Dear Sir/Madam

Integrated Care Provider Contract: consultation on the draft contractual documentation

The British Medical Association (BMA) is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

The BMA has been calling for greater integration and collaboration between different parts of the health service, health and social care, as well as more integrated working across the medical profession and other clinicians for a number of years. We believe that the Five year forward view new care models, including ACO/ICPs, should be clinically led, based upon consultation with all necessary stakeholders, and should ensure true collaboration between different sectors, based upon inter-organisational partnerships.

With respect to the ICP contract, we do not believe that new contractual models are required to achieve the stated aim of service integration and that the same outcomes can be achieved using existing frameworks, as the NHS England Vanguard sites have demonstrated.

The proposed changes represent a fundamental change to the way the NHS is run, managed and delivered and should be subject to Parliamentary scrutiny, with wider consultation and much increased engagement with secondary care. The proposed ICP models have been developed within a primary care scope and simply widening the scope without widening the engagement is not appropriate.

It is therefore vital that NHS England and the Department of Health and Social Care fully engage with doctors and patients regarding the formation of new integrated providers and invites full and proper scrutiny of the current proposals. We do not believe that the current consultation process, based on the narrow technical legal aspects of required regulatory changes, properly allows this. We would therefore strongly encourage greater consultation on the wider policy aspects and potential impact of the proposals to allow for the views of patients and doctors to be fully considered.

The BMA’s response to this consultation should not be viewed as agreement that these changes are appropriate. We are deeply concerned about the introduction of new models of care,
including ICPs, without statutory footing and believe that any collaborative care system should be free from competition and the internal market. However, while we do not agree with the way in which these changes are being brought about, we have responded on whether the proposed contract operates well, and in the interests of doctors and patients.

We hope that our enclosed submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely

[Raj Jethwa]
Director of Policy
**Question 1: Should local commissioners and providers have the option of a contract that promotes the integration of the full range of health, and where appropriate, care services?**

The BMA has been calling for greater integration and collaboration between different parts of the health service, health and social care, as well as more integrated working across the medical profession and other clinicians, for a number of years. We believe that all new models of care should be clinically led, based upon consultation with all necessary stakeholders, and should ensure true collaboration between different sectors, based upon inter-organisational partnerships. We are supportive of NHS England’s intentions for improved integration of care across organisations, however we have concerns around the proposals for single contract procurement for such models.

With respect to the ICP contract, we do not believe that new contractual models are required to achieve the stated aim of service integration and that the same outcomes can be achieved using existing frameworks. ICSs (Integrated Care Systems), for example, are already in operation and, while questions remain about their development, they operate on the basis of allowing collaboration/integration with local agreements without formal contracts.

Current procurement law means that combining multiple services into one contract risks the potential for non-NHS providers taking over the provision of care for entire health economies, as the contract would be subject to open competition rules. Moreover, a single ten-year contract would force re-procurement each time and create significant uncertainty. The BMA strongly supports the ongoing provision of a publicly funded and publicly provided NHS and calls for the government to clarify what safeguards will be in place to ensure that ICPs do not enable an increase in the role of independent sector providers in the NHS. Allied to this the financial requirements that are placed on the ICP provider through the contract could automatically limit the pool of parties/providers that could legitimately enter these arrangements. The scale of the services provided under this contract are automatically restrictive in terms of the parties who could legitimately bid for and hold the contract. Assurances would therefore be required that the contract and any procurement pre-conditions will not be set to such a level that only large private corporations, or other large healthcare providers such as acute hospital Trusts, will be capable of taking this contract.

It is also important that such contracts are not tendered for locally, without full consultation and support of local clinicians and the GP practices directly affected, as well as with local union representatives and Local Medical Committees. It is noted that the contract contains provisions for ensuring public consultation in services and that CCGs retain a statutory duty for public consultation on service redesign, amongst other duties pertaining to public involvement in healthcare commissioning. We also note that additionally, due to the nature of the ICP models, GP contractors within an area will also require not only close consultation on the decision to procure an ICP contract, but an expectation that any successful tender will require the active support and participation of GP contractors in order to be viable. However, the procurement, and creation of, a new wide-ranging healthcare provider will also have a deep impact on other doctors and healthcare professionals, depending on what services are including within the scope of the contract. We would therefore similarly expect commissioners, and any NHS providers intending to integrate into an ICP, to fully consult with their respective workforces in order to ascertain support, or otherwise, before any such procurement takes place.
The above sets out our overarching position and principle. The answers to the following questions should not be taken as our primary position, but are provided to make the contract more appropriate if it were to be introduced.
**Question 2:**
The draft ICP Contract contains new content aimed at promoting integration, including:
- Incorporation of proposed regulatory requirements applicable to primary medical services, included in a streamlined way within the draft ICP Contract
- Descriptions of important features of a whole population care model, as summarised in paragraph 30

