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FOREWORD

This draft guidance brings together learning, experience and expertise from a wide range of sources including clinicians and managerial leaders from across the country already engaged in the development and delivery of integrated care.

The guidance does not provide a blueprint for the development of a new delivery model but offers a practical step by step process for establishing the integrated care delivery model most appropriate to local needs.

We have suggested a three-stage design process, which starts with the offer to the people who use health and social care services and the change in delivery required to improve care, outcomes and experience. We have also drawn from the experience of the post-acute care enablement (PACE) pilot and early adopter sites to give a useful and real example of the methodology used for the design and delivery of their integrated care programme.

We then go on to explore the ways in which partners can collaborate to deliver care and the legal and contractual implications that may inform their choice of delivery model.

Going forwards we wish to work with local partners to test out this guidance and further develop all areas with insights derived from partners’ practical experiences of implementation. In doing so it is also our intention to test out a range of different delivery model options and explore the common barriers to and levers for change.

Finally, this guidance will be developed and refined alongside the emerging clinical commissioning strategy set out in the White Paper to support the leading role GP colleagues and local authorities will be taking in commissioning care in the future.

Janet Samuel
Programme Lead for Provider Models

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SRO, Head of Provider Support

September 2010
EXECUTIVE SUMMARY

The purpose of this document is to provide a practical guide to support the creation and development of new provider delivery models and organisational forms to support integrated care systems.

At this early stage it is primarily intended to prompt some pertinent questions to help organisations determine what it is they are trying to achieve, how and by whom. In other words, what are the outcomes – be they clinical, financial or strategic – that the organisation wants to deliver; who are the clinical and managerial leads that will be best placed to understand what changes are required; and which partnerships will need to be developed, broadened or changed to ensure success.

The recommended approach can be broken down into four key stages, three relating to design and one to implementation, around which this document is structured. Those stages are:

1. **Understanding the change required** Being clear about what you want to achieve – change should be needs and pathway-driven, designed to deliver improved quality, including better patient experience as well as increased efficiency.

2. **Identifying partners** Linking up people and organisations across the local health and care economy that will need to work together in new ways to deliver integrated care closer to home.

3. **Creating an organisational form** Agreeing arrangements including contractual changes to create the conditions that will allow new partnerships to succeed.

4. **Making it happen** Taking the right steps to implement change and connecting with the enablers – IT, workforce, estates – that will make that change happen.
INTRODUCTION

This document is a product of the NHS London Provider Models work stream, which has been established to support local health and social care economies in developing models for integrated care.

Its purpose is to provide a working draft practical guide to support the work being done by commissioners and providers across London to explore options for the development of new provider delivery models and organisational forms to support integrated care systems.

The drive for a more integrated approach to the delivery of health and social care and indeed many other public services is not new, but has been given new momentum by the need to radically transform the delivery of services if both the quality improvement and financial challenges facing services are to be effectively addressed.

This is a working document, which will be developed in time into a more detailed reference pack. It has been compiled following a period of desk top research with expert legal and contractual input, visits to organisations that are held up as beacon sites and through engagement with a wide range of stakeholders inside and outside the capital.

Throughout all of our work to date one consistent and clear message that has been received is that form must follow function. This document has therefore been structured in this way, taking the reader through the key elements of a process that begins with articulating a vision of how services will change for the people who use them– in terms of improving access to services and patient experience by making provision less fragmented and more joined up; in terms of improving the quality of health and social care services; and in terms of working with a wide range of partners to reduce health inequalities and improve health outcomes for the target population.

A second key theme is the need to establish strong clinical and professional engagement and leadership at the start of the partnership journey. The outputs from this engagement should inform not only the selection of an organisational form best suited to support care delivery but also the design of the governance arrangements that underpin that new organisational form or partnership.

OUR APPROACH

NHS London intends to work with partner sites across London to test out the suggested approach outlined in this guide in practice, identify key obstacles/ barriers and work with our expert panel to explore ways in which these can be overcome.

