ICP Contract: Questions and Answers

NHS England and NHS Improvement

ICP Contract: Questions and Answers

Integrated Care Provider Contract Package

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Prepared by: Primary Care Strategy and NHS Contracts Group

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Contents

1. What is an Integrated Care Provider?

Across England, areas are working to integrate services through greater collaboration. The NHS Long Term Plan set out that every area is expected to become an 'integrated care system' (ICS) by 2021. In ICSs commissioners and providers discuss how they can work together to oversee and manage improvements in services and health outcomes for local people within their collective budget. ICSs vary in size, but in general, an ICS will operate across a larger population than that covered by any individual provider.

The 'place' tier is at the heart of an ICS. It describes a geographic area within which different teams take shared decisions about resources, agreement of priorities and redesign of services. In practice, commissioners will often make contracting decisions at the 'place' tier. In some systems there may be multiple 'places', recognising for example common travel routes for patients, or the location of existing services.

An Integrated Care Provider (ICP) is one of the available options for systems to enable joined up decision making and integration of services in a 'place'. It 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)[1] of those services. An ICP, like many other lead providers, may sub-contract with other providers to deliver particular services. Instead of there being many contracts between local commissioners and providers, all or most health services for local people are covered by a single contract between the commissioners and the ICP.

An ICP is not a new type of legal entity, but simply the name for a provider organisation awarded an ICP Contract. Under current arrangements, a number of different types of organisation can hold NHS contracts and this does not change under the ICP Contract. These organisations include, for example, NHS trusts and foundation trusts and GP-led organisations such as an incorporated federation of GP practices.

Neither NHS England nor any other person (such as the Secretary of State for Health and Social Care) would 'designate' an organisation as an ICP. An organisation would become known as an 'ICP' only if and when it is awarded an ICP Contract, simply by virtue of holding that contract.

[1] Commissioners are bodies with statutory duties to arrange for the provision of health services. In broad terms, commissioning includes the planning, purchasing and monitoring of health services. In the context of health and social care services, local clinical commissioning groups (CCGs) are responsible for commissioning healthcare services for the people they serve; local authorities may commission (or directly provide) public health and social care services.

2. Why have we developed a new contract for ICPs?

The ICP Contract is intended to promote an environment at the 'place' tier (see above), in which different teams and services can come together in a coordinated way, incentivising organisations to focus on delivering better patient care and improving the health of the population as a whole. The contract is designed to allow this to be achieved in a transparent way, ensuring consistency with all national NHS standards and requirements, whilst establishing clear accountability through a lead provider. The long-term health and care outcomes for the population are the priority, and the prevention which the contract seeks to incentivise is vital to achieving improvement in those outcomes.

At present, health and care services are bought from and delivered by a range of provider organisations (including GP practices, NHS trusts and foundation trusts, local authorities, voluntary sector and private sector providers), under different contracts on different terms and with different funding and incentive arrangements. Those terms and financial arrangements do not always encourage providers to work together to provide joined-up care for local people, and no one provider has accountability for the health and care of any individual person.

In many parts of the country, commissioners and providers are working to try to overcome this, by putting in place overlaying agreements (sometimes known as 'alliance agreements') which formalise their commitment to work together to integrate the various different services, and together deliver them on a more coherent basis which better meets the needs of local people.

Some local commissioners want to go further: to commission packages of services through a single contract to build in integration and ensure that contracts, funding and organisational structures all help rather than hinder staff to do the right thing and to define more clearly who has overall responsibility for co-ordinating care.

We have therefore developed a prototype contract – a variant of the generic 'NHS Standard Contract' which is already used to commission a broad range of NHS services – that is specifically designed to enable integration through a single contract that could be used to commission both primary medical services and other health and care services. It sets out:

- a consistent objective to deliver integrated, population-based care
- consistency in terms and conditions, removing the risk of conflicting priorities or requirements getting in the way of clinicians doing the right thing for patients
- a population-based payment approach, allowing flexible redeployment of resources to best meet needs and encourages a stronger focus on overall health, rather than simply paying for tightly defined activities
- aligned incentives across all teams and services.

NHS England/Improvement is committed to ensuring a controlled and incremental approach to the adoption of the ICP Contract.

3. What changes have been made following the consultation?

We consulted on proposed contracting arrangements from August-October 2018. Around 3,800 written responses and feedback from stakeholder events across the country were received, which we have used to further develop the ICP Contract and accompanying guidance.

