Explanatory notes to the ICP Contract

NHS England and NHS Improvement

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Introduction

1 This document describes the proposed structure and content of the draft variant of the NHS Standard Contract for integrated care models on a section-by-section basis. For brevity, we refer to it here as the **ICP Contract**, or simply the Contract.

Overall content and structure of the ICP Contract

2 At the moment, NHS commissioners must use different contractual forms to commission primary medical services (for which GMS, PMS and APMS contracts are mandated through specific regulations and directions) and hospital and community health services (in respect of which NHS England's Standing Rules Regulations enable us to publish, and mandate use of, the NHS Standard Contract). But at the heart of an integrated care model is the integration between general practice and other community services – so a new type of contract, different from existing forms, is needed to commission integrated services from what is often known as an Integrated Care Provider (ICP).

3 For primary medical services to be commissioned as part of an integrated package we have ensured that the ICP Contract complies with statutory requirements already applicable to primary medical services. However, we also wanted to ensure that the ICP Contract is as streamlined as possible. We have therefore worked with the Department of Health and Social Care (DHSC) to develop a set of new 'Directions', a type of legislation which will underpin the specific primary medical services requirements within the ICP Contract, and are designed specifically for a contract for integrated services. The Department of Health and Social Care has undertaken a consultation that asked for specific views on the Directions, and plans to publish revised final-form Directions during Autumn 2019. Directions will initially only be made available on a case by case basis for specific areas after they are signed off through the Integrated Support and Assurance Process, satisfying Government scrutiny requirements. This will, again, help ensure ICPs are only implemented where they represent a good solution in the interests of patients and the public.

4 We may need to amend references to the Directions in due course to reflect their further development or replacement, as necessary.

5 The ICP Contract includes a range of provisions and clarifications arrived at as a result of our engagement with various local authorities and the Local Government Association (LGA). The intention is to ensure that the Contract is fit-for-purpose for commissioning public health and/or social care services as part of an integrated package of health and care services. Our work with local authorities and the LGA is ongoing, and may result in further development of the Contract with public health and social care in mind in due course.

6 Further amendments have been made to reflect the generic NHS Standard Contract 2019/20.

7 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.[1] In recognition of this recommendation, and the current expectation that the ICP

[1] 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)

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 Against this background, the nationally-mandated content of the ICP Contract (which would be consistent for every local contract based on it, except as explained in paragraph 11 below) can be seen as being derived from four key sources:

- **existing** provisions from the generic NHS Standard Contract, which we believe are essential requirements which must be retained in the Contract (NHS Constitution standards, for example, as well as national policy priorities and essential contract management processes)
- **simplified** requirements produced by merging an existing NHS Standard Contract requirement and requirements of the proposed Directions: requirements on training of staff, for instance
- **provisions** (indicative only at this stage, for the reasons explained above) specific to primary medical services, based on the proposed Directions
- **new** requirements specific to an integrated care model (improving population health, for instance, addressing health inequalities, providing seamless, integrated person-centered care, putting in place effective strategies for patient activation, developing shared electronic patient records).

9 Alongside these core proposed nationally-mandated provisions, the ICP Contract includes schedules which are for local completion. To reflect this, the Contract (in line with the generic NHS Standard Contract) is structured in three parts:

- **Service Conditions**, setting out the core requirements in clinical and service terms which any ICP will be required to deliver
- **General Conditions**, setting out the necessary contract management processes and standard, legal 'boilerplate' requirements
- **Particulars**, which record the signature of the Contract and contain all the locally-agreed schedules.

10 The proposed nationally-mandated provisions of the Contract would be locally adaptable in three respects.

- A slightly different mix of provisions would apply depending on whether the ICP is operating under either the 'fully-integrated' or 'partially-integrated' model. For the former, provisions would be included relating to core primary medical services, including operation of the patient list; for the latter, the Contract would exclude provisions relating solely to core primary medical services, and would instead make reference to the obligations of the ICP in relation to the integration of its services with core primary medical services (for the delivery of which practices will remain responsible). Colour-coding within the Contract sets out how this tailoring is likely to operate.
- We understand that some CCGs may be considering a scenario where they will have some practices opting to relate in a partially integrated way, and some in a fully integrated way. We anticipate that with further development (as a co-production with CCGs envisaging this scenario) it would be possible to accommodate this in the Contract. This is likely to involve, for example, distinguishing certain provisions,

which apply only in respect of some services/areas/sections of the patient population.

- The scope of each ICP is likely to vary; some may include mental health services, others may include a subset of acute services, others may include local authority-commissioned services (public health and/or social care). We have, where possible, designed the ICP Contract so that (as with the generic NHS Standard Contract) some provisions specific to particular types of service can "Not applicable" if those services are not within scope for a particular ICP. We will work on this further as the ICP Contract develops.

The service specification, outcome measures, and implications for contract management and assurance

11 The ICP Contract contains a number of proposed descriptors and indicators to define the requirements against which the Provider will be held to account. It contains a high level description of the mandatory core care model requirements, which will be supplemented locally by Commissioners through service specifications. The Provider will be required to comply with the generic nationally-mandated reporting requirements common to all NHS Standard Contracts and (where the service scope includes primary medical services) GP contracts, and against any quality indicators which are specified locally. An element of the Provider's total potential remuneration will be linked, via a Local Quality Incentive Scheme and a CQUIN scheme, to its achievement against locally- determined and nationally-determined quality indicators. Where the service scope includes primary medical services, the Local Quality Incentive Scheme may, insofar as it relates to primary medical services, replicate QOF. The Local Quality Incentive Scheme may also include quality and outcomes requirements and indicators relating to public health and/or social care services, where those are in scope for the ICP.

12 The ICP Contract allows for the inclusion of these descriptions and indicators as follows:

a) The Service Conditions (particularly SC1.8 to SC4) contain the mandatory core elements of the care model.

b) Schedule 2C in the Particulars will contain the locally-determined service specifications, adding flesh to the nationally-mandated core requirements. These may comprise either solely the Commissioners' Service Requirements, or Commissioners' Service Requirements supplemented by the Provider's Service Proposals (setting out how it intends to meet the Commissioners' requirements). Note that we have now provided for there to be separate specifications for healthcare services, public health services and social care services, if required – acknowledging the needs of local authority commissioners to provide for certain obligations to apply only in relation to healthcare services, or only in relation to public health and/or social care services. This is not intended to detract from the need to deliver services on an integrated basis.

c) Via GC9 (Information Requirements) and Schedule 7A (Reporting Requirements) the Provider will be required to report its performance against (amongst other things) the operational standards, national quality requirements, national indicators in relation to primary medical services, and any additional locally-determined indicators relevant to the Local Quality Incentive Scheme.

d) Schedules 5A and 5B in the Particulars set out minimum standards of performance required against the relevant nationally-mandated Operational Standards and National Quality Requirements.

e) Schedules 5C and 5D may be used to set out any locally-determined Local Quality and Outcomes Requirements and linked Local Quality Incentive Scheme respectively. These may involve either or both of (i) minimum quality and outcomes requirements, failure to achieve which may result in financial sanctions, and (ii) indicative quality and outcomes standards, achievement of which may unlock additional payments – which, where the service scope includes primary medical services, may replicate QOF in relation to those services.

f) Schedule 5D will set out a CQUIN scheme in relation to non-primary care health services, in accordance with current CQUIN guidance (https://www.england.nhs.uk/nhs-standard-contract/cquin/). Achievement of CQUIN indicators would unlock further additional payments, worth in aggregate an amount equal to 2.5% of the proportion of the Whole Population Annual Payment (WPAP) (on which see paragraph 80 below) attributable to non-primary care healthcare services.