As already described, this document represents a work in progress. In response to the appetite and interest from both commissioners and providers for some practical guidance we aim to deliver a co-created and tested product ready for widespread use in Autumn 2010.
THE WHITE PAPER

The new Government’s recent White Paper\(^1\) proposed certain changes in commissioning responsibilities which are outlined briefly below.

One key change is that consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities, are to commission the majority of NHS services for their patients. PCTs will cease to exist in 2013 and local GP consortia will be responsible for commissioning the majority of NHS services, including:

- elective hospital care and rehabilitative care
- urgent and emergency care (including out-of-hours services)
- most community health services, and mental health and learning disability services

An independent and accountable NHS Commissioning Board will be created to support the GP consortia in their commissioning decisions. The new NHS Commissioning Board will commission the following services that cannot solely be commissioned by the GP consortia (although the GP consortia will have influence and involvement in relation to the commissioning of these services):

- GP, dentistry, community pharmacy and primary ophthalmic services
- certain national and regional specialised services
- maternity services and prison health services

The White Paper and subsequent documents outline 4 key areas of greater responsibility for Local Authorities:

1. Leading on joint strategic needs assessments
2. Supporting local voice, and the exercise of choice
3. Promoting the joined up commissioning of local NHS services, social care and health improvement
4. Leading on health improvement and prevention activity

This will mean that local authorities and elected members will have much greater influence upon the commissioning of services.

These changes will mean changes to legislation and are also still subject to consultation and parliamentary debate. If enacted in the form outlined above, the changes to commissioning responsibilities outlined briefly above will mean that future contracts for these services may need to be split between two commissioners (i.e. a GP consortium and the NHS Commissioning Board) and/or split between different GP consortia. It is also likely to have an impact on the existing joint commissioning arrangements that are in place between PCT’s and Social Care. Local models for commissioning services will need to be established.

The guidance in this document is based on current legislation and changes may be made to it in the future. The proposed changes are likely to be relevant to the implementation of an integrated care system and should be considered in this

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\(^1\) *Equity and Excellence: Liberating the NHS*, Department of Health White Paper, 12 July 2010.
context. In this document, references to PCTs and commissioners should therefore be read in the context of the proposed changes to commissioning of health and social care.
GETTING STARTED

What do we mean by an integrated care system?

There is no top-down blueprint of what an integrated care system should look like. At a fundamental level, any integrated system should aim to improve the quality of services in terms of health outcomes and/or patient experience through the delivery of seamless and well co-ordinated health and social care. Systems may choose to focus on specific care pathways or aspects of service redesign, for example improved management of long term conditions or shifting traditional hospital services into the community.

Any proposed reconfiguration of services will however need to meet the following key tests set out by the Secretary of State:

- The proposal is supported by GP commissioners
- Arrangements have been made for public and patient engagement, including local authorities
- There is clarity about the clinical evidence base underpinning proposals
- Proposals take into account the need to develop and support patient choice

The recommended approach

As set out in the executive summary and in later sections, the recommended approach can be broken down into three design stages and one implementation stage, to help organisations determine what it is they are trying to achieve, how and by whom. These are:

- Understanding the change required: Being clear about what you want to achieve – change should be needs and pathway-driven, designed to deliver improved quality, including better patient experience as well as increased efficiency
- Identifying partners: Linking up people and organisations across the local health and social care economy that will need to work together in new ways to deliver integrated care closer to home
- Creating an organisational form: Agreeing arrangements including contractual changes to create the conditions that will allow new partnerships to succeed
- Making it happen: Taking the right steps to implement change and connecting with enablers – IT, workforce, estates – that will make change happen

Throughout this process the design and implementation of services must be clinically led and owned with strong clinical governance and evidence based pathways, building on existing good practice and successful models.

Case study 1: PACE

Post-acute care enablement (PACE) is a proven model of integrated service delivery, bringing together acute, community and social care providers to provide safe and appropriate care in the home for patients who no longer need to be in hospital.