Key changes that we have made following the consultation include:

- further strengthening the provisions in the contract about public accountability and transparency (see question 10 below: 'Will the holder of an ICP Contract be accountable to the public' for further details)
- making available a template integration agreement for local authorities and associated frequently asked questions, and updating the template integration agreement for GP participation
- updating other guidance as appropriate, including guidance documents about GP participation in an ICP and the integrated budget approach.

The ICP Contract has also been updated to reflect changes to the 2019/20 NHS Standard Contract.

Further details about the consultation and response are available here.

4. When will the ICP Contract be used?

The ICP Contract is being made available from 2019 in a controlled and incremental way, conditional on successful completion of NHS England and NHS Improvement assurance through the Integrated Support and Assurance Process (ISAP), and initially focusing on those commissioners which have already taken steps towards using an ICP Contract prior to our consultation.[2] This incremental approach is in line with the recommendation of the House of Commons Health and Social Care Committee.[3]

[2] ISAP provides an approach by NHS England/NHS Improvement to supporting and assuring the procurement and transactions related to complex contracts. Further details can be found in the ISAP documents at: https://www.england.nhs.uk/publication/ integrated-support-and-assurance-process (Information accessed 16 July 2018)
[3] The House of Commons Health and Social Care Committee's publication Integrated care: organisations, partnerships and systems inquiry Seventh Report of Session 2017-19 [p41] can be found on the House of Common's website: https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/inquiry4/ (Information accessed 25 July 2018)

We will ensure the use of the ICP Contract is controlled by making it available only by specific exception to the general mandate to use the generic NHS Standard Contract to commission non-primary care healthcare services. The ICP Contract will continue to develop through a process of co-production with early adopter commissioners and other stakeholders, and further iterations will be published when appropriate. We will also continue to provide guidance to support commissioners and providers that wish to use it.

Commissioners in Dudley have started a procurement with a view to awarding a contract for integrated services, and may ultimately use the ICP Contract.

5. How would the ICP Contract protect quality and patient safety?

Although the ICP Contract aims to support a new approach to service delivery, the key regulatory and policy requirements which underpin and safeguard the delivery of NHS services remain the same. Any provider of NHS services must comply with the registration and regulatory guidance and standards of the Care Quality Commission (including the fundamental standards of care), NICE, NHS Improvement and other regulatory and supervisory bodies, and must meet national standards on operational and other matters, and in respect of quality and safety, including those set out in the NHS Constitution. Any provider which holds an ICP Contract (and indeed any sub-contractors to that provider) will be subject to those same requirements.

6. Who could hold the ICP Contract?

As is the case for all NHS contracts, commissioners looking to award an ICP Contract must select the most suitable provider to hold the contract in accordance with their duties under public procurement rules.

Legally, a commissioner cannot unfairly discriminate between bidders. Bidders need to be able to demonstrate that they have the capacity and capability to deliver successfully on the requirements set out in the contract, which will include being accountable for the broad range of services which may be included in an ICP model.

In addition, through the ISAP bidders will need to demonstrate to commissioners and to NHS England and NHS Improvement during the procurement that they are capable of holding, and delivering, the proposed local ICP Contract and the wide range of health and care services it covers.

The experience of CCGs who have been exploring the possibility of an ICP Contract for their area supports the view that a statutory provider is likely

to be identified as the most capable organisation to hold such a contract. Statutory bodies have been selected as preferred bidders in the ongoing procurement in Dudley, the area where the first ICP Contract may be awarded.

7. Why does the current ICP Contract focus on statutory providers?

The House of Commons Health and Social Care Committee (HSCC) has recommended that "the law should rule out the option of non-statutory providers holding an Integrated Care Provider Contract".[4]

In recognition of this recommendation, and the current expectation that the ICP Contract is most likely to be held by statutory bodies, we have published a version of the ICP Contract now which is suitable for award to statutory bodies only.

If, within the current legislative framework, pre-procurement market engagement by commissioners indicated that a non-statutory organisation was interested in bidding for an ICP Contract, further conversations would be necessary.

A response to the HSCC's report will be published in due course.

8. Why do commissioners have to run a procurement process before awarding the ICP Contract?

The Public Contracts Regulations (PCR 2015) require that contracts for health and/or care services with a lifetime cost over the current £615,278 threshold generally must be advertised to the market. This does not necessarily mean that there will always be a competitive procurement involving multiple bidders before a contract is awarded; in some local areas, the response to the advertisement may result in the commissioners engaging in dialogue with a single bidder. However, commissioners are required to act fairly and transparently in all cases, and treat all potential providers of the relevant services equally.