a) Should these specific elements be amended and if so how exactly? Yes/no/unsure; and please explain your response.

b) Are there any additional requirements which should be included in the national content of the draft ICP Contract to promote integration of services? Yes/no/unsure; and please explain your response.

Integration under the ICP contract has to be taken in two forms. One as ‘fully integrated’ providers, under which primary care is delivered directly under the ICP contract itself, and one as ‘partially integrated’ providers, under which primary care is still delivered under the respective GMS/PMS contracts of local practices. Whilst we note that the contractual documentation states that a primary care provider will be able to determine whether they will provide services via a fully, partially or some other model, all models appear to point to the fact that primary care providers will lose autonomy and that the services (and potentially funding) under their core contracts will be eroded. The fully integrated model suspends the core contract with no detail of how the right to return could work in practice whilst the partially integrated model will, despite its promotion, result in a loss of autonomy and the potential erosion of the core contract (see the response to question 6 for details).

It is important that ICPs are bound by the same regulatory requirements as GP practices in respect of the provision of primary care, when they provide such services directly (i.e. under a ‘fully integrated’ model). To this end, we welcome the fact that the ICP Directions mirror those Directions covering existing primary care contracts (GMS, PMS, APMS), as these must align to those applicable to the GMS / PMS to protect against a divergence in the regulations underpinning the provision of these essential services (which could lead to unintended divergence in health provision), and look forward to further detailed consultation on these. Further to this, in order to ensure consistent delivery of primary care services, we would expect either for this mirroring to continue when amendments to GMS Regulations are made in the future, or reassurance that the Regulations underpinning ICP primary care services will form part of the wider contract negotiations that NHS England will have with the BMA.

In relation to the features of whole population care models, it would be beneficial to expressly include planning and provision of public health services within this definition, including those within the scope of the ICP presently provided or commissioned by non-NHS bodies, such as local authorities. Likewise, a clear indication of the responsibility of the ICP, in relevant cases, to provide social care services would also be helpful. These would, in addition, provide greater clarity on the practical integration of care through the whole population care provider. A vital aspect missing from the descriptions within the documentation, pertains to training and education under an ICP model of provision. Links to both undergraduate education and postgraduate training are maintained by the ICP, in order to ensure adequate provision of training and workforce.
Promotion of integration under the ICP contract pertains primarily to the ‘partially integrated’ use of the contract, and we note that the contract includes stated ‘integration activities’ when the contract is used for such purposes. This includes a general provision that “The Provider must ensure that the Services are fully functionally integrated with the General Practice Services [and the Integrated Services], to the effect that the Services and the General Practice Services [and the Integrated Services] are delivered in a seamless, person-centred fashion”, with the contracting allowing more specific items, such as workforce, access and estates planning, to be further identified. Any such activities must only be with the full consent of any participating providers, such as GP practices, and their clinical staff, especially when the activities directly or indirectly affect things such as working patterns, training and clinical provision.

Whilst for associate GP practices, this should all be set out within any respective integration agreement signed by the parties, we would be cautious as to the extent to which some practices may be fully aware of details of what they are signing up to, given the current financial and workload pressures affecting GP practices, or the extent to which the ICP organisation may try to apply pressure to individual practices in order to meet its contractual requirements towards these integration objectives.

Question 3:
The draft ICP Contract is designed to be used as a national framework, incorporating core requirements and processes. It is for local commissioners to determine matters such as:
- The services within scope for the ICP
- The funding they choose to make available through the contract, within their overall budgets
- Local health and care priorities which they wish to incentivise, either through the locally determined elements of the financial incentive scheme or through additional reporting requirements set out in the contract

Have we struck the right balance in the draft ICP Contract between the national content setting out requirements for providers, and the content about providers’ obligations to be determined by local commissioners? Yes/no/unsure; and please explain your response.