13 The balance of incentives regimes (including CQUIN, QOF and local incentive schemes) under existing commissioning arrangements will differ by area and setting. Alone, none of them would sufficiently capture the requirements of an ICP and provide assurance of delivery. The appropriate balance and combination of the incentive elements outlined above will be important to the successful delivery of high-quality integrated care by an ICP, so in respect of any proposed ICP these will need to be considered carefully by commissioners and will be reviewed by NHS England and NHS Improvement as part of the Integrated Support and Assurance Process (for details of this process, its scope and purpose, please refer to the Consultation Document).

The Care Model

14 For an ICP to be recognisable as the deliverer of integrated, person-centred care, the Contract must capture the essence of the integrated care provider model. The requirements of the care model are described in the Service Conditions – particularly in Service Conditions 3 and 4, for instance. All ICP contracts must include these requirements. The Service Conditions list requirements for how the set of services will need to be delivered, for example by requiring population health management, the use of information systems supported by risk stratification tools, or recording levels of patient activation.

15 This ensures that potential providers are fully aware of the commissioner's minimum expectations of delivery for an ICP. But the wording of the Service Conditions deliberately operates at a high level and does not describe the model of care in such a degree of depth as to prevent its evolution through learning or render it obsolete over the contract term.

Service specifications and clinical outcomes

16 Currently, commissioners often choose to develop service specifications which set out the details of individual services which providers are required to deliver and are prescriptive as to how those services are to be delivered. In an ICP context, longer term contracts require flexibility for ongoing service redesign and responsiveness to the needs of the population and developing best practice. Pinning down the detail of services and how they are delivered too tightly and/or for the entire duration of a proposed ICP contract would be overly restrictive. At the same time, some security about the nature of what the ICP must provide and what clinical and patient-reported outcomes it must achieve will be essential in holding the ICP to account for delivering high quality care. This might involve specifying types of services rather than their detail – or different approaches depending on the availability of good outcome measures. The key is to achieve the right balance.

17 Any proposed ICP contract will also need to be clear what process and obligations exist for the redesign of care, how commissioners are involved in the decision making, and how the Contract will evolve as services need to (subject always to the legal restrictions imposed by the Public Contracts Regulations and the Procurement, Patient Choice and Competition Regulations and to commissioners' duties to consult their populations on proposed service reconfigurations).

18 The ICP Contract leaves it to commissioners to decide how detailed they make their service specifications and to what extent they rely on specifying their required clinical and patient-reported outcomes to supplement the description of the care model and population outcomes. The Contract allows, at Schedule 2C, for a high-level description of the commissioners' service requirements to be augmented by a (more detailed) set of service delivery proposals from the provider, developed during the procurement process – or, alternatively, there can be a single service specification which draws on both the commissioners' requirements as stated in procurement documents and the providers' proposals put forward during the procurement process.

19 However, the commissioner may, for example, wish to specify certain services which must always be available to particular patient groups, or to specify particular premises or locations from which services must be provided, or impose quality standards (in addition to those imposed by the mandatory elements of the Contract) which must always be maintained.

Variations to the Contract

20 We anticipate that ICP contracts will typically be awarded for a duration significantly longer than is currently the norm for commissioning contracts for services other than primary medical services. Longer term contracts provide a stable framework within which a greater focus can be placed on improving health outcomes and wellbeing for the population. But they must not be inflexible or incapable of accommodating changing needs and expectations. The duration of any local ICP contract will be for local commissioners to decide and record in their local contract: the ICP Contract does not specify a duration.

21 We recognise that the Contract will need to have room for flexibility in order to ensure that it continues to reflect the latest best practice and policy across the NHS. We have mirrored existing provisions within the generic NHS Standard Contract (the

National Variation provisions) which allow NHS England to update the core terms of the Contract – for example where a new national priority is identified, or a contract provision needs to be updated.

22 In addition, of course, the Contract makes provision for variations (other than to the nationally mandated terms) to be agreed as necessary between commissioner and provider during the term of the local ICP contract (subject always to the legal restrictions imposed by the Public Contracts Regulations).

Section-by-section descriptions

23 Set out below are high-level explanations of the function of each main section or schedule of the ICP Contract, covering the Service Conditions, the General Conditions and the Particulars.

24 The following points should be noted:

- To accommodate those situations where a subset of acute hospital or mental health in-patient, outpatient and/or day case services is to be included within scope of an ICP, the Contract includes those nationally-mandated provisions from the generic NHS Standard Contract which apply specifically to those services: SC26.9 – 26.11 in relation to VTE and other acute illness, and SC26.17 – 26.19 in relation to food standards, for example.
- We have ensured that the Contract allows for 'tailoring' of the Service Conditions and Particulars, in the same way as is possible with the generic NHS Standard Contract. Thus, if mental health or acute services are not included within scope of an ICP, for instance, the Contract provisions specific only to those services will not apply. Similar tailoring will provide for local authority-commissioned services to be included or excluded, as required. Note that, as is the case with the generic NHS Standard Contract, the list of service categories in the opening section of the Particulars and at the beginning of the Service Conditions serves only to inform this tailoring: it should not be taken as indicating any direction from NHS England as to which services can, should or should not be in scope for any local contract.
- Detailed drafting notes in the Contract indicate how particular provisions are to be understood and how particular schedules would be used and populated locally.

Service Conditions

25 The overall purpose of the Service Conditions is to set out the core requirements in clinical and service terms which any ICP would be required to deliver.

SC1 Fundamental Obligations of the Provider and the Commissioners

26 This provision sets out overall obligations on the parties at a very high level, including requirements to comply with fundamental care standards and the NHS Constitution. Also included (for the partially-integrated model) is a requirement for the ICP to perform the Integration Activities set out in Schedule 3A.

Note that SC1.8 makes clear that the ICP may use and allocate resources as it sees fit to deliver the services which are commissioned under the Contract, but only within the

scope provided by the Contract and not in a way which would put the Commissioner in breach of its statutory obligations or in breach of procurement rules, or would constitute an unlawful delegation of the commissioner's functions.

Note also that, under SC1.9, the ICP must in carrying out its obligation have regard to the recommendations of Local Healthwatch.

(Source – expanded from the NHS Standard Contract, with new provisions for ICP Contract)

SC2 The Population and the list of Registered Service Users

27 This provision, taken with the detail set out in Schedules 2A and 2B of the Particulars, defines the population and geographical area to be served by the ICP. Note that the population may be described differently for NHS and local authority services. For the purposes of healthcare services, the population to be served by the ICP will comprise everyone registered with the ICP (or with practices integrated with it) and everyone else permanently or temporarily resident in the relevant geographical area and not registered with a GP practice which is not the ICP or a practice integrated with it.

It makes clear that, where the ICP is commissioned to provide core primary medical services, it must accept onto its registered list all permanent and temporary residents of the relevant geographical area, and may accept people who are not permanently or temporarily resident. It also makes clear that the ICP must make available to everyone within the defined population all healthcare services which are within the scope of the local contract, as appropriate for the needs of each individual.