[4] The House of Commons Health and Social Care Committee, 'NHS Long-Term Plan: legislative proposals Fifteenth Report of Session 2017–19' [p4] can be found on the Government website: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/2000/2000.pdf (Information accessed 11 July 2019)

9. Is this privatisation of NHS services?

No. The ICP Contract is not intended to, and does not, promote or encourage privatisation of NHS services or outsourcing of NHS services to private sector organisations.

We expect ICP Contracts would be held by public statutory providers. No CCG has yet awarded an ICP Contract, but statutory bodies have been selected as preferred bidders in the ongoing procurement in Dudley, the area where the first ICP Contract may be awarded.

10. Will the ICP Contract mean people may have to pay for NHS services?

No. ICPs must by law continue to provide NHS services free at the point of use,[5] just as providers of NHS services do now.

This is the case regardless of the type of organisation that holds the contract, and whether or not it is responsible for social care services alongside NHS services.

11. Will the holder of an ICP Contract be accountable to the public?

ICPs would be accountable to the public in the same way as other providers of NHS care. ICPs are not new types of legal entity – an ICP would simply be a provider organisation which is awarded an ICP Contract, and will be subject to the same legal requirements and obligations as any other provider organisations of that type. For example, if the ICP was an NHS foundation trust, it would be under the same duties as other foundation trusts.

The ICP Contract requires the ICP (whatever type of organisation it is) to involve and engage the public when it is considering developing and redesigning services, just as the NHS Standard Contract does. ICPs would be subject to NHS England guidance on patient involvement, and to the NHS Constitution. We have also included in the ICP Contract new standards more explicitly requiring ICPs to act in an open and accountable way, in response to consultation feedback. These include:

- requirements to hold board meetings in public

[5] Subject to the statutorily prescribed exceptions, for example in relation to NHS charges for overseas visitors under the NHS (Charges to Overseas Visitors) Regulations 2015.

- additional transparency standards requiring performance and financial information to be published and made available directly to patients and the public
- more explicit requirements, in response to specific suggestions in the consultation, for the ICP to take on board recommendations made by Local Healthwatch.

Commissioners of ICPs must continue to meet their statutory duties to the public, which would not be affected by the award of any ICP Contract.

12. Why is it envisaged that the ICP Contract could have a multi year duration?

The duration of any ICP Contract, as for local arrangements under the generic NHS Standard Contract, is not determined nationally, but is for local commissioners to decide, based on the model that they think would work best for their population. Where commissioners use the ICP Contract, we anticipate that they may agree a contract term of up to 10 years (as could in principle occur with existing contracts).

An important idea behind the ICP Contract is that by giving one organisation responsibility for providing health and care services for the whole local population, it will be able to shape services around what really works best. A longer-term contract offers the stability needed to incentivise the provider to improve longer-term outcomes by investing in services to manage and improve treatment and prevent deteriorations in health, rather than being focused solely on meeting short-term targets. It will inevitably take some time for the impact of any new care model to emerge and for the new provider to be able to show improvements in population health outcomes.

13. What would this mean for GPs; will participation be voluntary?

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 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.

In order to achieve this, different options have been created for GPs to work in partnership with ICPs, however no GP will be required to select one of these options; participation is voluntary. Locally, there should be broad engagement, including with GPs, on the appropriate model for integrated care, which should inform a decision to award an ICP Contract. GP practices holding General Medical Services (GMS) or Personal Medical Services (PMS) contracts would always retain the option to continue to deliver services under these arrangements. Practices which continue to operate under GMS or PMS contracts may enter into contractual arrangements to integrate their services with those provided by the ICP.

14. Why has NHS England created different participation options for GPs?

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.

In the 'partially integrated' ICP model, the commissioner would award an ICP Contract for a package of services excluding core general practice. The contract requires the ICP to integrate its services with those services delivered by local GPs. Practices keep their active GMS / PMS contracts and enter into an agreement with the ICP (the 'Integration Agreement'), setting out how they and the ICP will work closely together.

In the 'fully integrated' ICP model, the commissioner would award an ICP Contract for a package of services including core general practice. This would happen when GP practices choose to suspend their GMS/PMS contracts, allowing them either to work for the ICP directly as a salaried GP, or to become a subcontractor to the ICP. This option has been developed to give GPs more opportunity to join up care pathways and offer a more coordinated service to patients. Where GPs decide to become salaried, the ICP Contract requires that they are employed on terms and conditions no less favourable than those in the BMA model terms and conditions for salaried GPs.

