CCG roles where ICPs are established

NHS England and NHS Improvement

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Integrated Care Provider (ICP) Contract – supporting document

Publishing approval number: **000502**

Version number: 1

First published: August 2019

Updated: September 2019

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Introduction

1 The commissioning of Integrated Care Providers (ICPs) would have implications for Clinical Commissioning Groups (CCGs). While some ICPs may lead to a shift in the activities of both providers and commissioners, CCG statutory functions will not change.

2 The High Court has now provided guidance on this matter.[1] In summary, the Court has confirmed that, in principle, the integration of health and social care via a single provider of care (an ICP) where that provider has a substantial degree of autonomy over health care choices and resource allocation:

- **a)** is within the statutory powers of a CCG
- **b)** does not represent the unlawful delegation to ICPs of non-delegable functions or preclude CCGs from fulfilling their statutory functions
- **c)** is not contrary to the commissioner-provider split under the National Health Service Act 2006.

3 While CCGs' roles will continue to evolve, there will remain a need for an effective commissioning function in the NHS and CCGs need to ensure that they have the capacity and capability to continue to discharge their functions once an ICP is established. The NHS Long Term Plan describes how CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation.

4 This paper describes some implications for CCGs in commissioning an ICP. It:

- **a)** describes how CCGs will continue to be responsible and accountable for the delivery of their statutory duties and powers.
- **b)** defines CCG activities and suggests criteria that CCGs may wish to use in making judgements about the activities that ICPs may be commissioned to undertake.
- **c)** sets out the legislative framework for pooling budgets for NHS, social care and public health services – recognising that CCGs and local authorities may agree locally to commission an ICP to deliver social care and/or public health services alongside NHS services.

CCG statutory functions

5 Legislation sets out:

- **a)** the statutory duties of CCGs – the 'must dos' that they are legally responsible for delivering
- **b)** the statutory powers of CCGs – the things that they may do.

[1] See R (on the application of Dr Colin Hutchinson and Others) v Secretary of State for Health and Social Care and the National Health Service Commissioning Board [2018] EWHC 1698 (Admin).

6 In this paper we use the term 'function' to describe these statutory duties and powers.

7 As noted above, the High Court has now provided helpful guidance about the statutory framework. In R (on the application of Dr Colin Hutchinson and Others) v Secretary of State for Health and Social Care and the National Health Service Commissioning Board [2018] EWHC 1698 (Admin), the Court held the following, amongst other things (N.B. The references in square brackets are to paragraph numbers in the judgment):

a) Nothing in the 2006 Act "restricts the ability of a CCG to appoint single providers covering the entirety of a relevant locality" [para. 115(ii)]. Under the statutory framework, "CCGs have a broad power of arrangement and are required to act innovatively in this respect" [para. 115(ii)].

b) Arranging, via a commissioning process, to award a contract covering "the whole of a CCG's geographical territory" to a "single entity" for the "full suite of health services for which a CCG is responsible is also within the statutory powers of a CCG" [para. 115 (iii)]. Whether a CCG decides to use a contract of this breadth will depend on many factors, including the CCG's "assessment of local need and how it can be best" be met [para. 115 (iii)].

c) Nothing in the 2006 Act prevents a CCG from entering a contract which requires the provider to arrange for the provision of health care services through sub- contracting [para. 115(iv)].

d) The High Court further held in relation to a previous iteration of the contract that "nothing in the … contract[2] either represents the unlawful delegation… of non-delegable functions or has the effect of precluding CCGs from fulfilling their statutory functions" [para. 115(vii)]. The [contract] "recognises the non-delegable nature of the CCG functions and it includes measures (e.g. monitoring, supervision and enforcement) specifically designed to ensure that [the provider] act in a manner consistent with the CCG's functions" [para. 115(vii)]. The ICP Contract retains the above elements in fundamentally unaltered terms.

