Contracting arrangements for ICPs: Equality and health inequalities analysis

NHS England and NHS Improvement

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Integrated Care Provider Contract Package

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1. Introduction and context

This analysis outlines the anticipated equality and health inequalities impact of proposed contracting arrangements for Integrated Care Providers (ICPs). For the purposes of this document, this includes:

1. the NHS Standard Contract (Integrated Care Provider), also referred to as the ICP Contract (a variant of the generic NHS Standard Contract) – particularly those elements which differ from the NHS Standard Contract
2. the integrated budget, which forms part of the proposed arrangements for ICPs enabling a whole population approach, commonly described as a whole population budget (WPB).

NHS England, as a public sector body, is subject to two broad legal duties related to equality and health inequalities which extend to its development of the contractual arrangements for commissioning of ICPs:

a. the public sector equality duty (PSED) which specifically refers to the nine groups of people with protected characteristics, and requires NHS England to have due regard to the need to eliminate inequitable treatment of those groups, advance equality of opportunity and foster good relations
b. a general duty to have due regard to exercising its functions in a manner which is designed to reduce health inequalities. Health inequalities can affect any group, some of which are well-known and defined health inclusion groups.[1]

Like the generic NHS Standard Contract, the ICP variant is a national framework for local completion. This means that it lays out national rules and requirements for the delivery of services, but does nothing to prescribe the services that should be available to any given population. Similarly, it does not set a prescribed contract duration, nor any details relating to the funding available to any CCG. Without such details, it is only possible to assess the impact, as far as that is possible, of the national framework itself; it is not possible to reach any conclusions about the impacts of local models which could be commissioned by CCGs using the ICP Contract.

Therefore, it is critical that commissioners undertake their own equality and health inequalities impact assessments and community and service user engagement to understand the local impact of each individual contract commissioned (in accordance with their own legal duties). Any providers that may be contracted under an ICP Contract in future would also need to ensure that they undertake, where relevant, an equality and health inequalities impact assessment of local population groups and service user

[1] Inclusion Health has been used to define a number of groups of people who are not usually well provided for by healthcare services, and have poorer health outcomes. Traditional definitions cover people who are homeless and rough sleepers, vulnerable migrants (refugees and asylum seekers), sex workers, and those from the Traveller community (including Gypsies and Roma). NHS England's working definition also includes those undergoing or surviving Female Genital Mutilation (FGM) and Human Trafficking, and those who define themselves as being part of the recovery movement, both through substance misuse and mental health issues.

needs (the requirements for local providers are outlined further in this document).

This document draws on previous related work on equality and health inequalities – including the draft Equality Impact Assessment that was created jointly for the draft ACO Contract (as it was then known) and the generic NHS Standard Contract. Undertaking an equality and health inequalities analysis is an iterative process to analyse the impact of our work and identify any gaps and potential actions as a result of them.

2. Impact on equality and health inequalities

The aim of ICP contractual arrangements is to ensure that people receive integrated care that is focused on meeting their individual needs. This means that commissioners would use an ICP Contract predominantly where they wish to put in place care models such as the Multispecialty Community Provider (MCP) or the Primary and Acute Care System (PACS).[2] These models describe how a whole population model could be put in place that would focus on addressing the wider determinants of health and tackling inequalities.[3]

This section sets out the anticipated equality and health inequalities impact of the proposed contracting arrangements for ICPs, based on the national components of the ICP Contract and associated payment approach.

Provisions within the ICP Contract are supported by a performance management approach, as with the generic NHS Standard Contract that is already used for most NHS care. If the provider failed to fulfil its obligations, a management process would be put in motion which could include a performance notice, management meeting, a remedial action plan, and eventually withholding payments (General Condition 8 of the ICP Contract). The commissioner could then seek to commission another provider to fulfil its own legal obligations around continuity of service and those in the Equality Act 2010 and the Health and Social Care Act 2012.

2.1 Requirements already existing in the generic NHS Standard Contract

The ICP Contract is aligned to the principles and duties of the Equality Act. Under the National Health Service Act 2006 as amended by the Health and

[2] The Multispecialty Community Provider (MCP) emerging care model and contract framework can be found on the NHS England website: https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf (Information accessed 25 July 2018). The Primary and Acute Care Systems (PACS) – describing the care model and the business model can be found on the NHS England website: https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf (Information accessed 7 June 2019).

[3] More information on MCPs and PACs can be found on the NHS England website in the Multispecialty Community Provider (MCP) emerging care model and contract framework document: https://www.england.nhs.uk/wp-content/uploads/2016/07/ mcp-care-model-frmwrk.pdf, and the Integrated primary and acute care systems (PACS) - Describing the care model and the business model document: https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf (Information accessed 16 July 2018).