(Source – new addition for the ICP Contract, with elements from draft Directions)

SC3 Improving the Health of the Population

28 This provision sets out key responsibilities of the ICP for assessing population needs, addressing inequalities in health, wellbeing or outcomes, maximising disease prevention and ensuring timely diagnosis and prompt access to clinically appropriate treatment and care. The provision also requires the ICP to have in place information systems and data sharing arrangements which allow for risk stratification and targeting of care interventions.

(Source – new addition for the ICP Contract)

SC4 Care Tailored to Individual Needs

29 This provision sets out requirements on the ICP in terms of

- ensuring that people have a choice of readily-accessible locations at which to receive primary medical care services during normal working hours and that its other services are sufficiently accessible
- offering sufficient bookable and same day appointments, including at evenings and weekends
- organising care in an efficient manner and communicating appropriately with people and their carers, particularly in relation to the development of personalised care plans

- agreeing and implementing plans for the roll-out and operation of personal budgets (covering health care and, where appropriate, social care) to people with long-term conditions
- offering choice to service users wherever practicable, and ensuring that, where the legal right of choice of provider applies, people are offered this choice (including as to GP)
- assignment of an accountable GP
- identifying and monitoring people living with frailty

(Source – new addition for the ICP Contract, including elements adapted from the NHS Standard Contract and from draft Directions)

SC5 Regulatory Requirements

30 This provision requires the ICP to comply with the requirements of regulatory or supervisory bodies (such as NHS Improvement or the Care Quality Commission), to respond to the recommendations arising from any audit or incident report and to have regard to (or comply with where mandatory) guidance issued by NICE.

(Source – NHS Standard Contract)

SC6 Service Standards

31 This requires the ICP to meet appropriate standards, including the national and local quality and outcome standards relating to healthcare services set out in the relevant Schedules (Schedule 5 A, B and C). (The national standards referred to include those in the NHS Constitution relating to access and waiting times.) The ICP must also meet local requirements relating to public health and social care, where relevant.

(Source – adapted from the NHS Standard Contract)

SC7 Clinical and Service Governance

32 This requires the ICP to put in place an effective system of clinical governance and to ensure that it continuously reviews and evaluates the services it provides and makes ongoing improvements to services, reflecting the lessons learned from feedback, complaints, serious incidents, and surveys. The ICP must implement policies for reviewing death occurring under the ICP care, and must comply with national guidance on learning from deaths.

(Source – adapted from draft Directions and the NHS Standard Contract)

SC8 Commissioner Requested Services / Essential Services

33 The Commissioner Requested Services (CRS) regime, overseen by NHS Improvement, is aimed at ensuring the continuity of healthcare services which have been designated as essential by commissioners in the event of the provider of such services facing serious financial difficulty. The Contract wording simply requires the ICP to comply with its obligations under this regime.

34 The CRS arrangements apply to NHS Foundation Trusts and non-NHS providers, but not to NHS Trusts. For a situation where the ICP is an NHS Trust therefore the Contract sets out alternative provisions which allow a subset of essential services to be identified and a continuity plan to ensure their continued availability to be recorded (at Schedule 2G and 2H respectively).

(Source – shortened from the NHS Standard Contract)

SC9 Staff

35 These provisions require the ICP to ensure that:

- its services have sufficient appropriately qualified and experienced clinical and non-clinical staff
- staffing levels are planned and monitored and that the impact of staffing on service quality and outcomes is continuously reviewed
- staff have appropriate access to induction, professional development, training and appraisal
- proper pre-employment checks are carried out in accordance with both NHS and local authority requirements
- there are effective procedures in place through which staff can raise concerns about the safety and quality of services, with the ICP having a Freedom To Speak Up Guardian in place (any additional local authority requirements may be specified in Schedule 2J to the Contract)
- Social care staff are registered and certified with Skills for Care.

36 The provisions also require the ICP to put in place and implement a staff transition and development programme (Schedule 9A) – that is, a local plan covering (as necessary) the training, development, physical relocation and reorganisation of staff over time to meet the requirements of the new care model.

(Source – hybrid from draft Directions and (chiefly) amended NHS Standard Contract)

SC10 Co-operation

37 The provision places broad requirements on the ICP and the commissioners to co-operate with each other to ensure that standards of care provided are consistently high, that care is well co-ordinated across different pathways and providers, with good continuity of care for people receiving services, and that value for public money is maximised.

(Source – NHS Standard Contract)

SC11 Referral and Booking

38 These provisions deal with how the ICP is to receive and accept referrals for healthcare services and allow appointments to be booked into its services. ('Referral', as defined in the Contract, is essentially about a person's first contact with the ICP for a particular condition or care pathway; this can include a self-referral

or emergency presentation).

39 The provisions require that the ICP must accept clinically appropriate referrals into its services, in accordance with any referral protocols or clinical thresholds which may be set out in the contract locally (for instance in the Service Specifications at Schedule 2C or within Other Local Agreements, Policies and Procedures at Schedule 2J).

40 The provisions require that, in some instances, the ICP must also accept referrals into its services for people whose Responsible Commissioner is not a party to the particular ICP Contract (in other words, patients from more distant CCGs). This provision applies where acceptance of a referral is necessary to give effect to a person's legal right of choice of provider or in response to an emergency referral or presentation – so this provision would be relevant where, for example, mental health services are within the scope of the ICP. (Note: this does not mean that these out-of-area referrals are to be treated within the whole population annual payment. The ICP will be entitled to payment from the Responsible Commissioner.)

41 The provisions then further require that:

- the ICP offers patients an online booking facility for appointments in primary medical care services, with sufficient appointment slots available
- (under the partially-integrated model only) the ICP makes its services available to receive bookings from GPs and other primary care referrers through the NHS e-Referral Service, and uses reasonable endeavours to ensure that integrated GPs make referrals through that service
- where the ICP wishes to make an onward elective referral to a different provider, this is done wherever possible through the NHS eReferral Service.

(Source – hybrid from draft Directions and amended NHS Standard Contract)

SC12 Withholding and/or Discontinuation of Service

42 These provisions make clear that the ICP must not withhold a service from, or stop providing a service to, someone where to do so would be contrary to law or good clinical practice. But where (in cases of abusive, violent or threatening behaviour or other risk to staff) the ICP is forced to withhold a service temporarily, the Contract wording requires the ICP to make appropriate arrangements to resume delivery of services to such individuals promptly.

(Source – shortened and amended from the NHS Standard Contract)

SC13 Unmet Needs

43 This provision requires the ICP to notify the commissioner if it identifies an unmet need for health and social care (in respect of an individual or a group of people) – that is, a need which is beyond the scope of the services which the ICP itself is commissioned to provide and also beyond the scope of other services which the commissioner has commissioned and which the ICP could refer into. It is then the commissioner's responsibility to determine any further action.

44 For the partially-integrated ICP model only, further provisions in this section set out arrangements for onward referral, requiring the ICP to seek the agreement of the person's GP before referring the person on for non-immediate or routine treatment or

care that is not directly related to the condition which was the subject of the original referral.

(Source – amended from the NHS Standard Contract)

SC14 Public Involvement and Surveys

45 These provisions require the ICP to:

- involve and engage local people (both registered patients and others), its staff, primary care referrers and local community and voluntary sector organisations, particularly in considering and implementing developments to and redesign of services
- provide all assistance reasonably required by commissioners in relation to the latter's statutory duties to carry out formal consultation on proposals for service reconfiguration
- to operate the Friends and Family Test, seeking to maximise patient responses
- to carry out appropriate staff surveys and any other surveys (as set out in Schedule 7E).