Whilst the contract should allow for some degree of local flexibility in order to cater for any specific needs of local populations, the contract must contain stronger nationally agreed framework, particularly in respect of ensuring minimum levels of service provision by, and funding of, Integrated Care Providers.

Leaving both the service specification and funding requirements solely down to local determination, creates a number of risks.

Procurement of an ICP contract must not be used in any way as a cover for a reduction in services commissioned by CCGs and NHS England. Whilst local variation, to cater for specific population needs is understandable, NHS England needs to ensure that patients have appropriate access to services, no matter where they live. It will not be acceptable if commissioners exclude services from the contract, and subsequently refuse to separately commission them, due to local funding being tied up within the ICP. To ensure that patients within ICPs have as comprehensive and equal access to services as possible, the ICP contract must include a nationally defined minimum set of services, with additions and amendments to be included locally where required.
Similarly, ICPs, and the procurement of an ICP contract, must not be used as a cover for local commissioners to reduce funding for local services, or to cover up financial gaps in other parts of the local health service. With funding levels purely down to local agreement there is a risk that commissioners either try to under-price the cost of services, in order to return savings over the life of the contract, or fail to ensure that the funding for the contract rises in proportion to potential costs in the future, resulting in service becoming increasingly underfunded over time. It is also imperative that funding across England is transparent and consistent, ensuring that patients in one area should not lose out due to the commissioning or financial strategies for their local commissioning bodies, and that such bodies can be adequately held to account by doctors, patients and the public that they serve.

There needs to be a clearer understanding between those specifications/elements that will be nationally set and those that are capable of being determined locally. An obvious recent example of this is the Premises Strategy in Dudley (which is being suggested as an example of good practice for how this will work). This strategy automatically favours, to the exclusion of everyone else, their integrated care programme. Unless there are clear strategies on all aspects impacting on primary care which are inclusive of all GPs, then any suggestion that primary care providers will have the ability to determine the best model for integrating is extremely misleading. They will be forced to follow the locally prescribed route.

The contract must therefore, contain national agreed safeguards to ensure that funding levels provided under an ICP contract are such that the services provided are safe and ensure the best outcomes for patients.

**Question 4: Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers? Yes/No/unsure; and please explain your response.**

The BMA does not support the national tariff or payment-by-results, which we believe creates fragmentation and prevents collaboration between NHS providers, and would, therefore, believe that a model of funding which is based on the needs of patients and encourages closer co-operation would be more appropriate.

In respect of NHS funding alone, the model proposed in the consultation would be preferable to the existing approach, not least in bypassing the present competition between providers for resources.

However, the inclusion of social care within any pooled budget could present a significant risk. While the BMA recognises the vital role of social care within and alongside the provision of healthcare, and believes that it should be a fully funded, comprehensively provided service, we do not support the merging of NHS and social care budgets under the existing funding settlements for each sector.

Due to historic under-resourcing, the social care sector faces a reported funding gap of £2.5 billion. Any merger of funding streams could, therefore, lead to the redirection of NHS funds to plug gaps in social care and other areas. Therefore, it is imperative that NHS budgets are protected within any merger of funding streams.

Whilst it may be commissioned under one contract, the funding stream for each area should be separated out and separately negotiated.
This has multiple obvious benefits.

The first is that this avoids the very real risk of funding being eroded for core elements and/or monies being diverted away from their intended focus.

The second, which would address the concern that issues with an ICP could permeate to impact on all service areas, is that it ensures that there is an inbuilt mechanism for ring fencing risk/issues and avoids the domino effect that may otherwise apply where funding is completely centralised.

The third is that it ensures that primary care providers (whether they are fully integrated, partially integrated or otherwise) are aware of the funding elements that apply to the delivery of their services. This is key if primary care providers are to retain autonomy and either work with ICP providers in some other way or exercise their right of return (in the fully integrated model). Without the funding streams being preserved there is a huge question mark on what funding they will return to. Similarly, GP providers leaving the ICP following the initial contractual break period will face huge uncertainty over their patient numbers upon exiting the ICP contract, again creating a large amount of financial uncertainty and raising questions over how realistic any ‘right to return’ to former GMS/PMS contracts will be in reality.

