**HFMA response**
October 2018

# Contracting arrangements for integrated care providers

## Consultation by NHS England

## Who are we

The Healthcare Financial Management Association (HFMA) is the representative body for finance staff in healthcare. For the past 60 years, it has provided independent and objective advice to its members and the wider healthcare community. We are a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through our local and national networks. We also analyse and respond to national policy and aim to exert influence in shaping the wider healthcare agenda. We have a particular interest in promoting the highest professional standards in financial management and governance and are keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

## Our comments

### Q1. 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?

We agree that commissioners and providers should have the option of a contract described above.

We recognise that there is no single solution which suits every healthcare economy, and for some an integrated care provider (ICP) contract may provide the best arrangement. Therefore, we consider the option to have an ICP contract is helpful.

However, some HFMA members have expressed concerns that the lead provider arrangement is not an environment within which true collaboration is best fostered. Assigning a lead provider with sub-contracted providers, whether intentional or not, could create a hierarchical rather than collaborative structure of providers. There is also the potential for too much administrative and managerial strain to be placed on the lead provider. Various alternative systems where providers are all considered equal are already available and operating through collaboration agreements, alliance contracting and memorandums of understanding. Some examples of this are explored in the HFMA's recent briefing *How do you align resource plans across the system?*[1] However, we do recognise that having a lead provider will support clear arrangements for accountability.

## Q2. 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.**

## Should these specific elements be amended and, if so, how exactly?

We have no amendments to suggest.

## Are there any additional requirements which should be included in the national content of the draft ICP Contract to promote integration of services?

We have no additional requirements to suggest.

## Q3. 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?

We agree that the scope of services, the funding made available and the incentivising of priorities should, as much as possible, be set at a local level.

[1] HFMA, *How do you align resource plans across the system?*, October 2018

However, we would also highlight the need to ensure that by entering into an integrated care provider contract, providers are not disadvantaged by any incentives made available through the national tariff payment mechanism. For example, movements between any national incentives included in the initial baseline and financial incentives factored into future tariffs over the duration of the contract.

## Q4. Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers?

We support the different funding streams being pooled into a single budget and called for this in our joint report with PwC, *Making money work in the health and care system*[2]. However, in our opinion having a single board overseeing how and where those budgets are invested will have the greatest impact, as well as central accountability, and provide more flexibility.

It could be argued that within a healthcare system with strong leadership relations, the suggested flexibility could be accessed through the current levers available to commissioners and factored into the current contracting arrangements with individual providers. And that a system without strong working relations is unlikely to enter into an ICP arrangement due to the increased risk of contractual complexities and potential disputes. However, the additional administrative requirements created by the sub-contracting arrangements, increased transparency requirements and other potential additional costs associated with the ICP contract need to be considered.

## Q5. 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.**

## Do you agree or disagree with our proposal that these specific safeguards should be included?

We agree that these specific safeguards are all areas which warrant inclusion in an ICP contract arrangement.

However, we do have concerns regarding the impact of transparency safeguards. As primary care practices are effectively private partnerships they may be concerned with the level of transparency required in the business plan and would not want their finances published. This could lead to the formation of subsidiary companies, through which they will transact with the lead provider, thus protecting their liability, but adding another layer of complexity and cost to the arrangements

## Do you have any specific suggestions for additional requirements, consistent with the current legal framework, and if so what are they?

We do not have any specific suggestions to add.

## Q6. Should we create a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts?

[2] HFMA/PwC, *Making money work in the health and care system*, June 2018

Our members have raised concerns that GPs may not fully engage if they are able to continue to operate under their existing primary care contracts. There are also fears that GPs appear to be able to choose whether to be a sub-contractor to the lead provider or continue to be commissioned by the CCG, affording them a stronger negotiating position when entering into an ICP arrangement.

## Are there any specific features of the proposed options for GP participation in ICPs that could be improved?

How CCGs facilitate the relationship between trusts and GPs will have a significant impact on whether these arrangements succeed or fail.

## Q7. 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. The draft contract provides the ability for this to occur. However, it will be local priorities, incentives and enthusiasm for transformation which will determine whether or not this does actually occur.

## Q8. 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?

We have no additional safeguards to suggest.

## Q9. 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.

## Should we include much the same obligations in the ICP Contract on these matters as under the generic NHS Standard Contract?

Yes. We feel public accountability of an NHS organisation does not differ based on the type of contract they hold. Therefore, the ICP contract should include much the same obligations on these matters as under the generic NHS standard contract.

## Do you have any additional, specific suggestions to ensure current public accountability arrangements are maintained and enhanced through an ICP Contract?

No. We have no additional specific suggestions.

## Q10. 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.

## 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?

In our opinion, just describing the core features of a whole population model of care does not hold an ICP to a higher standard of transparency on value, quality and effectiveness. Additionally, we have concerns that the new requirements relating to financial control and transparency will have limited impact for the cost involved and include measures which are already undertaken by providers. Specifically:

- providing an independently audited financial business plan to the commissioner before the start of each contract year for review and comment, depending on the scope of the audit, appears to add a level of additional cost which would outweigh any benefit to the system
- operating 'open book' accounting – putting aside the concerns regarding the introduction of subsidiary companies, the operation of 'open book' accounting would not significantly reduce inappropriate clinical variation above and beyond the measures already being undertaken through the costing transformation programme
- submitting annual audited accounts and being transparent about remuneration of senior staff are no more than current providers are required to do.

## Do you have any additional, specific suggestions to secure improved value, quality and effectiveness, and reduce inappropriate clinical variation?

Rather than an independent audited financial business plan being required at the start of each contract year, this could be extended to every three years with a limited review in the intervening years.

## Q11. 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?

No.

## Q12. Are there any specific equality and health inequalities impacts not covered by our assessment that arise from the national provisions within the draft ICP Contract?

No.

## Contact

If you would like to discuss any of our comments in more detail please contact Andrew Monahan, policy and research manager: andrew.monahan@hfma.org.uk.