15. How will ICPs relate to primary care networks?

General practice is centrally important to delivering integration of services, and the NHS Long Term Plan signalled the national development of primary care networks (PCNs) as a fundamental building block for integrated care systems. More details were set out in the Five-year framework for GP contract reform published in January 2019.

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. Where practices are partially integrated with an ICP and retain their GMS or PMS contract, an ICP will be in a position to work closely with the networks in which those practices are members, in the same way as community providers across the country. Where GP practices decide to participate as fully integrated practices, the ICP will be responsible for delivering some core primary medical services, and so may be itself be a core member of a PCN.

16. Will patient choice be maintained under the ICP Contract?

Yes. The ICP Contract has been designed to make sure that the commissioning of multiple services through a single contract does not restrict the choices people have about how and where they receive care. The ICP Contract not only requires the ICP to ensure that the rights to choice people have under the NHS Constitution are respected, but also to offer further choices as to when, where and how people can receive the services they need wherever practicable.

17. Will ICPs serve everyone in their areas?

Yes, with a few exceptions.

As far as healthcare services are concerned, the area served by an ICP will be defined by commissioners, usually by reference to the practice areas of the GP practices integrated with it. For any public health services and adult social care services, the area served by the ICP is likely to be the area of the relevant local authority.

Where the ICP is commissioned to provide core GP services, all permanent and temporary residents of its area will have the right to register with it. The ICP may also accept people onto its list of registered patients people who are not permanently or temporarily resident in that area. The ICP will then be required to provide those core GP services for everyone who has registered with it.

The ICP must provide all other healthcare services specified by its commissioners for everyone registered as a patient with the ICP or with one of the practices integrated with it, and for everyone permanently or temporarily resident in its area and not registered with a GP practice elsewhere, as required to meet their individual needs.

18. How do social care and public health fit into the ICP Contract?

The importance of integration between health and social care services is widely recognised. The potential benefits of the integrated care model will be greater if social care and public health can be commissioned under an ICP Contract alongside NHS services.

Local authorities (LAs) have legal responsibility to arrange or provide certain public health and all social care services. We have worked with a number of LAs in areas in which an ICP is being considered, and with the Local Government Association (LGA), to consider how we can make sure the draft ICP Contract is fit-for-purpose for commissioning public health and/or social care services alongside NHS services. As part of this, we have considered the different statutory duties and powers of LAs and the potential impact on providers of, particularly, social care services. The current ICP Contract reflects feedback we have received from LAs and the LGA to date. We will continue to engage closely with local authority representatives to ensure we both learn from experiences elsewhere where health and social care integration has been successful, and in developing the ICP Contract further in due course to reflect new learning that arises out of its early use and to facilitate integration as far as current legislation allows.

Closer integration of NHS and LA services can be achieved through means other than a single ICP contract covering both sets of services. For example, an ICP commissioned to provide healthcare services only may be required by the contract to work closely with the LA and other providers of public health and/or social care services, and may enter into integration agreements with them to set out how they will work together.

19. What does the ICP Contract mean for the voluntary sector?

The voluntary sector plays a key role in delivering a population-based model of care, focused on the needs and wishes of individuals, which the ICP Contract is designed to support. The vanguards in the new care models programme have worked closely with local voluntary organisations to shape local services that support both health and wellbeing for local people.

Voluntary sector organisations bring important and unique expertise, and can enhance the opportunities for patient choice and personalisation. We anticipate that commissioners will require bidders for any ICP Contract to demonstrate how they will involve and work closely with local voluntary sector organisations to deliver choice and person-centred care.

20. Does the ICP model blur the so-called 'commissioner-provider' split?

The ICP model does not contravene a CCG's statutory duties to 'arrange for the provision of' health care services. Providers of NHS services already make decisions about how their resources are spent and how care is delivered. For example, where a NHS foundation trust holds a contract to deliver acute and community services, or for GPs running a practice.

The ICP Contract clearly prohibits the ICP from doing anything which would constitute an unlawful delegation of a CCG's statutory powers, or place the CCG in breach of a statutory duty.

However, the award of an ICP Contract – which places responsibility for all or most health services in an area with one provider – may mean the balance of activities carried out by the commissioner and provider could change. For example, the ICP may carry out population analytics to understand future health needs, something previously done more by commissioners and commissioning support organisations. The High Court has confirmed that this is lawful in principle.

21. Will the introduction of ICPs mean redesign of NHS services?

Given the ICP's focus on population health management, prevention and improvement of health and care outcomes, it is desirable that within the parameters of its contract, an ICP would undertake some improvements to and redesign of the provision of services to best meet these objectives.