Question 5: We have set out how the ICP Contract contains provisions to:
- guarantee service quality and continuity
- safeguard existing patient rights to choice
- ensure transparency
- ensure good financial management by the ICP of its resources.

a) Do you agree or disagree with our proposal that these specific safeguards should be included? Agree/ Disagree/unsure; and please explain your response.

b) Do you have any specific suggestions for additional requirements, consistent with the current legal framework, and if so what are they? Yes/No/unsure; and please explain your response.

We welcome attempts to guarantee quality and continuity of service provision and note that the requirement for transparency and financial management go well beyond the provisions within the current standard NHS contract and the respective GMS/PMS/APMS contracts. However, we would question NHS England’s ability to engage these provisions and adequately hold providers to account, especially a number of years into an ICP contract. Such providers will be responsible for the provisions of a wide part of the health economy across large geographical populations. If such providers are hit with either financial sanctions, which could threaten their stability and long-term viability, or, ultimately, with termination of the contract, continuity of care and health services across the entire area (and to tens of thousands of patients) will suffer. This will simply engender an attitude of ‘too big to fail’. Whilst we therefore welcome such contractual safeguards, we would recommend that they are adequately backed up by practical mechanisms for enforcement, and a commensurate requirement on commissioners to have fail-safes in place to ensure continued provision of service to patients in the event of contract termination or organisational failure on the part of the ICP. There is a very real danger that the impact caused by a failing ICP could, via a domino effect, spread to impact on the delivery of services that are, at present, individually
commissioned. Well led providers in all sectors (primary care, secondary acute care etc.) under robust individual contracts who have a vested and contractual interest in achieving the highest standards in their respective fields whilst working collaboratively in a manner that achieves the required aims, is far less risky as the risk of defaulting providers is ring fenced.

**Question 6:**

a) Should we create a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts? Yes/No/unsure; and please explain your response.

b) If yes, how exactly do you think we should create this?

c) Are there any specific features of the proposed options for GP participation in ICPs that could be improved? Yes/No/unsure; and please explain your response.

Yes, but this must be done in a manner where the choice of the GPs is maintained. Indeed, whilst the means for integration needs to be established the choice must remain with GPs as to how best to achieve this. GPs may well decide that the fully integrated or partially integrated models are sound, but if they don’t there is an obvious gap. We strongly reiterate that we do not believe that a new contractual model is necessary for service collaboration and integration, and we see no benefit for GP practices in signing up to such. Models of collaborative and integrated service provision are already in development in numerous areas, including NHS England’s own ‘Vanguard’ sites, which have operated without the need for a new contracting route. In such circumstances there must be a mechanism whereby the GPs can reject the proposed models and have a commitment that (i) their contracts, funding and services are ring fenced, (ii) they will have the flexibility to agree the contractual arrangement with the ICP to achieve greater integration and (iii) there will be a mechanism for them to unlock further money via (potentially) a separately commissioned contract to achieve this integration. There must also be guarantees that those that do not sign up to a proposed ICP contract will continue to receive access to and support from other services that are within the ICS – such as community nurses.

Facilitating integration in primary care doesn’t need such wholesale changes, nor does it require all practices to be part of one organisation. Closer and clinically effective collaboration can be achieved by reducing the associated risk for primary care providers. These risks (particularly those around the personal exposure of primary care contractors that operate as individuals and/or via a partnership) represent the biggest barrier to integration and indeed the recruitment of GP business owners. If this can be managed then, via their existing contractual arrangements, primary care providers would (and have shown that they will) work in close and productive collaboration. The outcomes from the GP Partnership Review may also have implications for how GP practices may wish to engage with the ICP agenda.

There must also be a commitment that local commissioning strategies will not ultimately erode the autonomy and choice of GP practices and other participating providers. The decision to participate in the contract, and what form any such participation may take, including the model of any integration must be the choice of the participating providers, including clinical staff, and clear safeguards need to be in place to protect against coercion by commissioning bodies.

Regardless of the model we would recommend that general practice and wider primary care funding and services must be ring fenced.
With regards to the proposed options for GP participation in ICPs:

**Partially integrated model.**
The most fundamental question with regards to this approach is the agreement that would be in place with the primary care providers who will retain their core contracts under the “partially integrated” model, i.e. “Integration Agreement”.

