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NHS Clinical Commissioners
The independent collective voice of clinical commissioners

NHS Clinical Commissioners response to the consultation on contracting arrangements for Integrated Care Providers

Wednesday 31 October 2018

I. NHS Clinical Commissioners

NHS Clinical Commissioners (NHSCC) is the membership body of Clinical Commissioning Groups (CCGs). Established in 2012, we have over 91% of CCGs in membership. We offer a strong national voice for our members on specific policy issues and support them to be the best they can to commission services effectively for their local populations.

To inform our response to the consultation on contracting arrangements for integrated care providers (ICPs) we have sought the views of our wider membership and conducted interviews with members of our Board, comprised of CCG leaders across geographical constituencies, including lay members, Chief Finance Officers, Chairs (clinical and non-clinical) and Accountable Officers. We share some of the key points that have arisen from this engagement, and in addition to this written response, NHSCC would welcome the opportunity to work with NHS England as plans for ICPs develop, to ensure that the voice and experience of the clinical commissioning community can help shape this developing policy area.

II. Overarching comments

Broad support for the aims of the ICP contract and opportunities it presents, but recognition that this should not be the only option available

Our members report widespread support for the underpinning principle behind the ICP contract to integrate care around the needs of a person, which offers the opportunity to deliver a better patient experience and improved outcomes. Many of our members have already taken strides towards this goal.

However, there was also recognition that the ICP contract model should not be the only available option to enable integration, as it may not meet the needs of all systems. It also has flaws, as it stands, when aiming to include primary care services.

Benefits of the ICP contract to enable a focus on outcomes and prevention

As well as supporting the broad direction of travel, our members note features of the ICP contract that offer opportunities to transform the delivery of care. It is seen to offer a means to align incentives towards outcomes, addressing current perverse incentives in the system i.e. where providers are paid by activity, rather than reducing the need for treatment in the first place. A system focus on outcomes and population health management could enable greater investment into prevention, including in primary care and public health.

A key potential benefit of the ICP contract is that it is designed to promote an integrated service model, affording the opportunity to commission primary care alongside wider NHS services, public health and social care provision. This has the potential to further integration and the delivery of person-centred care. This potential will only be realised if the draft ICP contract and the draft Primary Medical Services (ICP contracts) Directions are sufficiently worked through and implemented correctly; we highlight some of the issues that have been raised by our members in *'III Implementation challenges to be worked through'*.

Concern that the ICP contract must not be seen as the only/default option to enable integration
While our members are supportive of the direction of travel, the majority report that they do not have plans to use the contract in the near future – either due to current system maturity, nuances of local systems, or in some cases due to feeling it is unnecessary to facilitate integration.

Many felt that the ICP contract would only be applicable to systems that are already mature in terms of integrated local system working, with Dudley being a strong example. Other local areas report being on the path to achieving this, for example one member has commissioned integrated health and social care provision over a longer-term contract of seven years, through the standard contract. Other members describe local alliance agreements which are currently working well, built on a set of shared principles and bringing together organisations including CCGs, acute trusts, local authorities and the third sector.

Several of our members report that they would like to see a number of nationally approved formal integration mechanisms, in addition to the ICP contract. These would need to accommodate issues which the ICP contract is unlikely to address. For example, one member questioned the role of the independent sector, as currently they have contracted a lead independent provider to deliver services, which doesn't align with the requirements of the ICP contract. Another member highlighted how, due to substantial overall system deficit, the ICP contract would not work for their local area – but they would welcome alternative options. For those areas where an ICP contract is not suitable, having national guidance and approved alternative options could support such areas and make efficient use of resources, rather than each local area independently having to request extensive legal advice.

Some other members highlighted current advances in system working through Integrated Care Systems, local alliance agreements, the adoption of shared control totals, and the use of Section 75 agreements to pool budgets with local authorities. For some, these advances mean that they don't feel an ICP contract is necessary to support integration in their area. Due to the diversity of views, and the varied needs and maturity of local systems, we welcome the assurance that the contract is optional; sufficient flexibility must be afforded to enable commissioners to determine how best to meet the needs of their local populations.