Activities of CCGs

8 CCGs will continue to be responsible for the delivery of their functions. They have flexibility to decide how far to carry out activities related to these functions themselves, including in groups (e.g. through lead CCG arrangements); or through external commissioning support. They may also require, through contract provisions, an ICP to take action to support the discharge of certain CCG duties (e.g. to reduce inequalities or ensure patient choice). However, in all these instances the CCG will retain responsibility for its functions. These cannot be delegated. As part of the process of commissioning an ICP, CCGs would need to assure themselves of their retention of and ability to discharge their statutory functions.

9 In making judgements about the activities that may be carried out by ICPs, CCGs may wish to use the following criteria as a guide:

a) Consider whether the CCG must carry out the activities related to the discharge of a particular statutory function directly. For example, whilst all

[2] The Judge was referring to the previous version of the ICP Contract, published August 2017 and known as the draft ACO Contract. This was materially the same as the ICP Contract.

providers need to have in place arrangements to deal with complaints, so too must CCGs. Similarly, a CCG has a responsibility to produce an annual plan setting out how it proposes to exercise its functions. It cannot contract this out to a provider.

b) The CCG should be mindful that any activities undertaken by the ICP will only relate to services provided by that ICP. If those activities need to be carried out in relation to services for other patients, or care pathways delivered by another provider, the CCG will need to retain the capacity to carry out equivalent activities in respect of those other services or (where appropriate) obtain it from elsewhere.

c) The CCG should ensure that the ICP would be able to undertake the activities necessary to carry out its role and to enable the CCG to fulfil its functions. For example, if a provider is given an integrated budget it would need to have a clearly defined remit within its contract setting the parameters within which it may spend that budget and the flexibilities it has within those parameters. In this respect, the ICP would be in a similar position to providers under existing NHS Standard Contracts.

d) The CCG should ensure that it has the resourcing capacity and capability to fulfil (i) and (ii) above, particularly where some CCG staff may be transferred to an ICP.

10 CCGs and ICPs should maximise opportunities for making shared use of administrative resources. For example, creating and operating successful ICPs will require a new set of information management and analytical approaches to be adopted by both CCGs and providers. These include population-level predictive analysis to monitor care patterns, assess adherence to protocols and best practices, and to anticipate future needs. CCGs and ICPs should look at how they might work together to develop a shared business intelligence capability rather than invest in potentially more costly separate functions. The same applies to other back-office functions e.g. payroll. Conflicts of interest would need to be managed carefully.

11 The ICP Contract stipulates some requirements of ICPs which will, subject to the above described statutory constraints, include:

- the requirement to conduct a population health needs assessment and to develop strategies to improve the health and wellbeing of the population
- the requirement to seek to address underlying health inequalities
- the need to put in place information systems and risk stratification
- obligations to offer patient choice, including choice of primary care provider.

12 CCGs have enquired whether it would be possible for an ICP to manage third party contracts concerning services that are unrelated to those commissioned from the ICP. CCGs should maintain responsibility for making procurement decisions about these third party contracts (especially where the ICP may be an interested party) and must ensure that they maintain the in-house capacity and capability to oversee them. It will also be important to ensure that any role undertaken by an ICP to support the management of such contracts is free from conflicts of interest and a Chinese wall may need to be created for that purpose.

13 We have considered a number of ways in which ICPs may be able to support the management of third party contracts, for example:

- receiving notifications and reports from providers
- analysing data from providers for the purposes of reporting to the CCG in

order to inform its future commissioning intentions (subject to careful consideration of any potential conflict of interest / commercial confidentiality issues).

14 However there are activities around the management of third party contracts which should not be undertaken by ICPs, either because these are likely to create actual or perceived conflicts of interest or because they would not allow the CCG to retain appropriate oversight of these contracts, for example:

- carrying out discussions with suppliers in relation to contract terms and conditions
- conducting discussions with suppliers in relation to their performance against the terms of their contracts.
- taking any contractual action on behalf of the commissioner.

15 CCGs will also wish to consider the willingness of the third party provider to be managed by and share information with the ICP, given its role as a significant provider in the local health economy.