During 2009 two PACE schemes were piloted with Outer North East London
Community Services working with Barking, Havering and Redbridge University Hospitals NHS Trust, and the Bromley Community Provider Unit working with South London Healthcare NHS Trust. The way of working was tested with frail elderly patients accessing emergency acute care as an alternative to a hospital bed spell and with post surgical patients as an acute care at home model. Through developing locally-tailored models of collaborative working, community providers were enabled to deliver even the complex types of care that would normally keep patients in hospital, such as intravenous antibiotic therapy, post-operative wound care and management of infected wounds, including MRSA.

The PACE pilots demonstrated that care traditionally provided in a hospital can be effectively delivered in a clinically safe and appropriate manner in patients’ own homes, thereby reducing hospital stays significantly. The feedback from patients and staff has also been resoundingly positive.

The following four chapters set out the four-stage process in more detail, drawing on the learning from the development of PACE throughout to illustrate each stage of the proposed approach with a practical example.
1

**Understanding the change required**  Being clear about what you want to achieve – change should be needs and pathway-driven, designed to deliver improved quality, including better patient experience as well as increased efficiency.

“*Everything we design is based on the question: What does the patient need? It’s amazing how you design things differently when that’s your credo*”

Dr Claire Tresco, Primary Care Medical Director, Group Health Cooperative

Time and again the message we hear is the same: the patient must be your starting point. The evidence we have reviewed has highlighted the clear imperative to approach the subject of organisational change in this way, ensuring that questions about form follow answers about function. This will kick start the process of clinical and professional engagement and leadership that is key to effective transformation of services.

This section sets out some key lines of enquiry that can be used to determine the functional requirements of a new provider delivery model for an integrated care system.

1.1. **Define a clear strategy and set of objectives**

As stated in the introduction to this guidance, there is no top-down blueprint of what an integrated care system should look like.

A first and crucial step is to identify desired improvements in health outcomes, quality of services and patient experience that will drive change. These should be arrived at through a deliberative process involving clinicians, professional staff and managers, with representation from both commissioners and providers.

Some key steps:

1.1.1 **Define the scope of your integrated care system**

- On what parts of the system do you intend to focus?

  You may, for instance, choose to focus one of the following:

  - Expanding primary and urgent care services to reduce the use of A&E
  - Improving preventative services and the management of long term conditions in partnership with social care
  - Opportunities to shift activity from the acute sector and into community and home settings

- What is your target population?

  This may be defined by one or more of the following categories:
Dependent on the scope of your integrated care system the following steps may need to be undertaken in parallel with a number of work streams looking at population sub-categories and/or specific care pathways.

1.1.2 Adopt an evidence-based approach to service change

- Has a recent Joint Strategic Needs Assessment, health needs or similar assessment been undertaken to review the health issues facing your target population?

- Did the above process engage patients, members of the public and hard-to-reach groups within the target population as well as health and social care professionals and partner agencies currently serving that population?

- Were providers involved in the needs assessment to help local areas understand supply, demand and gaps in services?

- Are health needs assessments informed by an analysis of wider determinants such as housing, crime etc?

1.1.3 Be clear about what needs to change

- What are your priorities for action?

These may be drawn from one or more of the following categories:

- Tackling specific health conditions/ outcomes and determinant factors identified as priorities for your target population – for example through more pro-active management of health and well-being and prevention of ill health

- Addressing health inequalities within the target population or endemic to the population as a whole

- Improving the quality of services – outcomes and/or patient experience

- Why have these priorities been chosen? Priorities may be selected, for example, due to their high impact on health functioning; as a result of being identified as key issues by members of the target population and key stakeholders; or due to the anticipated scope for improvement through more effective, integrated working etc.

1.1.4 Agree how change will be enacted

- How will your priorities be addressed?

  - What are the potential options – what changes might be made to the way in which services are delivered etc.? Any solution should be
Based on the core principle of integrated and multi-disciplinary working upon which integrated care systems are based

○ What is the strength of the evidence of their effectiveness?