There are a number of concerns with the “Integration Agreement” as drafted. These include, without limitation:

a. The fact that the core contracts will be amended to include the “Integration Objectives” with little or no detail of what this will look like in practice. The partially integrated model (like the virtual MCP model) was always promoted as the model that will protect and preserve the core contract; clearly that is not the case. Any Integration Agreement must leave the core contract untouched so that if the ICP changes or collapses then the GP core contracts remain preserved.

Linked to the fact that core contracts will not necessarily be protected/preserved, services may be shifted between service contracts (so potentially services will shift from core GMS/PMS contracts to fall under the ICP contract and vice versa) where such shift is approved by the integration leadership team. Where they (the ICP leadership) approve such a shift, the primary care providers cannot refuse the necessary variation to their core contract. Clause 12.2 of the proposed Integration Agreement states:

> Cl 12.2: We acknowledge and accept that the Integration Leadership Team may decide that activity is shifted and that service specifications under the respective Services Contracts are varied (subject to agreement with the commissioners under the Services Contracts) in order to achieve the Integration Objectives. Where proposed variations are approved by the Integration Leadership Team, We must not refuse to propose such variations to the commissioners under Our Services Contracts.

This appears to be in outright contradiction to Clause 6.2, which protects the autonomy of individual participants within the ICP:

> 6.2 The Participants acknowledge and accept that the Integration Leadership Team is unable in law to bind any Participant so it will function as a forum for discussion of issues with the aim of reaching consensus among the Participants. The provisions of this Agreement do not affect the autonomy of any Participant or prevent any Participant from making decisions that bind that Participant.

b. The fact that there appears no money under the Integration Agreement to facilitate any such integration. What assurances do we have that GP providers will receive the necessary funding to “integrate” with the ICP provider?

c. In many ways linked to the above, the fact that it places potentially onerous obligations on the GP providers. One example:
**Cl 7.3:** The Primary Medical Services Providers must not do anything or refrain or delay from doing anything that would put the ICP in breach of the ICP Contract. The Primary Medical Services Providers must co-operate with the ICP to facilitate the delivery of the ICP Contract.

Having regard to the above, we would have serious reservations about the partially integrated model as it has the potential to erode the core contract and leave GPs, their practices and patients at risk.

**Fully integrated model.**

We retain serious doubts about the practicality of the ‘right of return’ proposals, open to GP practices should they agree to suspend their respective GMS/PMS contract and integrate fully into an ICP. Whilst, with the appropriate regulatory changes previously consulted on, it will be technically possible for a practice to return to a ‘suspended’ GMS or PMS contract there is no guarantee that the practice will return to an adequate level of funding, re-establish their practice list or rebuild their practice workforce. For example, there would be no guarantee for practices to return to their contracts for services beyond GMS/PMS (eg local enhanced services and previous CCG funding streams). It is likely that these will be contracted as part of the ICP contract, and so the practice would need to come to a subcontracting arrangement with the ICP if it wished to provide services beyond GMS/PMS. Furthermore, as the contract proposes patients stay with the ICP by default at any point beyond the initial two-year break point, there is no guarantee that practice returning to GMS/PMS would be able to survive at all. Similarly, practices that do manage to successfully leave will find themselves in direct competition for patients from a much larger organisation that would also control the area’s community nursing services. Much more detailed information and guidance on this process is required, including full details of any proposed suspension arrangements.

**Other options.** The most obvious option is to leave the primary care provision with the primary care providers who are, whether through necessity or choice, already working collaboratively to improve the provision of primary care in a manner that interlinks with community and other services. We believe it is much better to build a genuine collaboration with local GP leadership, for example via primary care networks, that is not based on a single commissioned organisation and retains independent contractor practices embedded in their local community. In raising this point, the primary care providers and any ICP should therefore have the flexibility of agreeing how best to integrate with one another. Looking at two ends of the integration spectrum:

1. **At its lowest level they may agree to a shared vision and/or ambition and work with one another via (for instance) Committees in Common whereby the necessary forum for discussing and implementing plans for furthering the provision of services to patients is created.**