(Source – hybrid from draft Directions and amended NHS Standard Contract)

SC15 Transfer of and Discharge from Care

46 These provisions set out requirements on the ICP when it is discharging patients from its care or transferring them to another provider. Under the provisions, the ICP must:

- have regard to relevant national guidance on discharge arrangements
- use its best efforts to support safe, prompt discharge from hospital and to avoid emergency readmissions
- where transferring a patient to another provider, agree and implement a patient-specific care transfer plan.

47 For the partially-integrated model, additional conditions apply, covering the requirement for the provision of a discharge summary or clinic letter to the GP and for supply of medication on discharge from inpatient care or following clinic attendance. (These are not necessary in the fully-integrated model, because the primary and community services are then within the same provider organisation).

(Source – amended from the NHS Standard Contract)

SC16 Service User Health Records

48 These provisions require the ICP to maintain patient health records on electronic systems which enable ICP staff to record and view clinical information about patient care. Note that these provisions reflect the requirements of the new General Data Protection Regulation: the new data protection regime which applies from 25 May 2018: see further below.

49 This section also requires that the ICP's clinical IT systems must have the necessary

open interoperable interfaces to allow key clinical data to be shared appropriately with healthcare professionals in other providers.

50 This section also sets out specific requirements for the ICP to:

- upload appropriate clinical information to, and enable relevant staff to view, each patient's Summary Care Record
- ensure consistent use of the NHS Number
- enter into a data-sharing agreement with other providers of urgent and emergency care services
- comply with existing requirements relating to the electronic transfer of patients' primary medical care records.

51 Finally, this section requires the ICP to put in place and implement an IT Development Programme (recorded at Schedule 10B), setting out its intentions for the developing, over time, the capability of its clinical and business intelligence systems.

(Source – hybrid from draft Directions and amended NHS Standard Contract)

SC17 Equity of Access, Equality and Non-Discrimination

52 These provisions require the ICP to avoid discrimination and to comply with the obligations set out in the Equality Act 2010. The ICP must also make reasonable adjustments for patients who do not speak English well or who have communication difficulties and implement the national workforce equality standards for race and (if the ICP is an NHS Trust or Foundation Trust) disability (reflecting the position under the current NHS Standard Contract).

(Source – NHS Standard Contract)

SC18 Other Local Agreements, Policies and Procedures

53 The Contract allows the parties to record other local agreements, policies and procedures at Schedule 2J. These could, for instance, be referral protocols or anything else which the parties may find it helpful to record within the local contract. The effect of the wording of Service Condition 18 is simply to give those agreements contractual force, meaning that each party must comply with any obligations set out in those documents.

SC19 Service Development and Improvement Plan

54 A Service Development and Improvement Plan (SDIP) is a written plan, agreed between the commissioner and the ICP, setting actions to be taken to improve any aspect of the services. If agreed, an SDIP would be included within the local contract at Schedule 7D. SDIPs may be agreed at any time to address local priorities, but NHS England may also from time to time mandate the agreement of SDIPs to cover specific policy priorities. The effect of the wording of Service Condition 19 is simply to give SDIPs contractual force, meaning that each party must comply with any obligations set out in an SDIP.

(Source – NHS Standard Contract)

SC20 Services Environment and Equipment

55 These provisions require the ICP to make sure that the premises in which services are provided and the equipment used are fit for purpose and that staff receive appropriate training in the use of equipment.

56 They also require the ICP to put in place (if required by commissioners) and implement a Services Environment Development Plan (recorded at Schedule 10A), setting out its plans for the utilisation and development of its estate.

57 New provisions, applicable if the ICP is an NHS Trust or Foundation Trust, restrict the operation of lawyers and claims management business on ICP premises.

(Source – amended from the NHS Standard Contract)

SC21 Duty of Candour

58 These provisions require the ICP to comply with statutory 'duty of candour' requirements to be open and transparent with people and their families about any problems or incidents which arise with their care.

(Source – NHS Standard Contract and draft Directions)

SC22 Complaints and Investigations

59 This section requires both the commissioners and the ICP to publish and operate appropriate complaints procedures. There are further requirements on the ICP in relation to the way in which complaints procedures must be publicised to people and their families.

(Source – hybrid from draft Directions and amended NHS Standard Contract)

SC23 Incidents Requiring Reporting

60 This section requires the ICP to comply with the NHS Serious Incident Framework and the Never Event Policy Framework.

(Source – hybrid from draft Directions and amended NHS Standard Contract)

SC24 Safeguarding, Mental Capacity and Prevent

61 These provisions set out requirements on the ICP in relation to its policies and procedures on adult and child safeguarding and its arrangements for meeting its obligations under the Mental Capacity Act, including requirements for staff training in both areas. This section also requires the ICP to comply with national guidance on implementation of the Government's Prevent (anti-radicalisation) strategy.

SC25 Emergency Preparedness, Resilience and Response

62 This section requires the ICP to comply with national guidance on emergency

preparedness, to put in place both an Incident Response Plan and a Business Continuity Plan and to provide appropriate support and assistance to the commissioners in the event of a public health emergency or incident. In respect of acute services, this section sets out particular requirements (as per the generic NHS Standard Contract, recognising the specific role of acute service providers in responding to emergencies and incidents).

(Source – NHS Standard Contract)

SC26 Other National Policy Requirements

63 This section sets out brief requirements on the ICP relating to the identification and operation of places of safety for patients with mental health problems; arrangements for infection control; arrangements for pastoral and spiritual care; arrangements for sustainable development, including action on carbon reduction; food standards (for patients, visitors and staff); involvement in and support of clinical networks, national audit programmes and (reflecting recent changes to the generic NHS Standard Contract) approved research studies; and the care of dying people.

It also includes new requirements around urgent access to mental health services, particularly for young people.

(Source – NHS Standard Contract)

SC27 Death of a Service User

64 These provisions set the reporting and other obligations of the ICP in relation to people who die.

(Source – hybrid from draft Directions and the NHS Standard Contract)

SC28 Certificates and Provision of Information to a Relevant Person

65 These provisions require the ICP to issue relevant medical certificates. (Source – hybrid from draft Directions and the NHS Standard Contract)

SC29 Prescribing

66 Under these provisions, the ICP must:

- comply with a number of specific requirements in relation to the prescribing of medication
- publish its formulary and ensure that it makes available all relevant treatments recommended in positive NICE Technology Appraisals.

(Source – hybrid from draft Directions and the NHS Standard Contract)

SC30 Further Miscellaneous Requirements in relation to Primary Medical Services

67 These miscellaneous provisions apply only to primary medical care services and set

out, for instance, arrangements for telephone services, including ensuring people are not charged a premium rate for calls.

(Source – draft Directions)

General Conditions

68 The overall purpose of the General Conditions is to set out necessary contract management processes and generic legal requirements. The General Conditions also contain a full list of the defined terms used in the Contract.

GC1 Definitions and Interpretation

69 Throughout, the Contract uses a range of capitalised 'defined terms'. For each defined term there is a definition set out in the Definitions and Interpretation section of the Contract (at the end of the General Conditions). This provision simply states that the Contract must be interpreted in accordance with these detailed definitions. It also sets out the order of precedence of the different sections of the Contract in case of conflict or inconsistency between them.