16 We have also been asked about the position regarding Individual Funding Requests (IFRs). Commissioners should retain decision making responsibility for IFRs. Where commissioners have contracted with Commissioning Support Services providers to support their IFR function, these arrangements may be maintained. ICPs could give input into the IFR process by providing information and representations, including in relation to the decision making process and framework, but they should not have decision making responsibility. CCGs and ICPs will need to agree which party will bear the cost of services provided in response to IFRs.

17 CCGs may want to consider whether the establishment of an ICP means that it would be appropriate to pool functions and management arrangements with neighbouring CCGs and/or local authorities. In some cases the CCG may want to consider merging with another CCG. The requirements and procedures for CCG mergers are set out in Procedures for clinical commissioning groups to apply for constitution change, merger or dissolution. However, regardless of transfers, pooling arrangements or constitutional changes, as explained above each CCG will retain responsibility for performance of its functions and there must be sufficient CCG resources and systems in place to perform these functions.

18 NHS England would look for assurance from CCGs that their future arrangements are robust and viable. The Integrated Support and Assurance Process (ISAP) for novel and complex contracts will support CCGs to run effective procurements and manage system risk, where new and complex contracts, such as those for ICPs, are proposed.[3]

19 We have previously worked with a number of new care models vanguards to consider how ICPs may undertake activities that are currently undertaken by CCGs, in order to manage whole pathways of care and a capitated budget. A summary of that exercise is attached at Annex A and is provided as an aid for local judgement.

[3] The ISAP guidance documents can be found on the NHS England website: https://www.england.nhs.uk/publication/integrated-support-and-assurance-process/ (Information accessed 17 July 2018)

Pooled budgets

20 The establishment of ICPs will require providers to deploy integrated budgets flexibly. To enable this, CCGs may wish to pool budgets with other commissioners.

21 The current legislation under the NHS Act 2006 enables some NHS bodies to establish pooled budgets across NHS England and CCG functions. Where social care and/or public health services are to be commissioned from an ICP alongside NHS services, CCGs will need to consider how they partner and pool budgets with local authorities. Section 75 of the NHS Act 2006 and regulations made under it allow CCGs and local authorities to pool budgets to commission services, and for NHS organisations to commission or provide services on behalf of local authorities (or vice versa). However, the legislative mechanism by which funds may be pooled, and the partners involved, are different, depending on the specific function and bodies involved. This means that commissioners of ICPs may choose to structure their arrangements in a variety of ways, depending on what they want to achieve. Annex B describes how different commissioning structures can commission different configurations of services.

Annex A: Commissioning activities

This list is not a comprehensive statement of CCG functions and activities. It is intended to provide a prompt for local discussions about the split of activities between the CCG and an ICP. In each case, responsibility for the function itself must remain with the CCG.

Activity/function that the CCG is responsible for	Description	Can the ICP undertake activities to support delivery? If so, how?
Strategic planning		
Assessing needs		
Population needs assessment	CCGs are obliged (with local authorities) to produce joint strategic needs assessments ("JSNA") (under section 196(1) of the 2012 Act) and joint health and wellbeing strategies ("JHWS") (under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007). The JSNA, and other needs analysis and horizon scanning, should be used to provide an understanding of population needs and expectations. Needs assessment should involve clinicians, patients and the public and should compare population data on outcomes and need against relevant benchmarks and best practice, and include an understanding of environmental and social factors as well as patient preferences.	Yes, the ICP can support the CCG in producing these assessments. Under current arrangements, providers already play a key role in providing population health data in support of the production of these assessments. ICPs will by definition usually hold contracts to deliver a greater proportion of services delivered in any one geographic area than was previously the case in that area. The larger scope of services and increased scale of provision incentivises the ICP to invest in greater levels of prevention population health analytics, particularly given its requirement to address medium-long term health and care goals and outcomes. The ICP would also need to conduct its own needs analysis to perform its contractual obligations efficiently and ensure that services are centred around the needs of the patient. This is likely to feed into the CCG's formal strategic needs assessments. ICPs are likely to have an improved understanding of their patient's health care needs, given the requirement imposed by the Contract (see Service Condition 3) on the ICP to address medium to long term health goals and outcomes and the requirement to provide a more holistic range of services.