Social Care Act 2012, CCGs and NHS England have duties in relation to health inequalities in the following areas:

- to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.13G and s.14T)
- to exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality and reduce inequalities in access to those services or the outcomes achieved (s13N and s.14Z1).

The ICP Contract reflects the NHS Standard Contract in that it specifically prohibits discrimination on the basis of the nine protected characteristics set out in the Equality Act 2010 s4(9), this being a mutual obligation on the commissioner and on the provider (any organisation holding an ICP contract). The ICP Contract also includes a range of other provisions that are specific to equality. These include:

- A range of provisions that specifically outline a provider's responsibilities in relation to 'Equality of Access, Equality and Non-Discrimination' (see Appendix 1). Amongst these requirements, the ICP Contract states that the provider, whether a public body or not, must comply with the obligations contained in section 149 of the Equality Act 2010, the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, and section 6 of the Human Rights Act 1998. The commissioner can require the provider, on reasonable request, to provide a plan setting out how it will comply with its obligations under these Acts and Regulations.
- All parties to the ICP Contract are also required to report on the compliance with the National Workforce Race Equality Standard and the National Workforce Disability Equality Standard, to be completed annually (ICP Contract Particulars, Schedule 7A).
- There are further existing obligations on providers with regard to safeguarding (Service Condition 24) and on ensuring that their staff are aware of and respect equality and human rights of colleagues, service users, carers and the public (Service Condition 9.6.6).

2.2 New core content describing the whole population approach required by the holder of an ICP Contract

2.2.1 Care model descriptions

In addition to the requirements already mirroring those which exist in the generic NHS Standard Contract, a number of new requirements are incorporated into the ICP Contract which relate to the integrated care models. These requirements are drawn from the MCP and PACS models, and are intended to ensure that the ICP takes a whole population approach, in particular regarding the need to:

- work towards the integration goals of the care model
- tailor the care model to the needs of individuals

- ensure that there is improvement to the health of the population.

A full list of these conditions is provided in Appendix 2. Overall, we expect these to have a positive impact on equalities and health inclusion groups. Some examples of how this could occur are highlighted below:

- The provider must actively consider the need to seek to reduce health inequalities between members of the population with respect to their ability to access health services and the outcomes achieved for them from the delivery of health services (Service Condition 1.2).
- The provider must have in place information systems and analytical capability to apply risk stratification tools (Service Condition 3.3). This would enable it to identify at-risk groups from the whole population (such as people with protected characteristics or from health inclusion groups), and consequently to ensure that its services are able to care for the needs of individuals in their population (Service Condition 4).
- The provider must implement a local approach to engaging the population in improving health and wellbeing in accordance with NICE Guideline NG44 (Service Condition 3.4.1). This would better inform the way it addresses the needs of the population.
- The provider must work collaboratively with the commissioners, the integrated practices and other providers and agencies. It will seek to identify and address the underlying influences on health and wellbeing for members of the Population and inequalities in health, wellbeing and outcomes between different sub-groups within the Population through the assessment of health and social care needs of the population (Service Condition 3.2.2).

By incorporating the new care model descriptions in the ICP Contract, the Contract tries to ensure that provision of the care model is consistent across the entire ICP population. In combination with the existing requirements around equality and health inequalities as outlined above, the intention of the ICP Contract is to reduce variation between different members of its population.

2.2.2 Additional content intended to underpin integration between primary medical services and other NHS services

The ICP Contract is specifically designed to aid the integration of primary medical services with other local health and care services to deliver the care model. The ICP Contract envisages two approaches to GP involvement and integration:

For a partially integrated approach, practices would continue to deliver core primary medical services under their existing GMS or PMS arrangements. The ICP would be responsible for the delivery of a package of other services and required by the ICP Contract to ensure integration of its services with the primary medical services delivered by the practices, in pursuit of locally-defined “integration goals”. The GP practices would enter into an Integration Agreement (see template agreement as part of the ICP

Contract Package) with the ICP,[4] setting out how they will work more closely together.

Full integration involves core primary medical services being commissioned with other services under the ICP Contract rather than through multiple different contracts. GPs could join an ICP as employees, or provide services on subcontract to an ICP.

The different options for voluntary GP participation give rise to a potential for a 'mixed economy' of different practices participating and providing services in different ways across an ICP population. The precise implications on equality and health inequalities will be dependent on factors such as the existing level of inequality amongst practices and the extent to which practices adopt different models of participation. Any impact should be carefully considered if such mixed economies emerge.