(Source – NHS Standard Contract)

GC2-4 Effective Date and Duration, Service Commencement, Transition Period

70 These provisions:

- set out the date on which the Contract becomes effective and the date on which it expires (the actual dates themselves are recorded in the opening section of the Particulars)
- require the ICP to satisfy any Conditions Precedent (set out in Schedule 1A) and to commence delivery of the services on the later of the Expected Service Commencement Date (set out in the opening section of the Particulars) or the day after the date on which all the Conditions Precedent are satisfied
- require the parties to implement any specific Transition Arrangements (in relation to mobilisation of the services under the new contract) which have been agreed and recorded at Schedule 2K.

(Source – NHS Standard Contract)

GC5 CCG Membership

71 This provision, which only applies under the fully-integrated model, requires that the ICP must be a member of each CCG which is a party to the contract.

(Source – draft Directions)

GC6 Co-ordinating Commissioner and Representatives

72 This provision identifies that (where there is more than one commissioner

organisation which is party to the Contract) one of those commissioners will act as Co-ordinating Commissioner acting as agent of the all the commissioners in undertaking a variety of contract management roles. Each individual commissioner remains a separate party
to the contract and separately responsible for its own actions and financial liabilities. The provision also requires that each commissioner and the ICP will nominate a representative to act as their key contact for day-to-day contract management. (The names of the Co-ordinating Commissioner and the Commissioner and Provider Representatives are set out in the opening section of the Particulars).

(Source – NHS Standard Contract)

GC7 Review

73 This provision allows for the Co-ordinating Commissioner and the ICP to hold meetings to review and discuss any matters in relation to the Contract. The standard frequency of Review Meetings is set out separately in the opening section of the Particulars. Urgent review meetings can also be called by either party on five days' notice.

(Source - NHS Standard Contract)

GC8 Contract Management

74 These provisions set out the processes by which the performance by each party of its obligations under the Contract can be managed. The separate steps involved are, in short:

- issuing a Contract Performance Notice (indicating that one party believes the other to have breached a contractual obligation)
- holding a Contract Management Meeting to discuss the Contract Performance Notice
- where necessary, undertaking a Joint Investigation to establish whether a contractual requirement has been breached
- agreeing and implementing a Remedial Action Plan (RAP) to put right any breach that has occurred.

75 By agreement, a RAP may set out financial consequences (for either commissioner or ICP) which apply where there is a subsequent breach of the agreed RAP.

76 The Contract provisions set out further circumstances in which, having gone through the contract management process, the Co-ordinating Commissioner may withhold funding from the ICP. This is the case where either:

- the parties have not been able to agree a RAP due to any unreasonable behaviour by the ICP; or
- a RAP has been agreed without specific financial consequences; the ICP breaches this and fails to remedy the breach even after the Co-ordinating Commissioner has issued an Exception Report to the ICP board detailing this failure.

77 In these situations, the Contract provisions allow the Co-ordinating Commissioner to withhold from the ICP reasonable and proportionate sums up to a specified maximum level. Initially, such withholding is temporary, with the sums repaid once the breach has been remedied. However, where the ICP remains in breach of a RAP

four weeks after the Co-ordinating Commissioner has issued an Exception Report, the sums withheld may be retained permanently.

(Source – NHS Standard Contract)

GC9 Information Requirements

78 These provisions

- require the ICP to comply with NHS information standards and to submit data and provide information and reports to national bodies and to commissioners locally (in line with the detailed requirements set out in Schedule 7A). Note that a number of these requirements are derived from the draft Directions, reflecting requirements on all GP practices.
- introduce the concept of an Information Breach (broadly, a failure by the ICP to comply with the requirements of General Condition 9 and Schedule 7A) and allow the Co-ordinating Commissioner to withhold or retain reasonable and proportionate sums in respect of Information Breaches
- enable the parties to agree, at any time, a Data Quality Improvement Plan (to be included at Schedule 7B).

(Source – shortened from the NHS Standard Contract; draft Directions)

GC10 Monitoring Activity

79 In comparison to the generic NHS Standard Contract, the ICP Contract focusses less on monitoring volumes of patient activity delivered, given the Whole Population Annual Payment approach and focus on outcomes. The provisions in this area are therefore more streamlined than those under the generic NHS Standard Contract, but they allow the parties, if they wish, to agree an Indicative Activity Plan (setting out, at Schedule 2E, the expected number and case mix of patients to be treated by the ICP's different services each year) and Activity Planning Assumptions (setting out, at Schedule 2F, the underlying factors which will influence the level of activity, such as referral volumes) – and to monitor actual activity against plan.

(Source – shortened and amended from the NHS Standard Contract)

GC11 Payment Terms

80 These provisions set out the arrangements under which the ICP will be paid by the commissioners. The provisions:

- describe the Whole Population Annual Payment (WPAP) (set out in Schedule 4A) and how it is to be adjusted over time (set out in Schedule 4B)
- set out the process and timescales for up-front monthly payments on account to be made by the commissioners, with a subsequent monthly process for reconciliation and validation of the final level of payment
- set out (provisional) arrangements for payment in respect of activity-based and other payment streams which are outwith the WPAP
- set out a process for dealing with contested payments and require additional interest

to be paid on late payments

- require commissioners to apply any financial sanctions set out in Schedules 5A, B, C and E in respect of breaches of national and local quality and outcome standards (except in specific situations where the ICP is receiving funding from the national Sustainability and Transformation Fund). The position on Never Event sanctions (ie their omission) is in line with the current generic NHS Standard Contract
- require the ICP to administer and collect all statutory charges which patients are liable to pay, including under the overseas visitor charging regulations
- require the ICP to co-operate with the Nationally Contracted Products Programme, to make full use of NHS-wide buying power, and reflect the generic NHS Standard Contract requirements regarding purchase of high cost drugs and devices and adalimumab
- require the ICP to use only NHS England commissioned Genomics Laboratory Hubs for relevant tests.

(Source – hybrid from draft Directions and shortened/amended NHS Standard Contract, plus new content specific for the ICP Contract)

GC12 Quality Incentive Schemes

81 These provisions set out the process through which the ICP can earn payment under CQUIN. National guidance on this Scheme is available here: https://www.england.nhs.uk/nhs-standard-contract/cquin/

82 The detailed arrangements allow for the detail of the CQUIN Scheme to be set out at Schedule 5D, including the level of any payments to be made in advance. They require the ICP to submit reports to the Co-ordinating Commissioner, showing its progress against the Scheme and set out a process whereby the final level of payment due under the Scheme can be determined and made.

83 These provisions also provide for a locally-agreed quality incentive scheme, the details of which are to be set out in Schedule 5C.

(Source – NHS Standard Contract and new addition for the ICP Contract)

GC13 Gain/Loss Share Arrangement

84 The Contract enables the parties to agree a gain-and-loss-share arrangement in relation to the commissioners' level of expenditure on acute hospital or other services – reflecting and incentivising the role an ICP may play in prevention of disease and ill-health and in ensuring patients are treated in the most suitable setting. The details of the operation of this arrangement, to be agreed locally in line with national guidance, would be set out in Schedule 4C. General Condition 13 simply requires the parties to operate the arrangement described in the Schedule.