Resource allocation and priority setting		
Commissioning: i.e. arranging for the provision of services to meet the reasonable needs of people for whom the CCG has responsibility; promoting the NHS Constitution in doing so.	Section 3 of the NHS Act 2006 requires each CCG to arrange for the provision certain health services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility. The CCG must promote the NHS Constitution in doing so.	No. The ICP could not commission services. An ICP would be able to subcontract services within the scope of what it has been commissioned to provide and the parameters of its contract with the CCG and with the permission of the CCG. In principle, this is not contrary to the statutory framework.
Allocating CCG-level resources	Deciding how to use the CCG budget in order to deliver the best outcomes for the population served. This includes setting the integrated budget for the ICP and allocating resources to services not provided by the ICP and for patients not covered by the ICP.	The CCG is responsible for deciding how best to meet the needs of the population served, commissioning a model of care designed to meet those needs, and deciding what flexibilities the provider(s) of that care should have as to the way in which services are delivered. The CCG determines the overall funding dedicated to any contract, building in projections about population age, disease morbidity and expectations around demand. That does not mean that no provider can take decisions as to resource allocation or care design. Providers already make day to day decisions on treatment and resource allocation across their service portfolios. They already allocate clinical and management resources in respect of those services in the manner that the provider determines will best meet the needs of its patients, as long as it is able to meet the core operational standards and quality requirements associated with the services in question. Existing arrangements do not require providers to account for what they spend on contracted services. This provides a deliberate and operationally necessary flexibility, from time to time, to ensure operational standards, quality requirements, and additional

		contractual requirements continue to be met. This will continue with ICPs, which will be expected to allocate their budgets in order to deliver the outcomes detailed in its contract, within the parameters specified in that contract (which will be developed and agreed locally) and ensure that its allocation is used in an effective, efficient and economical way to deliver patient-centred services.
Mandated expenses	Responsibility for ensuring that funding is provided for any in-year commitments made by the government or NHS England.	Yes, ICPs could have a role in flowing down mandated expenses to subcontractors.
Procuring services		
Designing services		
Annual commissioning plan	Each CCG must publish an annual plan setting out how it proposes to exercise its functions pursuant to section 14Z11 of the 2006 Act.	No.
Strategic planning of services across the CCG patch	Taking a holistic view of service provision, incorporating ICP and non-ICP services, developing cross-system plans, vision and accountability centred around the needs of its patients.	Yes, the ICP should decide how best to configure and provide services that it is contracted to deliver, within the parameters set in its contract. It should also use data to stratify risks and target interventions and ensure that services are designed around the needs of patients. The ICP would also be required to take steps to ensure its services integrate with those provided by others.
Shaping structure of supply		
Managing and developing the supply chain for services provided across the CCG's area (including across the ICP)	Stimulating the market to ensure there are a number of high-quality options for patients available when commissioning services, and that there are alternative providers available in the event of provider failure.	Yes, the ICP should stimulate the market to ensure there are a number of high-quality options available when it is sub-contracting services that it is contracted to provide in order to best meet the needs of its patients.
Procurement of health services (as well as the ICP) by the CCG	Decisions relating to the award of clinical and non-clinical contracts across the CCG (including the ICP Contract). This activity involves ensuring that all applicable	The ICP would not have a role in the commissioning of services by the CCG. However, the ICP should be responsible for all sub-contracting that it opts to carry out within the parameters set out in its contract subject to the CCG's permission.