- What function or range of products or services will therefore need to be delivered as part of your integrated care system?

In developing your service specification the following will need to be considered:

○ What is the clinical model of care?
  ● Criteria for defining the patient/population cohort
  ● Combined assessment tools to be used or developed
  ● The design of the care pathway and nature of care to be provided in each part of the pathway

○ What is the operational model?
  ● Which teams and competencies need to be brought together to effect this change? (to be covered in more detail in Section 2)
  ● How should teams be structured; what will be the key roles and responsibilities?
  ● In what locations will services be delivered and what will be the hours of operation?
  ● How will information systems be brought together?
  ● What permissions and agreements will be required to operate the service? What are the implications for new and existing contractual arrangements?

○ How will services be governed?
  ● Who will be the supervising clinician at each stage of the care pathway?
  ● What decision making and escalation processes need to be put in place?
  ● What standard documentation will be required and/or needs to be developed?
  ● How will risk be managed?

What is excluded, why, and how will transfer of care be managed

1.2. Create a financial benefits case that articulates the anticipated impact on the area's health economy

Any case for change should be supported by robust analysis of the financial impact of the proposed changes. This should include:

- The value case (in terms of cost/quality) for each service to be provided
- The recurrent and non-recurrent resources that will be required to implement the proposed changes
- The predicted financial impact within the services involved and across the local economy as a whole e.g. including the costs and benefits for commissioners and providers
1.3. Define the success criteria for your integrated care system

The success of your integrated care system should be linked back to the priorities for action identified as part of this initial stage of development and the intended improvements in health outcomes and services. A set of measurable key performance indicators (KPIs) should be developed and agreed by all partners with clinical and non-clinical instruments identified to measure health outcomes and patient experience.

Learning from PACE

The following scorecard was developed as part of the PACE pilots to assess the impact of the integrated service against five key elements of success.

<table>
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<tr>
<th>Scorecard measure</th>
<th>Instruments</th>
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<tr>
<td>Clinical outcomes</td>
<td>• Sheffield Complexity Scale (Enderby and Stevenson, 2000)</td>
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<tr>
<td></td>
<td>• Modified Barthel Index (Shah et al., 1989)</td>
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<tr>
<td></td>
<td>• EuroQol (EQ-5D)</td>
</tr>
<tr>
<td></td>
<td>• Palliative Care Outcome Scale (completed by staff and patients)</td>
</tr>
<tr>
<td></td>
<td>• Acute monitoring referrals</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Likert and free text questionnaires by post after care completed (recommended by the Kings Fund)</td>
</tr>
<tr>
<td>Operational and financial impact</td>
<td>• Number of patients accepted</td>
</tr>
<tr>
<td></td>
<td>• Bed days saved</td>
</tr>
<tr>
<td></td>
<td>• Nature and cost of care packages provided</td>
</tr>
<tr>
<td></td>
<td>• Post-discharge destination and readmissions rates</td>
</tr>
<tr>
<td>Staff experience</td>
<td>Likert and free text questionnaires</td>
</tr>
<tr>
<td>Stakeholder support</td>
<td>Likert and free text questionnaires</td>
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THIS SECTION WILL BE FURTHER DEVELOPED FOLLOWING TESTING WITH PARTNER SITES
Identifying partners  Linking up people and organisations across the local health economy that will need to work together in new ways to deliver integrated care closer to home

“Partnership is characterised by a greater degree of openness, communication, mutual trust and sharing information”

Managing risks with delivery partners: A guide for those working together to deliver better public services, Office of Government Commerce, 2005

Once the functional requirements of your new integrated care system have been determined the next stage is to begin to consider the range of partners and level of integration and collaboration required for the delivery of transformed services: who will need to work together and at what level in order to enact change. This should also include an assessment of whether existing partnerships are fit for purpose to carry out a new role.

