract (on the terms in effect at the time of reactivation, subject to any variation of those terms which may be agreed between the contractor and the commissioner). For PMS practices choosing to reactivate, the right to convert to GMS on the same terms as other PMS contractors will remain in place.
- 94** In advance of the contract being reactivated, the commissioner would write to all patients who are resident within the practice's former boundary and on the ICP's patient list to advise them of the GP practice's decision to reactivate, and their right to choose to stay registered with the ICP, register with the re-activated practice or register elsewhere. If the GP practice reactivates its contract at year two, the default position would be that patients previously on their registered list follow their GPs to be re-registered with the practice. If the GP practice chooses to reactivate their GMS/PMS contract at a later point, then patients would remain registered with the ICP unless they request to register with the reactivated the GP practice, or register elsewhere. This reflects the need to balance stability and choice to patients, and reflects the ongoing changes to a practice and ICP's resident population over time.
- 95** As mentioned above, there are limits as to what can be nationally guaranteed on reactivation, and a number of important practicalities would need to be worked through locally. For example:
- a.** GP practices returning to GMS/PMS would need to consult with the ICP and any affected staff about which staff, if any, will transfer to the reactivating practice. In any event, the rights of affected staff under TUPE will take precedence.
 - b.** What happens to estates will depend on the arrangements agreed when the practice entered the ICP. GP practices should, therefore, consider the possibility that they will wish to reactivate and the points during the term of the ICP Contract at which they can reactivate, when coming to an agreement with the ICP over estates.
- 96** Suspension and reactivation therefore require careful consideration, and the decision to reactivate should be taken after engagement with patients, staff and other stakeholders, allowing a practice to make an informed decision and to ensure that it plans accordingly for its re-establishment under a new contract.

Will I have to make a financial commitment?

- 97** ICPs may require capital for three areas:
- a.** Start-up costs: to develop the infrastructure to deliver the care model
 - b.** Working capital: to pay salaries etc. prior to receipt of revenue
 - c.** Contingency reserves or guarantees: to ensure the ICP has a reasonable level of resilience to the down-side risk of holding the Contract.
- 98** Depending on their organisational form, ICPs will access capital from different sources. If GPs are looking to participate as partners or owners in a new legal entity, then that may require a financial commitment, however we do not expect that this will normally be the case. The ICP can offer the opportunity for GPs to benefit from surplus created by realised efficiencies or new commercial opportunities. However, we would always recommend that GPs seek advice and where necessary limit their liability before making any personal investments.

What happens when the Contract ends?

- 99** NHS England expects the term of an ICP Contract to be of up to ten years. A local contract may provide for an extension. Towards the end of the contract commissioners will need to decide how they wish to re-commission the services within scope of the Contract. If they decide to continue with the ICP model they would, under current law, be obliged to run a procurement exercise before awarding a new contract.
- 100** GPs who have suspended GMS/PMS contracts will have a choice at this point: if they had suspended their primary medical services contracts, they could choose to reactivate these and return to independent contractor status, unless they wanted to be involved in a future ICP under the new contract. As mentioned above, on termination of the ICP Contract, the default position would be that patients will automatically transfer to the reactivated practice if they live in its boundary, unless they choose to register with another GP. The need and opportunities for the involvement of practices in future ICP arrangements would then be expected to mirror that for the first contract, and participation would remain voluntary.

Will my pension be affected?

- 101** GPs should not lose access to the NHS Pension Scheme because of a move to an ICP. Access to the NHS Pension is dependent on the type of contract held by the GP's partnership/employer, and their status within that organisation. Where a GP is a partner in a practice, their primary care income is eligible for the NHS Pension Scheme assuming it is received under a GMS, PMS or APMS Contract. Where they are employed they are able to access the NHS Pension Scheme through their employer, which would likely be a practice (i.e. they are a salaried GP), NHS Body, or Independent Provider (assuming IP status in the NHS Pension Scheme had been applied for under the 2014 Regulations).
- 102** In a partially integrated ICP this situation does not change, as current primary care contracting arrangements do not change. Under a fully integrated ICP the GP will move out of the practice model into a much larger organisation, where their routes to access will be either as a sub-contractor or employee. We have worked through two broad changes to the NHS Pension Scheme Regulations, to ensure that

continuing access to the NHS Pension Scheme will be possible in both of these situations. These are:

- a. Recognising the ICP Contract as an eligible contract in order to allow access to the NHS Pension Scheme under NHS Pension Scheme Regulations, so that, assuming the organisation obtains employing authority status through one of the currently available routes outlined above (most obviously the Independent Provider route), the GP will accrue pensionable service on the same terms as all other employees (i.e. as “officers”).
- b. There is agreement, in principle, to allow access to the NHS Pension Scheme as a sub-contractor, on the basis that an NHS ICP sub-contract will be a qualifying contract. The intention is that GP practitioners working in practices which move to become sole sub-contractors to an ICP (for example), would therefore be able to access the NHS Pension Scheme for their sub-contracting income as before, on the basis that earnings from an ICP standard sub-contract would be eligible to be pensioned. Practice staff would also retain access to the NHS Pension Scheme where the practice is granted IP status under the relevant regulations.

103 Collectively these changes allow GPs who become employed in ICPs access to the NHS Pension Scheme, because the employing organisation will hold an ICP Contract, and therefore will be able to access the NHS Pension Scheme as above, no matter whether the employer is an NHS or non-NHS organisation. Where a GP decides to become an owner of a larger (non-NHS) company or partnership, they should ensure they have an employment position within the ICP to continue to access the NHS Pension Scheme (although as an officer). This will ensure consistency with the current access rules which do not allow the shareholders or partners of independent sector providers of NHS services to access the NHS Pension Scheme directly.

104 Where a GP is sub-contracted to an ICP, the changes stated above will allow the partner(s) to pension primary care income under the practitioner rules, as they do currently.

How will my personal income and benefits be affected?

105 In a partially integrated ICP, existing contracts for core primary medical services will remain operational – and therefore the associated income will not be affected.

106 GP practices will need to ensure that they are satisfied with the role and package of benefits being offered to them within a fully integrated ICP before participating. To provide comfort for GPs wishing to move to the fully integrated ICP as an employee, the draft Integrated Services Provider Contract Directions set out a legal requirement that ICPs offer salaried GPs terms and conditions that are at least as favourable as those set out in the BMA model contract for salaried GPs (as is currently required of GMS or PMS practices). GPs can, of course, negotiate personal salaries and benefits above the BMA’s minimum terms and conditions to reflect the roles and responsibilities they choose to take on within the ICP and their level of seniority.

Conclusion

- 107** GPs are fundamental to the delivery of integrated care, whether this is provided by an ICP or through a collaborative arrangement between multiple different organisations in a system. The decision to move to an ICP can only be taken where local proposals command the support of local general practice, and this document is intended to help GPs in considering whether and if so, how they might choose to participate in or work with an ICP.
- 108** We have worked to create a range of participation options for GPs who wish to join an ICP, allowing them to do so in a way that best suits the preferences of individual practices and partners. In any type of integration however, the larger scale and improved services which an ICP will be expected to deliver should offer benefits and opportunities for GPs. We expect these to include: opportunities for joined up working and taking new leadership roles over multi-disciplinary teams; the potential for economies of scale to release time and pressure in general practice, improving job satisfaction; and expanded, more flexible career opportunities which support recruitment and retention.
- 109** We hope this document will stimulate interest in the ICP model, and we encourage interested parties to use it to support local discussions. If you would like to send comments or contact us, please email nhs.cb.contractshelp@nhs.net.