(Source – new addition for the ICP Contract)

GC14 Liability and Indemnity

85 These provisions:

- require the ICP to indemnify the commissioners against losses (broadly defined) which the commissioners may suffer as a result of the ICP's negligence or breach of Contract

and vice versa

- require the ICP to put in place (and to ensure that any sub-contractors it employs also put in place) appropriate indemnity arrangements in respect of employers' and public liability and clinical and professional negligence. This means that it is the ICP's responsibility to ensure all employees have clinical negligence cover, and to pay for this cover or reimburse employees where they have secured the cover themselves. Cover for clinical negligence liabilities must be by way of CNST/CNSGP membership where available.
- require the ICP to ensure (and demonstrate to the Co-ordinating Commissioner) that the indemnity arrangements it has put in place in respect of clinical negligence will cover a period of 21 years following termination or expiry of the Contract.

(Source – NHS Standard Contract and draft Directions)

GC15 Assignment and Sub-Contracting

86 These provisions set out obligations on the ICP and the commissioners as to the extent to which they may transfer, assign or sub-contract to other bodies their rights and obligations under the Contract.

87 The ICP may not assign or novate the Contract without the approval of the Co-ordinating Commissioner, who may require any replacement ICP to provide a guarantee from its parent or another party as a condition of giving that approval.

88 In respect of sub-contracting by the ICP, the provisions:

- require that the decision by the ICP to let a sub-contract is subject to the approval of the Co-ordinating Commissioner and (where relating to primary medical services) NHS England
- impose further restrictions on sub-contracting of primary medical services, consistent with current GMS/PMS requirements (including those relating to sale of goodwill)
- state that such approval may also cover the terms and form of the proposed sub-contract
- set out that, as a condition of approval, the sub-contractor may be required to sign a Direct Agreement with the commissioners (under which – in the event of financial failure of the ICP organisation – the commissioners can automatically become the direct commissioners of the sub-contracted services, thus protecting service continuity)
- allow the commissioners to require a sub-contractor to be appointed, removed or replaced in specific circumstances – for example, where existing arrangements are failing
- make clear that the ICP remains responsible to the commissioner for the performance of any sub-contractors it employs.

(Source – hybrid from draft Directions and amended NHS Standard Contract)

GC16 Variations

89 This section deals with how the local provisions of the Contract may be varied during its term. The key points are these.

- The Contract distinguishes between those elements which may be varied by the parties locally (the bulk of the content of the Particulars) and those which may not (the General Conditions and Service Conditions – unless, in the case of the latter, to reflect a change to the scope of services).
- NHS England may at any time publish a National Variation to the national terms of the Contract; failure by the ICP to accept a National Variation may lead to termination of the local Contract.
- The parties may record, at the commencement of the Contract, a series of Scheduled Variations (at Schedule 8) which the Co-ordinating Commissioner may then enact at its discretion. These are pre-planned changes to the scope and scale of the Contract – such as the intention, for example to bring additional services into the ICP's scope at a particular point in the future. It is essential, under the Public Contracts Regulations 2015, that such planned future changes are set out clearly in the Prior Information Notice or Contract Notice published by the commissioner at the outset of its procurement process and in the Contract itself.
- Otherwise, General Condition 16 sets out a process by which either party can propose, and the parties can together agree and implement, variations to any of those elements of the Contract for which local variation is permitted. The wording makes clear that such variations must be agreed by all parties; they cannot be imposed.
- However, the Co-ordinating Commissioner may require a variation to the Commissioners' Service Requirements or the Provider's Service Proposals where that is necessary to deal with inconsistencies between them or with poor performance.

(Source – expanded from NHS Standard Contract)

GC17 Dispute Resolution

90 These provisions set out a process for the resolution of any disputes which may arise once the Contract has been signed. The process involves three stages:

- escalated negotiation, involving senior staff within each party not previously involved in discussions about the disputed issue
- mediation by the Centre for Effective Dispute Resolution (CEDR) (or an equivalent independent body) or arranged jointly by NHS England and NHS Improvement if all parties are NHS bodies.
- expert determination, under which an expert in the relevant field, identified and agreed locally between the parties or nominated by CEDR, reviews submissions from the parties in relation to the disputed issue and gives a final and binding judgement on the appropriate outcome.

(Source – NHS Standard Contract)

GC18 Financial Transparency and Audit; Transparency of Earnings

91 These provisions:

- require the ICP to produce an audited Financial Business Plan in relation to its performance of the Contract at the start of the Contract, to be updated and audited annually to demonstrate that it remains accurate and based on reasonable and

prudent assumptions. This plan will provide the benchmark for consideration of variations to service requirements and adjustments to the WPAP

- oblige the ICP to operate an open-book accounting process vis-à-vis the commissioner, providing periodic audited financial statements of actual income and outgoings in relation to the Contract
- require the ICP and any sub-contractors to publish annually all of the following information:

- average annual GP earnings (as required under current primary care contracts)
- actual annual remuneration of directors (or equivalent) and the ratio of median annual staff remuneration to annual remuneration of the highest-paid director, (in line with the requirements on NHS providers under Department of Health and Social Care accounting rules)
- earnings of any employee earning above £150,000 (we acknowledge that local authority commissioners may wish to specify their own transparency requirements, if more stringent)

require the ICP to publish on its audited Financial Business Plan, its audited financial statements, and each monthly Service Quality Performance Report, on its website.

(Source – new addition for the ICP Contract, in part reflecting draft Directions)

GC19 Undertakings in Relation to Financial Matters and Assets

92 This section includes provisions which:

- require the ICP to maintain a register of the assets used for delivery of the services and place certain restrictions on the disposal of those assets
- prohibit the ICP from making material acquisitions or investments other than in accordance with the Financial Business Plan without Commissioner consent
- place controls on the ICP's ability to terminate, change or deal with key agreements which it has entered into in support of the Contract
- require the ICP to pass all Contract revenues through an approved bank account

These provisions are designed to provide assurance to commissioners as to the ongoing viability of the ICP and service continuity, and as to how the WPAP is used, and are applicable whether the ICP is to be a statutory body or an independent sector organisation.

(Source – new addition for the ICP Contract)

GC20 Not Used

93 Not used.

GC21 Inspection and Quality Audit

94 These provisions:

- set out arrangements under which national regulatory and supervisory bodies, commissioners and their representatives can enter the ICP's premises for the purpose of observing, auditing or inspecting the premises and the services being provided

- require the ICP to implement and/or respond to relevant recommendations made in any report by a national regulatory or supervisory body or as a result of any audit
- require the ICP to implement an ongoing programme of clinical audit and report on this to the Co-ordinating Commissioner
- allow the Co-ordinating Commissioner to appoint an auditor to audit any aspect of the ICP's performance under the Contract, including the clinical services provided and the charges made for these.

(Source – hybrid from draft Directions and shortened NHS Standard Contract provisions)

GC22 Suspension

95 Under these provisions, the Co-ordinating Commissioner is able – in specific, defined circumstances – to require the ICP to suspend provision of a particular service (for instance, where there are material concerns about the safety of the service). Provision of the service may then only be recommenced once the ICP can demonstrate that it can provide the service to the required standard. For the period for which the service is suspended, the commissioners may make an appropriate reduction in the amount they pay to the ICP.

As an alternative, or in addition, to suspending the relevant services, the Co-ordinating Commissioner may require the removal or replacement of a sub-contractor, the appointment of one or more new sub-contractors, the agreement of a remedial action plan, and/or to be represented at Provider board meetings at which the issues in question are to be discussed.