2.2.3 Whole population models of provision: Establishing integrated budgets

Under the ICP Contract, the commissioner will bring funding together in an integrated budget to cover a package of services, instead of paying for different sets of services separately. The ICP Contract would accommodate this by providing for a Whole Population Annual Payment (WPAP), which would represent the majority of funding available under the Contract. As the provider's budget will be based on the full scope of services that are commissioned under an ICP Contract, it could allocate its resources between them in a way which best provides for its population's short and long term needs. It would have the flexibility to design and invest in its services in a way which promotes better longer-term health and care outcomes for the population thus contributing towards compliance with equality and health inequalities requirements set out in the Contract. Further details about the proposed WPAP approach are outlined in the integrated budgets overview.

The equality and health inequalities impact of the integrated budget approach would be determined by the way that budgets are constructed locally. The WPAP approach would be implemented using the existing flexibilities available to commissioners and providers of NHS services pursuant to the National Tariff Payment System (NTPS). Payments of this nature may be agreed under the national tariff by the commissioner and provider agreeing "local variations" for nationally priced services within the scope of the WPAP (i.e. by agreeing to vary the national prices and specifications for those services), bundling them with other relevant services, and agreeing a single payment for a single package of services, in accordance with the NTPS rules. As set out in the NTPS, the local variation rules are intended to give commissioners and providers an opportunity to innovate in the design and provision of services for patients. The rules and principles applicable to local payment approaches in an ICP

[4] Frequently asked questions for the template Integration Agreement can also be found on the NHS England website.

context are identical to those which apply when commissioners wish to use the generic NHS Standard Contract, in particular that:

- the approach must be in the **best interests of people**
- the approach **must promote transparency** to improve accountability and encourage the sharing of best practice
- the provider and commissioner(s) must **engage constructively** with each other when trying to agree local payment approaches.

It is important to note that whilst the controls in place nationally around the use of local variations and the development of the WPAP are identical for the ICP Contract as for the generic NHS Standard Contract, further work would be required locally for each new ICP Contract to think through the service specification and any changes to underlying payment mechanisms, and consequently, any potential impact of those on local inequalities. This process would require local assessment. The overall impact of any new contract would also be subject to national assessment.

With the flexibility of budget allocation across a range of services, it will still be important to ensure that resources are spent on the population as intended – and there may be a risk that if this did not occur, people with protected characteristics or from health inclusion groups may be affected. However, the commissioner will need to ensure that it mitigates appropriately against any risk that, in order to improve its financial performance, the ICP restricts access to services or allows the quality or safety of care provision to deteriorate. There are different ways that improvement in care provision can be encouraged and maintained – for example a commissioner may wish to specify certain services which must always be available to particular patient groups. As outlined previously, it would also remain the responsibility of local commissioners and ICPs to consider the equality and health inequalities impact of their actions.

2.3 Potential impact on specific groups of service users

Generally, no negative impact for specific groups has been identified from the analysis of the new elements that have been incorporated into the national ICP framework, as described above. The population health management approach, which the ICP Contract is intended to underpin, involves the requirement for providers to take a holistic view of the needs of various sub-groups of the population. People with complex needs – for example, many older people – are likely to particularly benefit from this approach. The contract has also been designed to ensure the ICP has wide responsibilities for providing care to the whole population, comprising everyone registered with that ICP (or with a GP practice partially-integrated with the ICP) wherever they live, and everyone permanently or temporarily resident within the ICP's area, unless they are registered with a GP practice which is not part of the ICP. The ICP would therefore be responsible for providing care for homeless people, travelers and others who live within its area.[5]

[5] If local authority-funded services are within scope for the ICP, the population served by the ICP for those services will be defined so as to cover the population for which the local authority is legally responsible.

Commissioners would be allowed to use the ICP Contract to purchase services for their population. The specific practical impacts of this national framework would be determined by the local decisions made by commissioners in determining a care model and selecting an appropriate provider. Depending on local commissioning decisions, there could therefore potentially be an impact upon any people and groups with 'protected characteristics' under the Equality Act 2010 (age, disability, gender reassignment; marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation). There are also various groups within populations that may experience health inequalities in relation to access and outcomes – for example, people from the health inclusion groups described earlier.

However, the above analysis highlights the need for local contracts to be subject to full engagement and involvement. This is to ensure that the impact of the use of the ICP Contract is fully documented and understood, and appropriate action taken.

3. Patient and public involvement

Patient and public involvement is important to help us be aware of any equality and health inequalities issues relating to the contractual framework for ICPs.