2. **At the other end of the spectrum, if there is a desire to shift service provision from primary care providers to the ICP then the GMS/ PMS contract and regulations already allow for this possibility through the use of sub-contracting services whether in whole or part.**

There also remain serious concerns about attempts by local commissioning bodies to coerce GP practices into participating in an ICP in some form. Whilst we acknowledge that NHS England’s
position nationally is that such participation is optional, the centrality of GPs to ICP models means that, should commissioners wish to pursue this policy as part of their wider commissioning strategy, there is a serious temptation for them to attempt to pressure GPs into cooperating. Indeed, we have already seen example of this happening in some localities, where new funding is dependent on working in this particular way. There therefore needs to be clear and explicit instructions to local commissioners that such behaviour is unacceptable, and that an ICP must only be pursued with the full prior agreement of their GP population. In such cases where coercion is alleged to have taken place, NHS England should have available a system of investigation and redress, to ensure that the full and proper procedure had been followed, together with the mechanism for independent external scrutiny.

Question 7:
a) Do you think that the draft ICP Contract adequately provides for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services? Yes/No/unsure; and please explain your response.
b) If not, what specifically do you propose? Please explain your response.

It is welcome that the contract has provision for the inclusion of local authority services within an ICP, which should improve integration and reduce the existing fragmentation within the system. However, it is vital that these services are properly funded, and that funding intended for NHS services is not used to plug gaps in these areas.

NHS staff working in local authority services, both within an ICP and sitting outside of it, must also retain NHS terms and conditions. This is especially important in the event that any services currently provided by the NHS are provided by a local authority or other entity within an ICP contract.

In addition, under the existing terms of the contract it is clear that some health and care services may continue to be provided outside of the ICP. While the exact composition of services within an ICP contract should be determined locally, the interface between services within and without it will be pivotal to ensuring effective integration and improved patient care.

Question 8: The draft ICP Contract includes safeguards designed to help contracting parties to ensure commissioners’ statutory duties are not unlawfully delegated to an ICP:

- It provides a framework within which decisions can be taken by the ICP, based on a defined scope of services which the commissioners require the ICP to deliver
- It includes a number of specific protections, outlined in paragraph 83, which together prohibit the provider from carrying out any activity which may place commissioners in breach of their statutory duties

Are there any other specific safeguards we should include to help the parties to ensure commissioners’ statutory duties are not unlawfully delegated to an ICP? Yes/No/unsure; and please explain your response.

It is welcomed that the contract includes clarity and requirements ensuring that commissioners do not unlawfully or otherwise, transfer their statutory responsibilities onto the ICP. However, we would caution that NHS England needs to be able and willing to fully police these provisions in order to avoid any inadvertent breach. There is a clear conflict whereby the Commissioning body is responsible for ensuring that the terms of the contract are fully and appropriately met, but may itself have breached these terms by inappropriately/unlawfully delegating statutory
duties to the ICP. In these cases there needs to be a clear and persistent system whereby commissioning bodies can be properly monitored and held to account if this does take place.

**Question 9:**
The draft ICP Contract includes specific provisions, replicating those contained in the generic NHS Standard Contract, aimed at ensuring public accountability, including:
- Requirements for the involvement of the public as explained in paragraphs 89-93
- Requirement to operate an appropriate complaints procedure
- Complying with the ‘duty of candour’ obligation

a) Should we include much the same obligations in the ICP Contract on these matters as under the generic NHS Standard Contract? Yes/No/unsure; and please explain your response.
b) Do you have any additional, specific suggestions to ensure current public accountability arrangements are maintained and enhanced through an ICP Contract? Yes/No/unsure; and please explain your response.

We would expect the ICP contract to meet the same obligations as the Standard NHS Contract as a bare minimum, and we welcome that these obligations within the ICP do appear to go further than those within the NHSCSC but we believe that these should in fact go much further. The potential scope of an ICP organisation, and the service which they are commissioned to deliver under the Contract, means that the effect that the ICP can have on service design and delivery across a local health economy potentially goes much deeper than a provider operating to provide a specific service under the Standard Contract, as currently happens. We note that commissioners will still retain their existing statutory obligations with regards to public involvement in commissioning of services, once operating an ICP contract it will, in effect, be the ICP organisation that undertakes changes to the way that the services that it has been commissioned to provide under the contract are delivered. We also welcome the contractual requirement for public, staff and other providers to be fully consulted on changes to the provision or scope of services.