(Source – from the NHS Standard Contract, with additional content)

GC23-25 Termination, Consequence of Expiry or Termination, Provisions Surviving Termination

96 General Condition 23 sets out the circumstances in which the Contract may be terminated by either party before its expiry date and the process to be followed for termination to be effected. The provisions allow for termination on a no-fault basis by either party, with a notice period determined locally (sufficient to allow for recommissioning and transition, as necessary) and recorded in the Particulars. They also allow for termination with immediate effect in specific instances of default, either by the ICP or by the commissioners. Note that in the case of the ICP, these events of default now include one linked to enforcement action relating to personal data breaches, in line with Cabinet Office recommendations. Note also that the default event relating to the NHS pension scheme is mirrored by one relating to the relevant local government pension scheme.

97 General Condition 24 deals with what happens when the Contract expires or is terminated. The provisions place a requirement on the ICP to assist the commissioners in managing the transition to a new provider, ensuring continuity of service provision. They require both parties to implement any Exit Arrangements – which may include financial arrangements (agreed locally and recorded in Schedule 11).

98 General Condition 25 confirms that any rights, duties or obligations which are expressed to survive (or which by implication survive) the expiry or termination for

any reason of the Contract, together with all indemnities, will continue after expiry or termination, subject to any limitations of time expressed in the Contract.

(Source – amended from the NHS Standard Contract)

GC26 Employment or Engagement following NHS Redundancy

99 These provisions relate to situations where the ICP intends to employ, in relation to healthcare services, an individual who has recently received a redundancy settlement after being made redundant from a Very Senior Manager position within an NHS organisation. The provisions effectively require the ICP to ensure that, if it does employ such an individual, arrangements are made for the repayment of the redundancy settlement, either in full or in part, based on a formula set out within the Contract wording.

(Source – NHS Standard Contract)

GC27 Confidential Information of the Parties

100 These provisions allow management information shared by one party with the other to be identified as confidential and then set out circumstances in which such information may and may not be disclosed by the party which receives it.

(Source – NHS Standard Contract)

GC28 Patient Confidentiality, Data Protection, Freedom of Information and Transparency

101 These provisions:

- set out detailed requirements on the ICP in relation to information governance and the protection of personal confidential data
- describe the responsibilities of the ICP to assist the commissioners in complying with their disclosure obligations under the Freedom of Information Act and the Environmental Information Regulations.

Note that these provisions, and the related Schedule 7I and defined terms, accommodate the requirements of the General Data Protection Regulation, which came into effect on 25 May 2018, reflecting changes those made to the generic NHS Standard Contract in 2018 following consultation.

(Source – amended from NHS Standard Contract)

GC29 Intellectual Property

102 These provisions set out the arrangements for managing the intellectual property rights (IPR) of either party. In essence the provisions state that no party will acquire the IPR of any other party but that each may use the other party's intellectual property – in the ICP's case for the sole purpose of providing the services, in the commissioners' case for the exercise of any of their statutory functions.

(Source – NHS Standard Contract)

GC30 NHS Identity, Marketing and Promotion

103 These provisions require the ICP to comply with the NHS Identity Guidelines (including for instance use of the NHS logo).

(Source – NHS Standard Contract)

GC31 NHS Counter Fraud and Security Management

104 This section sets out requirements on the ICP for ensuring that it has adequate counter-fraud arrangements in place and cooperates appropriately with NHS Protect.

(Source – NHS Standard Contract)

GC32 NHS Accounting

105 We have included provisions here highlighting the need for the ICP to provide certain accounting information to DH if it is a body within the DH group for accounting purposes. We will be working with DH to refine these requirements over the coming months.

(Source – new addition for ICP Contract)

GC33 Change in Control

106 These provisions require prior agreement of the Co-ordinating Commissioner to a change in voting control of the provider entity which holds the ICP Contract, or of a Material Sub-Contractor (except where that entity is a public company or in the case of a change in membership or constitution of a local authority); the ICP must notify the Co-ordinating Commissioner of other changes in who owns or directs any interest in the ICP or a Material Sub-Contractor.

(Source – amended from the NHS Standard Contract)

GC34 – 47 Miscellaneous provisions

107 These legal 'boilerplate' provisions cover a number of different areas. For instance, they set out how conflicts of interest are to be managed; they define certain 'prohibited acts'; they set out the contractual position in cases of force majeure; they describe situations in which third parties may exercise rights under the Contract; and they define how formal notices under the Contract are to be served. We have added a new requirement obliging the ICP to co-operate with any local authority commissioner in relation to its Best Value duty.

(Source – largely from the NHS Standard Contract)

Particulars

108 The Particulars contain all the sections which require local input, including details of the parties to the Contract, the service specifications and schedules relating to payment, quality standards and reporting. The tables below describe, for each Schedule in the Particulars, the content which is expected to be included.

Schedule 1 – Service Commencement and Contract Term

A	**Conditions Precedent**	Insert here details of any documents that must be provided and/or actions which must be completed by the ICP before it can start providing services.
B	**Commissioner Documents**	Insert here details of any specific documents that have to be provided by the Commissioner(s) to the ICP prior to Service Commencement.
C	**Extension of Contract Term**	Record here any provision made locally (as part of an open procurement process) for the duration of the Contract to be extended.
D	**Key Documents**	Include here supporting contracts and other arrangements which are not to be varied, terminated etc without the consent of the Co-ordinating Commissioner.

Schedule 2 – The services

A	**The Population**	Include here details of the population which the ICP serves. Note that the Population may be defined differently for healthcare services and for public health and social care services, reflecting statutory responsibilities of CCG and local authority commissioners.
B	**The Contract Area**	Include here a locally-determined map outlining the geographic area which the ICP serves. Note that the Contract Area may be defined differently for healthcare services and for public health and social care services, reflecting statutory responsibilities of CCG and local authority commissioners.
C	**Service Specifications**	

C1	**Commissioners' Service Requirements**	Include here local descriptions of the services to be provided by the ICP, to the level of detail seen as desirable by the commissioner. These may cover inputs, volumes and/or clinical outcomes. They must make clear which services are in scope and out of scope and must define clearly the services to be provided by the ICP and how the ICP should support the activities of the CCG and/or Local Authority Commissioners. Separate requirements may cover healthcare services, public health services and social care services acknowledging the needs of local authority commissioners to provide for certain obligations to apply only in relation to healthcare services, or only in relation to public health and/or social care services. This is not intended to detract from the need to deliver services on an integrated basis.
C	**Service Specifications**	
C2	**Provider's Service Proposals**	Include here how the provider intends to satisfy the commissioners' requirements at C1 above. These proposals should be developed and agreed through the course of the procurement process (and might be varied by agreement at different points during the term of the Contract). Separate proposals may cover healthcare services, public health services and social care services acknowledging the needs of local authority commissioners to provide for certain obligations to apply only in relation to healthcare services, or only in relation to public health and/or social care services. This is not intended to detract from the need to deliver services on an integrated basis. As an alternative to separate Commissioners' Service Requirements and Provider's Service Proposals, Schedule 2C may instead set out Service Specifications which draw on both the Commissioners' requirements as stated in procurement documents and the Provider's proposals put forward during the procurement process.
C3	**Excepted [Healthcare] Services**	List here those healthcare Services other than primary medical essential services which the parties have agreed that the ICP will not be required to provide to members of the Population who are not permanently or temporarily resident in the Contract Area.
D	**Development Plan for Personalised Care**	If it has been agreed locally that the ICP is to play an active role in the provision and implementation of personalized care, personal health budgets, personal budgets for social care and/or