	procurement law and guidance is followed.	
Operational management		
Planning capacity and managing demand		
Demand management across the CCG	Putting in place actions across the CCG to control levels of demand on particular services (e.g. emergency services).	Yes, the ICP should create and manage demand management plans for their populations to enable patients to make appropriate choices.
Service development		
Engagement and consultation on service change proposals.	Section 14Z2 obliges CCGs to involve the public in the planning, development, consideration of and decisions upon service change proposals.	Yes, it is likely that ICPs would be involved in service re-design and potentially change the method or point of delivery for some services within parameters set in their contracts. Public involvement on such changes may be required by ICPs and the public and patients should be central to decision making. ICPs should develop new ways to involve their population in the design and use of services.
Service delivery		
Integrating the provision of services across the CCG	A CCG has a duty to exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would improve the quality of those services (including the outcomes that are achieved from their provision).	Yes, the ICP should put in place smooth pathways between services provided by (and sub- contracted by) the ICP. In practice, the integration of services cannot be achieved without the involvement of providers. Indeed, currently providers will often set up joint organisational structures with CCGs to achieve more integrated services e.g. through an “alliance agreement”. The key element of change in an ICP scenario is that the ICP will hold responsibility for a wide range of services itself. Organisational barriers will be removed, and even where these are replaced with subcontracting relationships, the ICP will be able to put in place smooth pathways between services provided by (and sub-contracted by) the ICP.
Addressing health inequalities	CCGs are obliged to have regard to the need to reduce health inequalities under section 14T of the NHS Act 2006.	Currently, this statutory duty to address health inequalities is exercised in a number of ways – most obviously by commissioning services to address particular areas of need. A CCG can arrange for health needs assessments (discussed above) to identify the primary drivers of health inequalities, and it will use this intelligence to make

		decisions about the commissioning of services. The ICP Contract (at Service Condition 1.2) imposes a specific obligation on the ICP to have regard to the need to reduce health inequalities when performing its obligations under the ICP Contract. This does not in any way absolve the CCG of responsibility for its statutory duty, but merely imposes a contractual obligation on the ICP which supports the CCG's discharge of that statutory duty. Through working with GPs more closely, an ICP is likely to have greater opportunities than other NHS providers to target interventions on the reduction of health inequalities and develop a joined up system which meets the needs of patients. This enhanced expectation is set out in the ICP Contract (see Service Conditions 1.2 and 3).
Ensuring efficient use of funds		
Planning of cost improvement schemes across the CCG	Development of schemes to improve efficiency and reduce cost pressures in the CCG budget.	Yes, the CCG may request information, input or ideas as to how cost improvements could be made. Providers, including the ICP, are well placed to offer these.
Implementation of cost improvement schemes related to health services (including the ICP) commissioned by the CCG	The implementation of cost improvement schemes which relate to services commissioned across the CCG, including the ICP.	Yes, CCG's cost improvement schemes may require changes in behaviour from the ICP in order to be successful e.g. changes in referral behaviour.
Decision making relating to funding routes	Decisions relating to who pays, who the responsible commissioner is and what the most appropriate funding stream for care provided to different patients is e.g. continuing health care assessment.	Yes, where appropriate (i.e. because it covers a pathway delivered by the ICP or involves one of the ICP's patients) the ICP should provide evidence to inform such decisions.
Implementing patient centred care		
Pathway planning, signposting to services and care navigation across the CCG	Supporting people to access and navigate well planned pathways for health and social care services across the CCG area.	Yes, the ICP should support the CCG in planning smooth pathways built around the needs of individuals that incorporate services provided by the ICP and other providers.