However, we would strongly recommend that, not only should the commissioning body be provided with evidence of such consultation, and the impact thereof, but that the provider should also have a duty to provide such evidence to those subject to the consultation on whom such service change will impact (i.e. staff, partner organisations etc.), as well as to have due regard to the results of the consultation. There also needs to be a contractual mechanism where the ICP cannot implement changes that could reasonably be expected to impact on a patients’ reasonable access to services without such consultation. There is also a need to consult with primary care providers where a change could reasonably be expected to impact on their ability to deliver services under their contract or impact on them either financially or legally.

**Question 10:**
It is our intention to hold ICPs to a higher standard of transparency on value, quality and effectiveness, and to reduce inappropriate clinical variation. In order to achieve this the draft ICP Contract builds on existing NHS standards by incorporating additional provisions describing the core features of a whole population model of care and new requirements relating to financial control and transparency:
a) Do you think that the draft ICP Contract allows ICPs to be held to a higher standard of value, quality and effectiveness and to reduce inappropriate clinical variation? Yes/No/unsure; and please explain your response.

b) Do you have any additional, specific suggestions to secure improved value, quality and effectiveness, and reduce inappropriate clinical variation? Yes/No/unsure; and please explain your response.

No. Although NHS Improvement and NHS England will have an assurance role prior to the awarding of the ICP contract, and CQC will regulate ICPs in line with their statutory duties, it is unclear what specific system regulation will be in place to ensure compliance when the ICP is in operation. Given the potential extent of services provided by an ICP, formal system regulation will be required to ensure proper oversight over the performance of an ICP and of any delegation of commissioners’ statutory duties, as well as to resolve any instances of provider failure.

Without a clear regulatory framework, especially in light of the likely restructuring of secondary care services within an ICP, it is not clear that ICPs will be held to a higher standard of transparency. It should also be noted that clinical variations will be impossible to eradicate in a model where so much is decided locally and left to the ICP to decide. This must be avoided, and adequate safeguards introduced.

There remains a gap over realistic measures that could be implemented if the ICP (or parts of it) are failing in their duties. This stems from our earlier point regarding issues having the ability to permeate across all parts of the ICP. Greater clarity is required on the realistic measures that will be introduced if issues materialise.

For example, currently, in circumstances where there is a fundamental breach of contract, patient safety and/or the commissioners are at risk of excessive financial exposure, the commissioners can terminate the contract and endeavour to find a care taker arrangement and/or a new provider.

This is simply not viable in the case for ICPs. There is seemingly no genuine practical mechanism for handling fundamental breaches in the ICP setting; it is too big an entity as presently proposed. Patients could suffer, and commissioners could be left at the mercy of organisations that are almost immune to challenge given the lack of alternatives.

An alternative approach could be to ring-fence services and funding, whereby service areas, if distinct and small enough, could be separated out and separately commissioned if problems arose.

In addition, when operating under a ‘partially integrated’ version of the contract under which GP practices remain independent and separately contracted bodies, nothing within any proposed Integration Agreements between the member parties should hold them liable for the actions of others beyond their control. Such Agreements must protect such providers from failures elsewhere within the overall ICP or wider system architecture.

Question 11:
In addition to the areas covered above, do you have any other suggestions for specific changes to the draft ICP Contract, or for avoiding, reducing or compensating for any impacts that introducing this Contract may have? Yes/No/unsure; and please explain your response.
It is recognised that the contractual Directions contain provisions to provide that such providers will employ GPs on terms no less favourable than the BMA model salaried GP contract, as per the GMS contract. It is vital that such protections are offered to all doctors employed under any ICP provider, with an adherence to nationally agreed terms and conditions in line with the rest of the NHS. Any move away from nationally negotiated working protections will be unacceptable and this should be a pre-requisite of any body providing services under the ICP contract.

It must also be recognised that a movement of GP practices within a geographical area away from GMS to the proposed ICP contract will result in a significant reduction in the statutory levy which funds Local Medical Committees. There must therefore be a mechanism within the Contract to allow the continuation of this funding, on behalf of the ICP’s constituent practices.