The ICP contract is not a means to integration – strong local relationships must come first
A contract is not in itself a means to achieve integration. It must be recognised that sufficient groundwork is required for local areas to build local trust and relationships with providers, and we know that the strength and maturity of these relationships varies significantly across local areas. NHSCC and NHS Providers have commissioned research to explore the changing nature of relationships between commissioners and providers in the context of integrated place-based commissioning, to be published

in December 2018. We would be happy to share this forthcoming work with NHS England to further shed light on key enablers and barriers to the realisation of more collaborative and integrated working, as well as the current status of local relationships.

Within the current regulatory and accountability frameworks, barriers to integrated working will remain
Without revisions to the broader regulatory environment and accountability frameworks within which organisations operate, the ability for organisations to make decisions for the best of the system, rather than just in the interests of their individual organisations, will be hindered. For example, our members highlight that due to local boards being accountable for their own organisation, well-performing organisations may be unable to take on the risk of partnering with those in more challenged positions e.g. financially. Approaches to system monitoring and regulation would need to change to facilitate sharing of system risk. Our members also feel that responsibilities for assurance and regulation need changing. A single process that covers all the health and care organisations across a place should encompass indicators that are the sole responsibility of a specific organisation within a place but also indicators that are the responsibility of every organisation across the place, to mandate 'collective responsibility'.

III. Implementation challenges to be worked through

Clear and transparent communication
Clear communication to both the public and the health community about the purpose and scope of ICP contracts is required for successful implementation. Our members note that the ICP contract consultation is document heavy and complex to navigate and whilst our members appreciate the efforts to engage early on the contract itself, there is a lot of information to absorb at this early stage of development. It may therefore be difficult for patients or members of the public to gain sufficient understanding of the contract and its implications. Given that some of our members feel that this is the 'Accountable Care Organisation (ACO) contract rebadged', public trust needs to be worked on to ensure that the same concerns that were raised in discussion about the ACO contract are addressed – transparency, and clear national and local level communication will be key.

Primary care
Our members feel strongly that primary care, including but not limited to general practice, should play a key role in local systems, however they note a number of challenges to the inclusion of GP services in particular becoming part of an ICP. There are strong pressures currently in the system, including around workforce, workload, indemnity and the partnership model, which first need to be addressed to put primary care on a stronger footing. In many areas, the delivery of primary care at scale has not yet developed – a lot of work needs to be done to first set the ground. Inclusion of primary care in an ICP contact is therefore not an immediate option for most areas.

Our members welcome the option for GPs to become either partially integrated (whereby GPs continue to deliver under existing GMS or PMS arrangements) or fully integrated (whereby primary medical services can be commissioned through an ICP contract and GPs become either salaried GPs of the ICS or subcontractors). Partial integration is seen to be a reasonable stepping stone, providing some initial protection around core services.

However, on the whole, neither fully or partially integrated models were felt to fully address the incentives that would be required for GPs to participate in ICPs. This is just one detail that will need to be worked through with primary care colleagues. Others include the need to address concerns that primary care could be destabilised, and discussion of the risk and reward share of participating primary care organisations. Our members would also welcome further information around the incorporation of primary care, including community pharmacy, eye and dental care.

Furthermore, we note that there are a number of parallel activities being undertaken in the area of primary care, and general practice in particular. It is important that these align to produce a common vision. NHSCC submitted evidence to the Independent GP Partnership Review, and the General Practice Premises Policy Review. Specific draft directions about the mandatory requirements of GP services providers who choose to participate in an ICP contract are currently out for consultation until December. The advent of Primary Care Networks is also a key issue. The ICP contract must be compatible with any future Primary Care Network contract. The publication of the long-term plan is expected to also provide crucial policy direction – primary care will need to play an integral role and at the national level, and the direction of travel needs to be clear.

Process, finance and risk

There are several challenges that need to be addressed in areas of process, finance and risk – a selection of which our members highlighted and are presented below.