Patient choice	CCGs are obliged to ensure patient choice in certain circumstances by section 14V of the NHS Act 2006 and the NHS Constitution.	Yes, the ICP must ensure that, having chosen to access their services, people are offered appropriate levels of choice if they are referred on e.g. by a GP into elective care services. People should also be offered a choice of GP. Service Condition 6 of the NHS Standard Contract requires the provider to comply with relevant guidance regarding patients' rights to choice of provider and consultant. The ICP Contract, at Service Condition 4.15, imposes equivalent obligations on the ICP, but also goes further, in acknowledgement of the systemic role of the ICP and its role in relation to primary medical services, as described above.
Personalisation, person centred care (including self-care and realising the value) and personal health budgets	Ensuring that, where appropriate, patients are offered personal health budgets or integrated personal commissioning. People receiving NHS Continuing Healthcare (or continuing care in the case of children) have the legal right to a personal health budget. Ensuring that people with long term conditions and low knowledge, skills and confidence (activation) are identified and supported to take control of their own health and wellbeing through access to personalised care and support planning and activities such as self-management education, health coaching and peer support.	Yes, the ICP should support people who wish to have a personal health or integrated personal budgets. Where an ICP is involved in NHS Continuing Healthcare, they should include the option of personal health budgets and make people aware of them. ICPs should identify and support people with long term conditions and low knowledge, skills and confidence to take control of their own health and wellbeing.
Monitoring and evaluation		
Managing performance		
Development of outputs, outcome measures and monitoring	Develop, measure and monitor the outcomes against which the performance of the ICP will be assessed and against which decisions on payment	No. The CCG must continue to perform its statutory function to arrange the provision of services, including by monitoring the performance of the contract in accordance with the contract

	will be made.	management provisions of the ICP Contract. These are the same as or more extensive than those in the generic NHS Standard Contract.
Contract management for services within and outside of the ICP scope	Using performance data to assess compliance with the terms of the contracts signed by providers (including the ICP). Applying penalties as necessary and agreeing remedial actions where providers are not compliant.	Yes, the ICP would be responsible for managing any contracts it has with sub-contractors. This would not, by definition, include services outside of the ICP scope, or services provided by the ICP itself. In short, the ICP cannot contract manage itself. Under current lead provider arrangements, it is standard practice for a CCG to monitor and manage the lead provider, and for the lead provider to monitor and manage the organisations to which it subcontracts. If an ICP has subcontracting arrangements in place, as is likely across a range of services, the ICP would assume responsibility for the management of subcontractors, in the same way as current providers are responsible for their range of subcontracts.
Quality monitoring / contract management of sub-contracted Services	Ensuring that any services that are sub-contracted by the ICP meet the same quality standards as expected of ICP- delivered services.	Yes, quality monitoring of the services being delivered through a sub-contract should be carried out by the ICP as the contract holder.
Oversight and management of system performance	Taking responsibility, as system leader, for the overall performance of the whole local health system, not just the performance of individual providers/ services within the system.	The ICP would only be responsible for the performance of the services it delivers and sub-contracts.
Oversight of risk and reward mechanisms	Using the contract to put in place mechanisms which spread risk between the CCG and the ICP and which incentivise desired behaviours and performance by using appropriate rewards.	No. While it is not appropriate for the ICP to have oversight of reward mechanisms it may seek to influence them through the contract negotiations (to the extent permitted by public procurement rules). Separately, the ICP may wish to design and implement incentive schemes for its sub- contractors.
Seeking public and patient views		
Management of FOI requests	Responding to Freedom of Information requests	Yes, the ICP should provide data/respond as appropriate. If the ICP

and provision of data for responses	and/ or providing the necessary information for others to respond to jointly.	is a public body the Freedom of Information Act will apply to it directly.
Complaint handling	Receiving, distributing and responding to complaints received about services commissioned by the CCG, including those provided by the ICP.	Yes, the ICP should respond to complaints in the same way that other providers have a responsibility to respond (or should provide the necessary information for the CCG to respond).

ANNEX B: How different commissioning structures can commission different configurations of services

This non-exhaustive table (which aims to simplify a complex legislative framework) should be used as a guide only and local commissioners should seek their own advice when entering into local arrangements.