The ICP Contract and supporting documents have been developed based on extensive engagement.

The engagement included a 12-week public consultation on the contracting arrangements for ICPs, from 3 August to 26 October 2018. As part of the public consultation, feedback on the draft equality and health inequalities analysis was gathered. People were able to respond to the consultation questions via a number of routes:

- an online survey
- attendance at one of the four regional events that took place across the country
- the ICP email inbox
- by post, direct to the New Business Models Team at NHS England.

During this time NHS England was able to review and develop the ICP Contract, along with the EHIA, using feedback from internal and external stakeholders. NHS England's response to the consultation can be found here.

Any localities considering the use of the ICP Contract also need to carry out their own local engagement exercises as they develop their care model. Local commissioners have their own involvement and consultation duties.

Appendices

Appendix 1 – Service Condition 17 Equity of Access, Equality and Non-Discrimination

Provision	Application
17.1 The Parties must not discriminate between or against members of the Population, Carers or Legal Guardians on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, or any other non-medical characteristics, except as permitted by Law.	**All**
17.2 The Provider must provide appropriate assistance and make reasonable adjustments for members of the Population, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral or learning impairments). The Provider must carry out an annual audit of its compliance with this obligation and must demonstrate at Review Meetings the extent to which Service improvements have been made as a result.	**All**
17.3 In performing its obligations under this Contract the Provider must comply with the obligations contained in section 149 of the Equality Act 2010, the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and section 6 of the HRA. If the Provider is not a public authority for the purposes of those sections it must comply with them as if it were.	**All**
17.4 In consultation with the Co-ordinating Commissioner, and on reasonable request, the Provider must provide a plan setting out how it will comply with its obligations under SC17.3. If the Provider has already produced such a plan in order to comply with the Law, the Provider may submit that plan to the Co-ordinating Commissioner in order to comply with this SC17.4.	**All**
17.5 The Provider must implement EDS2.	**NHS Trust/ FT Providers and Sub-Contractors**
17.6 The Provider must implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing that standard.	**All**
17.7 In accordance with the timescale and guidance to be published by NHS England, the Provider must:	**NHS Trust/ FT Providers**

17.7.1 implement the National Workforce Disability Equality Standard; and 17.7.2 report to the Co-ordinating Commissioner on its progress.	**and Sub-Contractors**

Appendix 2 – New service conditions introduced associated with care model for ICPs (compared to the generic NHS Standard Contract)

Provision	Application
SC1 Fundamental Obligations of the Provider and the Commissioners 1.2 In performing its obligations under this Contract, the Provider must have regard to the need to reduce inequalities between members of the Population with respect to their ability to access health services and the outcomes achieved for them from the delivery of health services.	**All**
1.3 The Provider must perform the Integration Activities in accordance with the requirements set out in Schedule 3A (Integration Activities) and in pursuit of the Integration Goals.	**All**
SC3 Improving the Health of the Population 3.1 The Provider must perform its obligations under this Contract in such a way as to secure continuous improvement in the quality of services provided to the Population in connection with the prevention, diagnosis or treatment of illness, with a view to securing continuous improvement in the treatment outcomes achieved and in the health status of the Population.	**All**
3.2 The Provider must develop and implement strategies to improve the health and wellbeing of the Population. The Provider must: 3.2.1 maintain a documented, current and thorough assessment of the health [and social] care needs of the Population; 3.2.2 work collaboratively with the Commissioners, the Integrated Practices and other providers and agencies to seek to identify and address the underlying influences on health and wellbeing for members of the Population and inequalities in health, wellbeing and outcomes between different sub-groups within the Population; 3.2.3 support the Population to adopt healthy lifestyles, ensuring that Staff use every contact they have with members of the Population as an opportunity to maintain or improve health and wellbeing, in accordance with the	**All**

principles and tools comprising in Making Every Contact Count Guidance; 3.2.4 where clinically appropriate, provide information and support to Service Users (particularly those with long term conditions) to develop the knowledge, skills and confidence to take increasing responsibility for managing their own ongoing health, wellbeing and care through self-management education, health coaching and peer support, and provide information and support to their Carers or Legal Guardians to assist those Service Users in doing so and 3.2.5 provide the Services and perform the Integration Activities in such a way as to: 3.2.5.1. maximise the extent to which disease and conditions are alleviated or prevented, and to which members of the Population can live healthy lives in their own homes; 3.2.5.2 ensure timely diagnosis of diseases and conditions and prompt access to clinically appropriate treatment and care wherever indicated, making onward referrals as clinically appropriate and in line with agreed referral protocols to other providers of health and social care services commissioned by the Commissioners; and 3.2.5.3 minimise unplanned hospital attendances and admissions.	
3.3 The Provider must ensure that it has in place information systems and analytical capacity, supported by use of a recognised risk stratification tool and, where appropriate, by data sharing arrangements with other providers of health and social care) which allow it to: 3.3.1 understand the health and care needs of the Population and predict the extent to which members of the Population are at risk of developing different diseases or conditions; 3.3.2 identify unwarranted variations in the delivery, experiences, and outcomes of care; 3.3.3 identify opportunities to improve the quality, equity and efficiency of care;	**All**