However, the ICP would be subject to the same rules and requirements as any other provider of NHS services when considering service change. Changes to service provision would need to be carefully considered, and may be a matter on which both commissioners and the ICP will need to engage with local people, staff and affected organisations. Further details about the requirements that an ICP would need to follow are set out in NHS England guidance and the ICP Contract.

22. Is primary legislation required to create ICPs?

Primary legislation is not required to create ICPs.

An ICP will not be a new type of legal entity. 'ICP' is a term we use to describe a provider of health and care services which enters into an ICP Contract with a commissioner.

The ICP Contract does not contain any provisions that are contrary to existing primary legislation (as confirmed by the High Court and the Court of Appeal) and so does not require primary legislation before it can be used. There will be no 'designation' of ICPs by NHS England or the Secretary of State for Health and Social Care (or any other body).

While the ICP Contract can be used without changes to primary legislation, NHS England and NHS Improvement have proposed that legislation is changed to ensure that the Secretary of State has clear powers to establish new NHS trusts for the purposes of providing integrated care through an ICP Contract, where both an integrated care model and the creation of a new trust are supported by local commissioners and providers. The creation of such a new trust may be appropriate where local parties cannot identify a suitable existing organisation to perform the role of ICP for their area. The proposed changes to legislation remain subject to acceptance by Government and enactment by Parliament. If enacted, these changes will not preclude the award of an ICP Contract to an organisation other than a newly-created trust, for example to an existing NHS trust or foundation trust. Further information on the proposals can be found at https://www.longtermplan.nhs.uk/wp-content/uploads/2019/02/nhs-legislation-engagement-document.pdf.

23. Will the ICP Contract have a wider scope and higher value than many current contracts?

Yes, and we have designed the ICP Contract with that in mind.

The scale of an ICP Contract and the systemic importance of an ICP locally make it important that the ICP budget will be used appropriately, that necessary services will continue to be delivered, and that the ICP will remain on a sound financial footing.

We have included a number safeguards in the ICP Contract, to ensure that the ICP's budget is always used as intended to improve the overall health and care of the population in the short and longer term. These new provisions aim to ensure financial accountability, transparency and robustness. These are in addition to safeguards reflecting those included in the generic NHS Standard Contract, including commissioner rights to terminate the ICP Contract if the ICP does not meet quality or other performance requirements, and rights to terminate individual services or sub-contracts.

In addition, NHS England and NHS Improvement have introduced the ISAP to support commissioners to make a robust assessment of the ability of any organisation to hold and deliver an ICP Contract before awarding such a contract.

24. Will funding for individual services be protected under an ICP model, where payment is via a single integrated budget?

The majority of budget available to the ICP under the contract will be paid, in instalments, as a whole population annual payment (WPAP), which the Court of Appeal has confirmed is lawful in principle. This integrated budget is arrived at by local commissioners based on the size of the ICP's population and current spend on services in scope for the ICP. An ICP is incentivised to use its budget on early interventions, management of long-term conditions, and supporting people to stay healthy, thereby (over time) reducing the need for unplanned and preventable interventions. The ICP has the scope to spend its budget flexibly, to ensure the most effective use of its resources to meet the needs of its population. It is for the ICP to determine how best to allocate its budget in order to meet the requirements for short and long term improvements in population health set out by commissioners in the contract.

However, as they do when commissioning services using the generic NHS Standard Contract, commissioners will want to ensure that any ICP Contract they award provides safeguards against undesirable restriction of services by the ICP or impact on the quality or safety of care. It may, for example, wish to specify certain services which must always be available to particular groups of people, or impose quality standards (in addition to those imposed by the mandatory elements of the ICP Contract) which must always be maintained.

25. What do ICPs mean for the local workforce?

ICPs change nothing about employment law or employment practice within the NHS. However, as a provider responsible for a wide range of integrated services, an ICP should be able to offer new opportunities to people working in health and care services locally (both within its organisation and with its sub-contractors and integrated providers), with greater use of multi-disciplinary teams, providing scope for more varied and rewarding careers.

26. Will VAT recovery issues continue to affect NHS bodies?

ICPs do not affect VAT law and rules. Lack of VAT recovery on NHS contracted-out services can occur, as highlighted in the review of the Cambridgeshire UCP contract. It is clear that the adverse VAT recovery position which affected the UCP contract continues to apply to similar contracting structures, and is not likely to change in the foreseeable future.

Local commissioners and providers will need to have regard to this position, and providers in particular will need to consider carefully the VAT implications of any organisational form and sub-contracting arrangements, just as they do now.