		integrated personal budgets, set out here the specific actions required of both the ICP and Commissioners.
E	**Indicative Activity Plan**	Include here, if desired, locally-determined indicative volumes of activity expected to be undertaken by the ICP in different services (for purposes of monitoring, not payment).
F	**Activity Planning Assumptions**	Include here, if desired, locally-determined assumptions (about demographic change, disease prevalence, clinical need, referral and treatment rates) which will influence demand for the service the ICP provides.
G	**Essential Services**	List here Essential Services (identified by commissioners locally) (NHS Trusts only – CRS regime applies to other providers).
H	**Essential Services Continuity Plan**	Include here the ICP's Continuity Plan for Essential Services (NHS Trusts only – CRS regime applies to other providers).
I	**Clinical Networks**	Set out here any Clinical Networks in which the Provider is required to participate.
J	**Other Local Agreements, Policies and Procedures**	If there are specific local agreements, policies and procedures with which the ICP and/or Commissioner(s) are to comply, enter details of them here.
K	**Transition Arrangements**	There may be certain things that need to be done before the Service Commencement Date in order that services commence smoothly. Details of any such arrangements should be inserted here.
L	**Transfer of and Discharge from Care Protocols**	Include here any local protocols with which the ICP must comply.
M	**Safeguarding Policies and Mental Capacity Act Policies**	Include here any local policies with which the ICP must comply.

Schedule 3 – Integration Activities (partially-integrated ICP only)

A	**Integration Activities**	Include here a locally-drafted description of how the ICP will work with local GP practices (and perhaps with providers of other local health and care services) to ensure that Services delivered under the ICP Contract are appropriately integrated with services which continue to be delivered by local practices (and/or other providers). This should be consistent with the Integration Agreements entered into by the ICP and partially-integrated GP practices (and/or other providers).
B	**Integration Goals**	Include here the underpinning goals which the ICP is intended to pursue in terms of integration of its services with GP services (and/or other services).
C	**Integrated Practices**	List here the GP practices with which the ICP is to integrate. It is the aggregate of these Integrated Practices' patient lists that will largely define the patient population to be served by the ICP under the partially integrated model (at least for healthcare services – see above).
D	**Integration Providers**	List here providers of other health and social care services with whom the ICP must integrate.

Schedule 4 – Payment

A	**Whole Population Annual Payment**	Describe here the opening Whole Population Annual Payment, allocated between: Part A: The Healthcare Services Part B: The Public Health and Social Care Services
B	**Adjustment of Whole Population Annual Payment**	Describe here agreed arrangements by which the different elements of the WPAP identified in Schedule 4A will be periodically adjusted – for scheduled and unscheduled variations and for other factors.
C	**Activity-Based Payments and Other Payment Streams**	Describe here any activity-based payments – eg in relation to vaccination programmes – which will form potential (conditional) ICP income streams outside the WPAP.
D	**Gain/Loss Share Arrangement**	Describe here the gain-and-loss-share arrangement in relation to the commissioners' expenditure on acute hospital and/or other services (or cross-refer to a separate gain/loss agreement).

E	**Local Variations**	Insert here the completed NHS Improvement template for each Local Variation to national prices and/or national currencies reflected in the WPAP (or in Activity-based payments) and any subsequent adjustment to it.

Schedule 5 – Quality Requirements

A	**Operational Standards**	These are NHS Constitution and equivalent standards, to be included as relevant to the services within scope of the ICP (as indicated by the key in the right hand column).
B	**National Quality Requirements**	These are further nationally-set quality standards, to be included as relevant to the services within scope of the ICP (as indicated by the key in the right hand column).
C	**Local Quality and Outcomes Requirements Incentive Scheme**	Include here details of any locally-determined quality and outcomes requirements.
D	**Local Quality Incentive Scheme**	Include here details of any locally-determined quality incentive scheme.
E	**CQUIN**	Include here details of the CQUIN scheme to apply to the ICP.
F	**Clostridium difficile**	This sets out the arrangements for determining any financial sanction in relation to cases of clostridium difficile which applies to an ICP which provides acute inpatient services.

Schedule 6 – Governance

A	**Documents Relied On**	Identify here any documents, consents or certificates that have been relied on by any party in deciding whether to enter the Contract.
B1	**Provider's Material Sub-Contractors**	Include here details of any sub-contractors which the commissioners have designated as material to the ICP's service model.
B2	**Sub-Contractor Direct Agreement**	Include here the template Sub-Contractor Direct Agreement (to be entered into between the Commissioner(s), the ICP and the Sub-Contractor).

Schedule 7 – Contract Management, Reporting and Information Requirements

A	**Reporting Requirements**	This sets out nationally-mandated requirements for central submission of datasets and local submission of datasets and Contract reports by the ICP to the commissioner. Additional local requirements can be added as necessary.
B	**Data Quality Improvement Plans (DQIP)**	DQIPs can be added to the Contract as and when agreed locally.
C	**Incidents Requiring Reporting Procedure**	Insert here the details of the agreed procedures for reporting, investigating, and implementing and sharing lessons learned from Serious Incidents, Reportable Patient Safety Incidents and Other Patient Safety Incidents.
D	**Service Development and Improvement Plans (SDIPs)**	SDIPs can be added to the Contract as and when agreed locally.
E	**Surveys**	Insert here the requirements for frequency, reporting and publication of mandated surveys and any additional locally agreed surveys.
F	**Provider's Financial Business Plan**	Include here the ICP's proposed financial business plan.
G	**Provider Data Processing Agreement**	For use when (as is likely to be the case) the ICP is to process data on behalf of the commissioners for the purposes of the Contract. This sets out the detailed arrangements under which the ICP will act as data processor on behalf of the commissioners. The Annex must be populated locally.

Schedule 8 – Scheduled variations

A	**Scheduled Variations**	Describe here any planned variations which are known at the outset of the Contract and which may be implemented at the commissioners' discretion at particular points – potentially covering new services being brought into ICP scope, for instance.

Schedule 9 – Staff

A	**Staff Transition and Development Programme**	Include here the ICP's plan for training, development, location and organisation of staff over time to meet the requirements of the new care model.
B	**TUPE**	This sections sets out nationally mandated requirements in relation to staff transfers under TUPE.
C	**Pensions**	Insert here locally-determined provisions relating to access to NHS and/or Local Government pensions schemes for ICP staff. Guidance relating to suitable provisions in respect of the NHS Pension Scheme is available via NHS England's website.

Schedule 10 – Services Environment Development Programme and IT Development Programme

A	**Services Environment Development Programme**	Include here the ICP's programme for developing its physical premises in order to be able to deliver the new care model.
B	**IT Development Programme**	Include here the ICP's programme for developing its IT capabilities in order to deliver the new care model.

Schedule 11 – Exit Arrangements

	Exit Arrangements	Include here details of practical and financial arrangements to take effect on expiry or termination of the Contract.

Schedule 12 – Guarantee

	Guarantee	Include here the Template Guarantee which may be required to be provided as a condition of consent to assignment or change in control.

Schedule 13 – Local System Operating Plan Obligations

Local System Operating Plan Obligations	Include here any specific obligations which either the Provider or any Commissioner has undertaken to perform as part of STP/ICS arrangements.

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