3.3.4 plan and deliver targeted preventative care interventions that take account of the specific needs of individual members of the Population; 3.3.5 monitor improvements in the experience of care, health outcomes and well-being of members of the Population; and 3.3.6 record levels of Activation among Service Users on an ongoing basis, using a recognised measurement tool.	
3.4 The Provider must: 3.4.1 implement a local approach to engaging the Population in improving health and wellbeing in accordance with NICE Guideline NG44; 3.4.2 use all reasonable endeavours to promote and support voluntary, community-led activities amongst the Population which promote better health and wellbeing and support the provision of the Services and the Integrated Services; 3.4.3 maintain an ongoing, up-to-date directory of those activities, the organisations involved in providing them and the community facilities and resources used to support them; and 3.4.4 make this directory available and publicise it through appropriate means to the Population.	**All**
3.5 The Provider must ensure that the [Healthcare] Services are made available as appropriate to Care Home Residents. The Provider must deliver those [Healthcare] Services, [and] must implement a programme of clinical support for the Care Homes [and must perform the relevant Integration Activities], with the objectives of improving the health and care of the Care Home Residents and minimising avoidable admission of Care Home Residents to hospital.	**All**
SC4 Care Tailored to Individual Needs Access to services 4.1 The Provider must ensure that it publicises (through Staff, on its website and through other appropriate means) details of the nature and hours of availability of: 4.1.1 Primary Medical Services and urgent care [Healthcare] Services which are intended to function on an open-access basis; and 4.1.2 other relevant open-access urgent care services provided by other health and social care providers commissioned by the Commissioners, with the aim of ensuring that the Population is	**All**

aware of the purpose of each of those services, and where and when they can be accessed.	
4.2 In delivering Primary Medical Services, the Provider must use all reasonable endeavours to: 4.2.1 offer to each member of the Population the choice of a range of premises, sited at readily-accessible locations throughout the Contract Area [in accordance with the requirements set out in the relevant Service Specifications], at which to receive Primary Medical Services throughout Core Hours; 4.2.2 offer sufficient pre-bookable and same-day appointments (with GPs and/or other clinical Staff as appropriate) during Core Hours to meet the needs of the Population, including during evenings and at weekends as a realistic alternative to appointments between the hours of 8.00am and 6.30pm Monday to Friday; and 4.2.3 provide each week, outside of Core Hours, a minimum of 30 minutes of face-to-face GP appointment capacity per 1,000 members of the Population.	**All**
4.3 In delivering [Healthcare] Services other than Primary Medical Services, the Provider must use all reasonable endeavours to provide care and treatment for each Service User from a convenient location as close to that Service User's home as possible. The Provider must ensure that each [Healthcare] Service is available to Service Users at times and on days convenient for them, including during evenings and at weekends where clinically appropriate.	**All**
4.4 The Provider must continually monitor and assess the demand for each [Healthcare] Service by location, time of day and day of the week. At the reasonable request of the Co-ordinating Commissioner, the Provider must provide to the Co-ordinating Commissioner: 4.4.1 details of its rationale for its provision of [Healthcare] Services by location, day or week and time of day, including details of actual utilisation of [Healthcare] Services and distances travelled by Services Users; and 4.4.2 evidence that the Provider's decisions on the location and availability of the [Healthcare] Services have been informed by engagement with the Population.	**All**
4.5 In delivering the [Healthcare] Services, the Provider	**All**

must use all reasonable endeavours to offer each Service User clinically appropriate alternatives to face-to-face contact with Staff, using a range of different technologies and ensuring that the technologies selected are suitable for the needs of the individual Service User.	
4.13 The Provider must ensure that: 4.13.1 with effect from no later than [ ], any Service User with a long-term condition or on a complex care pathway is supported by a named lead clinician and a named Care Co-ordinator; and 4.13.2 with effect from [ ], it has in place, and that Staff implement and comply with, protocols for the care of Service Users with long term conditions. The Provider must be able to demonstrate its compliance with this requirement by audit in relation to each relevant [Healthcare] Service.	**All**