In practice this work may be done concurrently as part of the process to determine the functional requirements of your integrated care system. The recommended key lines of enquiry can be broken down into the following sections:

2.1. Identify the organisations that need to be involved

- What skill sets are required to deliver the identified function or range of products or services?
- Which organisations are best placed to deliver?

The list may comprise some or all of the following:

- Acute and mental health trusts
- Community services providers
- GPs and Primary Care Practitioners
- Local authorities
- Voluntary and independent sector providers
- Existing integrated services

2.2. Ensure there is commitment to the development of an integrated care system

- Is there a commitment from all partners to the delivery of the identified improvements in health outcomes and services? Energy will need to be invested in relationships to build trust and a shared vision
• Is there a commitment to work collaboratively to achieve these goals, including:
  • Preparedness to negotiate and compromise in order to reach agreement
  • Sharing of responsibility, benefits and risk
  • Maintaining a dialogue and working in an open and transparent manner

2.3. Identify credible clinical and managerial leaders

“New partnerships need champions with the charisma, authority and negotiating skills to get the show on the road”

A fruitful partnership: Effective partnership working, Audit Commission, 1998

• Be clear about who is leading the design of your integrated services – can you identify a credible leadership team that commands the respect of external agencies?

• Capable and integrated clinical and managerial leadership is essential – professionals from across different health and social care settings should be involved in the re-design of care pathways

• Be clear about who will be accountable for outcomes and delivery – do all partners understand their own and collective responsibilities and accountabilities?

2.4. Define the nature of partnership that is required

The functional requirement of your integrated care system will help to determine the depth of collaboration and integration required between partners.

In assessing whether existing partnerships are fit for purpose to carry out this new role it is recommended that a mapping exercise should be undertaken as illustrated in Figure 1 below.²

² We have to stop meeting like this: the governance of inter-agency partnerships, Care Services Improvement Partnership, Glasby and Peck, 2006
The depth and breadth of collaboration required between partners may vary dependent on the particular services under consideration, for example adult services will typically be characterised by well developed relationships between a small number of providers (often health and social care), whereas children's services tend to bring together a much broader range of partners (e.g. education, youth offending teams, health and social care etc.) but may be less likely to have developed formal partnership arrangements. In this example, as set out in Figure 2 below, a single, fit for purpose solution will need to be developed for an integrated care system encompassing both adult and children's services.

Figure 2: Partner relationships in adult and children's services
Learning from PACE

In developing an integrated care service, organisations involved in the PACE pilots established three distinctive groups:

- **A co-ordination group** – to approve the final clinical, operations, governance and costing models – typically comprising the Directors of Operations from each organisation
- **A clinical reference group** – to design each of the models and work up service specifications – typically comprising expert clinical leads from each specialty
- **A commercial group** – to design the costing model – typically comprising finance staff from each organisation

In addition, each of the organisations involved in the PACE pilots agreed the following principles of collaboration to ensure successful implementation:

- Quality should be the primary driver
- Service redesign should be based on clear evidence of clinical effectiveness with expert clinical involvement
- Services redesign should be independent of organisational boundary considerations
- All parties should commit to resolving (rather than accepting) problems that undermine collaboration
- Duplication of provision should be targeted
- There should be respect for different staff groups’ professional competencies
- There should be no cost shunting between organisations
- All partners should be involved early in the care planning process
- The right information should be collected and shared between partners
- There should be a clearly articulated governance model – covering ownership, risk management, decision making and escalation processes

An overview of the PACE governance and documentation model is set out in Appendix 5.

2.5. Private partnerships and public/private partnerships

This section is to be developed.
THIS SECTION WILL BE FURTHER DEVELOPED FOLLOWING TESTING WITH PARTNER SITES
Creating an organisation form  Agreeing arrangements including contractual changes to create the conditions that will allow new partnerships to succeed

The degree to which collaboration and integration between partners is required for the effective delivery of services should be used to design a provider delivery model for your integrated care system. This in turn will determine the extent of organisational change and restructure is required.