The first relates to the process of implementing an ICP contract – Dudley CCG are experiencing timescales for implementation of around three years, including a lengthy Integrated Support and Assurance Process (ISAP). On the basis of the pilot in Dudley, there is potential to adapt and streamline this process – without this, systems may refrain from using the contract. Procurement remains a key issue, whereby CCGs, subject to EU legislation, have to undertake a procurement exercise. In the case of Dudley, procurement took approximately 12 months. NHSCC continues to highlight this issue and has recently produced 5 key 'asks' to enable and support integration across system and place – our below ask seeks specifically to address barriers around procurement, and for further information please find the full list of 'asks' appended to this document for your information.

> ***NHSCC enabling ask: Procurement, competition and choice***
> *Strengthen elements within Section 75 of the Act so that procurement is only needed if the commissioner cannot secure the changes needed with the providers working within the place and system. Change the rules around competition and choice so that using competitive and choice levers are only introduced if the commissioner cannot secure the transformative changes needed. Re-look at how patient choice operates by giving responsibility to the 'place' and system to work with its population to secure a mandate from them for the circumstances within which patient choice should prevail, linked to the ICS/STP strategic plan and priorities. Remove the powers of the CMA to make judgements with regard to competition between and mergers of NHS organisations.*

There is broader uncertainty surrounding the awarding of longer-term contracts of up to ten years. Given short term NHS funding cycles, and unstable funding arrangements of many smaller providers including

community sector organisations, our members question the ability of many organisations to commit to contracts of this length. The ICP contract therefore needs to build in opportunities for contract review on both sides if threshold concerns about quality/outcomes or finance are hit. To ensure a continued role for patient choice, and to avoid destabilising smaller providers, this issue needs to be worked through. Another issue surrounds resource allocation, which needs to ensure that funding goes to areas where it can have the greatest impact on population health, as opposed to plugging the deficits of providers in challenged positions.

Furthermore, not all areas have a large enough entity in place to share risk, and certain systems such as those with significant overall deficits will not be in a position to enter into the contract. It would be helpful for our members to have more information around risk and reward share in ICPs. Our members highlight the need to ensure that small providers aren't exposed to undue risk – at present they feel there is little incentive for smaller or financially stable providers to participate in an ICP contract.

Accountability and oversight

The consultation document and supporting document '*CCG roles where ICPs are established*' make clear that CCGs participating in an ICP contract will retain their statutory responsibilities. Our members see the value in CCGs requiring an ICP to take action in support of some of these functions, for example the reduction of health inequalities.

Within this context CCGs will perform a more strategic commissioning role and ICPs will take on new functions, for example analysis of population health needs, risk stratification, and resource allocation. Crucially, a balance needs to be struck between CCGs and an ICP in order to ensure that appropriate oversight mechanisms are in place, while also avoiding being overly prescriptive, in recognition that sufficient flexibility and time must be afforded to local partners to enable transformation to take place. This will be a challenging balance for CCGs to strike, and in addition to the supporting consultation document on CCG roles, our members would benefit from national guidance as to how to ensure appropriate oversight mechanisms are in place, as well as clarification over the mechanisms by which commissioners can challenge providers if outcomes are not being met. CCGs must have real power to ensure that outcomes are met, and currently there are concerns about how this could be achieved, for example noting restrictions on the use of penalty clauses.

Our members also highlight the importance of non-executives and lay members as crucial in the assurance of standards and delivery of good governance within provider and commissioner organisations. Further information about the role of non-executives and lay members within ICPs would therefore be helpful and could contribute to the enhanced levels of transparency and accountability as proposed in the consultation document. NHSCC's Lay Member Network would welcome the opportunity to work some of these issues through with our members.

Lead provider

Our members are keen to ensure that the role of a lead provider is open to a broad range of providers and not just large acute trusts who may have a proven ability to win contracts and established management capacity. Our members would like to see other providers such as mental health trusts and GP federations also having opportunities to lead ICPs, highlighting the importance of strong involvement from the community, particularly to drive forward the prevention agenda.