What services do I want to commission from an ICP?	What commissioners need to be involved (see note 1)?	How can I pool the budgets to create an ICP budget for a fully integrated ICP?	Are there any restrictions?
A: A new care model providing primary medical services, community health services and acute care	A single CCG	This is generally not possible as funding for primary medical care is ring- fenced under the Delegation Agreement (but see note 2) The CCG would need to establish aligned budgets for the ICP (which can have a single contract), to ensure that primary medical care funding remains ring-fenced within the ICP's total budget	Yes Funding for primary medical care is ring-fenced under the Delegation Agreement
B: A new care model providing primary medical services, community health services, acute care, social care and LA commissioned public health	A single CCG with one or more local authorities	This is generally not possible as funding for primary medical care is ring- fenced under the Delegation Agreement (but see note 2) Funding for the other services can be pooled under a s75 Partnership Arrangement Subject to restrictions (see right), this can include: some CCG functions and specified local authority health-related functions. The CCG would need to establish aligned budgets for the ICP (which can have a single contract), to ensure that funding for primary medical care and invasive procedures remain ring-fenced within the ICP's total budget	Yes Funding for primary medical care is ring-fenced under the Delegation Agreement Some functions cannot be part of a s75 partnership arrangement (see note 3)

What services do I want to commission from an ICP?	What commissioners need to be involved (see note 1)?	How can I pool the budgets to create an ICP budget for a fully integrated ICP?	Are there any restrictions?
C: A new care model providing community health services, social care and LA commissioned public health	One or more CCGs with one or more local authorities	Under a s75 Partnership Arrangement	Some functions cannot be part of a s75 Partnership Arrangement (see note 3)
D: A new care model providing community health services, acute care, social care and LA commissioned public health	One or more CCGs with one or more local authorities	Under a s75 Partnership Arrangement Subject to restrictions (see right) this can include: some CCG functions and specified local authority health-related functions The CCG would need to establish aligned budgets for the ICP (which can have a single contract), to ensure that funding for invasive procedures remain ring-fenced within the ICP's total budget	Yes Some functions cannot be part of a s75 partnership arrangement (see note 3)
E: A new care model providing primary medical services, community health services, acute care, social care, LA commissioned public health and s7A public health services	A single CCG with one or more local authorities and NHS England (see note 4)	Currently not possible in respect of funding for s7A publich health functions as this is ring-fenced and excluded from s75 agreements Funding for primary medical care is also fin-fenced under the delegation agreement The CCG would need to establish aligned budgets for the ICP (which can have a single contract), to ensure that funding for primary medical care, s7A public health services and invasive proceures remain ring-fenced within the ICP's total budget	Yes Some functions cannot be part of a s75 partnership agreement (see note 3)

What services do I want to commission from an ICP?	What commissioners need to be involved (see note 1)?	How can I pool the budgets to create an ICP budget for a fully integrated ICP?	Are there any restrictions?
F: A new care model providing primary medical services, community health services, acute care, social care, LA commissioned public health and specialised services (see note 5)	A single CCG with a local authority and NHS England	This is not possible as funding for primary medical care is ring- fenced under the Delegation Agreement Funding for the other services can be pooled under a s75 Partnership Arrangement Subject to restrictions (see right) this can include: some CCG functions; specified local authority health-related functions; and specialised services (although most specialised services are excluded from the scope of s75 given the exclusion of invasive treatments) The CCG would need to establish aligned budgets for the ICP (which can have a single contract), to ensure that funding for primary medical care and invasive procedures remain ring-fenced within the ICP's total budget	Yes Some functions cannot be part of a s75 partnership arrangement (see note 3)

Note 1 – This table assumes that the CCG has been granted delegated responsibility for commissioning primary medical care.

Note 2 - For the early ICP sites, we will consider amending the delegation agreement on a case-by-case basis to allow primary medical care funding to be pooled with funding for other services, including local authority services through a s75 agreement where these are in scope.

Note 3 – NHS functions which currently cannot be part of a s75 partnership agreement:

- surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments
- s7A public health services
- primary dental services
- pharmaceutical services
- primary ophthalmic services
- emergency ambulance services

Note 4 – It is not possible for s7A functions to be given to more than one CCG jointly.

Note 5 – CCGs wishing to include specialised services within the scope of an ICP Contract should contact their regional specialised commissioning contact in the first instance.