For the main part this section sets out in detail the legal and contractual implications for the principal provider delivery model options. Alongside this are some checklists that can be used by both providers and commissioners to assess the suitability of different models in light of the local context and specific function of the proposed integrated care system.

As described in the introductory sections this guidance will be tested out and further developed with partner sites for final publication in October 2010.

3.1. Principal provider delivery model options

The principal provider delivery models have been developed through a series of NHS London workshops and are discussed in more details in section 3.6.5 of this guidance.

Option 1: Single provider or Integrated Care Organisation (ICO)

Separate organisations merge into a single incorporated body that delivers all services on behalf of the original organisations.

This model proposes that separate organisations may merge into a single incorporated body that delivers all the services on behalf of the original organisations.
This proposed model is similar to Health Maintenance Organisations (HMO) in the US (although the integration relationship in the US is between the insurer and provider).

The term “ICO” often refers to a vertical integration of providers involved at different states of the care pathway. This proposed delivery model for an integrated care system aims to establish an integration of provision with primary care and for this reason GPs would need to be part of this newly established single organisation. In the context:

- It may be unlikely that any NHS Trust or Foundation Trust would be dissolved or merged (in statutory terms) with primary care providers (such as GPs). However, although not represented in the model above, it may be possible for an NHS provider to employ or engage primary care providers (subject always to compliance with the legislation relating to primary care contracting)
- This model may also represent a corporate joint venture (where the parties are not dissolved but continue to remain as separate entities).
- The portfolio of a single integrated care system provider could extend to cover acute services, but would be dependant on the scope of the integrated care contract

**Option 2: Multiple providers e.g. through a partnership/ joint venture/ networks – assumes a single/ integrated contract**

Where the organisations have a common business or service overlap, funds and control move to a separate incorporated Joint Venture which delivers services to that population segment

It was proposed that this model could be used where the provider organisations share a common business, funds and control move to a separate incorporated joint venture which delivers services.

This may take the form of a legally established entity with separate governance and management structure. For example, a form of collaborative partnership, joint venture or network/ federation of providers. Please see section 3.6.5 for more information on corporate joint ventures.
A further example of a governance structure for option 2 is set out below:

![Diagram of governance structure]

Organisations commit to a common governance arrangement where they have a geographical overlap otherwise incorporation, governance and funding remain separate.

Option 3: Multiple providers e.g. through a primary contractor – assumes a single/integrated contract

![Diagram of multiple providers structure]

Primary contractor sub-contracts and coordinates the commissioned work. Sub-contractors accountable to primary contractor.

One of the benefits of this model for commissioners is that the sub-contractors are accountable to the primary contractor. This would enable the commissioner to focus on outcomes as the management of the contract may be less complex. The potential disadvantages relate to gaps in service delivery and the complexities of GP contracting. This model reflects the contractual model set out in section 3.6.5 of this guidance and some of the key factors to consider in relation to this model are set out in that paragraph.

Option 4: Multiple providers – PCT effectively acts as primary contractor – assumes a single/integrated contract can be broken down into component parts

This model proposes that the status quo would effectively be maintained and the PCT would retain control of all contractors. This may be seen as the least effective way to support integration and promote transformation of service delivery. This model reflects the contractual model also set out in section 3.6.5 of this guidance and some of the key factors to consider in relation to this paragraph.
3.2. Evaluating delivery models – provider checklist

Key questions for providers assessing delivery model options:

- Quality of services: Will the model support integration of teams, evidence-based service and pathway redesign and improved patient experience? Will it foster innovation?
- Will it support patient choice and be attractive to patients?
- Good governance: Does the model allow for:
  - Strong capable leadership with clear roles and responsibilities, lines of reporting and accountability?
  - Effective and timely decision making across organisations?
  - Effective governing structures (i.e. board/committees) with clear roles for individual members?
  - Effective financial risk management – how will risks to overall delivery against the contract(s) and therefore income be effectively managed?
  - Effective clinical risk management – as above
  - Effective performance management – how will performance be managed across organisations against shared targets/standards?
- An effective workforce: Is the model conducive to the recruitment and retention of staff with appropriate skills and experience? Are perceptions about organisations and working practices barriers to change?
- Financial sustainability: Including:
  - Will it support new financial incentives and mechanisms to enable delivery of care in lower cost settings and create real cost savings?
  - Will it achieve economies of scale be attained?
  - Does the model allow for the delivery of efficiency savings including allocative efficiencies but also the reduction in fixed costs/utilisation of back office estate and other infrastructure?
- Revenue control: How will income be received and shared amongst providers?
- Information technology and information management: Will the model drive or constrain increased compatibility between information management and communication systems and sharing of patient records between organisations etc.

3.3. Evaluating delivery models – commissioner checklist

Key questions for commissioners assessing delivery model options:

- Quality of services: Will the model allow patient care to be streamlined in a single process both within and across professions and organisations e.g. through use of shared information and guidelines? Key tests include delivery of improvements in health outcomes and services, including patient experience
• Contractual integration/efficiency and sustainability: Contractual integration is required in order to abrogate powerful organisational self-interest and perverse systems incentives that drive negative behaviours. The key test of this is whether the model can contribute to the delivery of allocative efficiencies. Can care be delivered at less cost? Can acute provision be decommissioned? Can residential care be avoided?

• Accountability: Are there adequate means of holding all providers to account? i.e. this may be an issue where a primary contractor is sub-contracting to other providers

Further details on the key considerations for commissioners are set out in section 3.6 below.

3.4. Evaluating delivery models – selection table

Once these lines of enquiry have been explored a selection table can be used to assess the suitability of each model for both commissioners and providers.

Figure 3: Example of a selection table

<table>
<thead>
<tr>
<th>Model</th>
<th>Providers</th>
<th>Commissioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single contractor</td>
<td>Advantages</td>
<td>Disadvantages</td>
</tr>
<tr>
<td>Joint contract</td>
<td>Assessment against provider criteria a-f</td>
<td></td>
</tr>
<tr>
<td>“Super-contract”</td>
<td></td>
<td>Assessment against commissioner criteria a-c</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.5. Governance arrangements

Governance can be defined as the procedures associated with the decision-making, performance and control of organisations, providing structures to give overall direction to the organisation and to satisfy reasonable expectations of those outside it.³

THIS SECTION WILL BE FURTHER DEVELOPED FOLLOWING TESTING WITH PARTNER SITES

The following governance assessment tool can be used as a checklist for newly formed or existing partnerships.

³ Corporate governance in the public services: issues and concepts, Public Money and Management, Hodges, Wright, and Keasey, 1996
Governance Assessment Tool (copyright: INLOGOV 2003)

Public accessibility
1. Are meetings of the board advertised?
2. Are meetings of the board open to the press and public?
3. Are the public entitled to see reports considered by the board?
4. Are the reports that the board will consider available for the public to consult prior to the meeting?
5. Are the public entitled to see minutes of board meetings?
6. Is there an annual general meeting that the public can attend?

Internal governance
1. Does the partnership have a memorandum of association or other document defining its role and powers?
2. Does the partnership have a written constitution or set of standing orders defining how it will conduct its business at meetings?
3. Is membership for a limited period of time? If so, for how long?
4. Does a quorum apply at board meetings? If so, what is it?
5. Are written minutes of board meetings produced?
6. Are there allowances or other payments for members? If so, how much?

Member conduct
1. Is there a code of conduct to regulate the behaviour of members at board meetings?
2. If there is a code, are board members required to agree to be bound by it?
3. Is there a register in which board members detail their financial and other interests? If so, is this compulsory? And is it open for public inspection?
4. Is there a system for declaring conflicts of interest at meetings? If so, what is the procedure and where is it set down?
5. Is there a procedure for ensuring that members declaring conflicts of interest take no part in the decision? If so, what is the procedure and where is it set down?