Support will need to be given to enable lead providers to fulfil a new role within an ICP. Our members note existing expertise in Commissioning Support Units and CCGs that could be shared with providers to develop this capacity. Many providers will not yet be well equipped to deliver population health management and risk stratification functions that will be delivered by the provider under an ICP – consideration needs to be given as to how best to support the transfer or development of this skill set.

Inclusion of local authorities

Our members are positive about the potential for ICP contracts to be used to commission integrated services, including some services which currently fall into the remit of local authorities, from a 'lead' provider that is responsible for delivering integrated services. Our members agree that the potential benefits of a population based, preventative approach will be greatest if public health and social care services are also included in an ICP contract. However, bringing together local authority and health commissioning in this way will present a number of challenges. There are key differences in local authority boundaries and those of patient flow in localities. Our members also highlighted key differences in the operation of local authorities and the health sector, in particular related to accountability and financial deficit, where local authorities are unable to run a deficit but NHS bodies can. Clarity would also be beneficial in terms of where the Better Care Fund will sit in local areas including using the ICP to deliver integrated services.

IV. For more information

If you would like any further detail on our response please do not hesitate to contact our Head of Policy and Delivery, Sara Bainbridge at s.bainbridge@nhscc.org, or Senior Policy Officer, Emily Jones at e.jones@nhscc.org.

Appendix

NHSCC 5 key 'asks' to enable and support integration across system and place

Achieving these may require legislative change and/or may require the use of current legislation in a different way – for example through NHS England powers of direction for CCGs and NHS Improvement powers of licensing for Foundation Trusts, as long as that supports 'bottom up' aspiration around STP/ICS place & system integrated working.

1. **Responsibility to improve health & health outcomes.** Revise the section that specifies responsibilities of different parts of the NHS to legislate that NHS providers as well as NHS commissioners have responsibility for improving health & health outcomes across a place and system (ICS and/or STP) as well as to their own organisation within that place and system.

2. **Regulation & Assurance**. Amend the responsibilities for assurance and regulation so that there is a single process that covers all the health and care organisations across the place to encompass
   - indicators that are the sole responsibility of a specific organisation within a place but also
   - indicators that are the responsibility of every organisation across the place, so as to mandate 'collective responsibility'.

3. **Payment Reform.** Revise the sections that describe how payment for care will be made so that the payment system is changed to reflect the move towards integration & collaboration across NHS providers within a place. This would include replacing the default to PBR tariff with a mandate for commissioners and providers to mutually agree a contract form with no default. If they can't agree a contract then there is no default position. This should be viewed as a measure of system maturity and mutual agreement should be the expectation, but if necessary could, by exception, be enforced by:
   - Making PSF and CCG uplift conditional on reaching agreement
   - Increase in arbitration fines to both parties to avoid this becoming the new default and to ensure there is a compelling incentive to reach agreement
   - Awarding new 5YFV / Long term plan transformation funding based on systems being able to reach agreement.

4. **Accountability & governance.** Revise the sections that cover accountability & governance to include who is accountable for what functions, including the responsibility to consult and the expectations around governance across the place and system around ICSs and STPs. This needs to clarify NHSE's role as a commissioner and reserved powers in order to avoid 'double delegation' of duties. Ensure that this also clarifies expectations around the management of potential conflicts of interest particularly at place level. Give providers and commissioners the ability to form joint committees for specific functions, for e.g. to enable integration, reduce inequalities

5. **Procurement, competition & choice.** Strengthen elements within Section 75 of the Act so that procurement is only needed if the commissioner cannot secure the changes needed with the providers working within the place and system. Change the rules around competition and choice so that using competitive and choice levers are only introduced if the commissioner cannot secure the transformative changes needed. Re-look at how patient choice operates by giving responsibility to the 'place' and system to work with its population to secure a mandate from them for the circumstances within which patient choice should prevail, linked to the ICS/STP strategic plan and priorities. Remove the powers of the CMA to make judgements with regard to competition between and mergers of NHS organisations.