Accountability
1. Does the partnership have to prepare an annual report? If yes, is this a public document?
2. Does the partnership have to prepare an annual budget? If yes, is this a public document?
3. Does the partnership have to prepare annual accounts? If yes, is this a public document?
4. Is the partnership subject to external audit?
5. Is the partnership subject to external inspection?
6. Is there a complaints process available to citizens or service users?
7. Is the partnership under the jurisdiction of an ombudsman or inspectorate?
8. Is the partnership required to meet targets agreed with any other bodies?
9. Does the partnership make a formal report to any other bodies (including the member organisations)?
10. Can members be recalled by their nominating bodies?

For further information visit: www.inlogov.bham.ac.uk/research/esrcpartnership.htm
3.6. Legal and contractual guidance

This section provides Commissioners with legal guidance as to some of the legal issues associated with the implementation of an integrated care system. This section sets out some general guidance only and does not address all of the legal and contractual issues that will be relevant to each PCT. This section should not be viewed as a substitute for legal advice and PCTs should seek their own specific legal advice on these issues. The changes to commissioning responsibilities proposed in the White Paper must also be considered in this context.

3.6.1 Introduction

A primary aim of an integrated care system is to support the efficiency and affordability of care provision by moving care to a local (rather than hospital) setting. An integrated care system may bring together some or all of the following:

- primary care
- mental health
- community care
- secondary care or acute services
- pharmacy
- dental services
- social care

It is important to ensure that contracts for services to be provided in an integrated care system do not duplicate existing contracts for the provision of those services. If there is more than one contract for the provision of services, this may mean that a commissioner will pay twice for the same service.

This integration and movement of services raises a number of legal issues. In particular, it is important to consider the following:

- **contract law** and **legislation**, in particular in relation to:
  i. changing existing contract terms; and
  ii. choosing appropriate contract terms for the amended services and an appropriate joint venture model

- **procurement law** implications of changing contract terms and procuring “new” services

- **consultation law** implications of changes to provision in healthcare

- **property law** in relation to the occupation of premises and ownership of assets

- **employment law** issues in relation to transfers of staff, including pensions issues and, possibly, redundancy

In this guidance, we consider the key issues that may arise in relation to some of these issues. Property and employment law considerations fall outside the scope of this guidance and appropriate advice should be sought in each case.
Please see the comments on page 6 of this document regarding the changes proposed to commissioning of health and social care in the White Paper.

3.6.2 Existing service provision – legal and contractual landscape

**Overview**
This section considers the existing contractual arrangements that the PCT is likely to have in place with service providers. It is important the PCT identifies all its existing contracts for clinical services as this is the first step towards ultimately determining which contracts need to be varied or replaced to establish an integrated care system.

**Existing Contractual Arrangements**
The contractual arrangements that a PCT is likely to currently have in place for its clinical services are illustrated in the diagram below.

Under law and/or guidance, PCTs must use specific contracts when contracting for clinical services and the appropriate contract depends on the services commissioned. Some (but not all) of the contracts are required to comply with legislation. The appropriate contract that must be used for each type of service is set out in the table below:

<table>
<thead>
<tr>
<th>Clinical Service Commissioned by PCT</th>
<th>Type of Contract</th>
<th>Do specific regulations/directions govern the contract?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute</td>
<td>Standard DH acute contracts</td>
<td>No</td>
</tr>
<tr>
<td>2. Community</td>
<td>Standard DH community services contracts</td>
<td>No</td>
</tr>
<tr>
<td>3. Mental Health</td>
<td>Standard DH mental health and learning disability contract</td>
<td>No</td>
</tr>
<tr>
<td>4. Primary</td>
<td>PMS contracts</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>APMS contracts</td>
<td>Yes</td>
</tr>
<tr>
<td>Service</td>
<td>GMS contracts</td>
<td>PDS contract</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------</td>
<td>--------------</td>
</tr>
<tr>
<td>5. Pharmacy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Dentistry</td>
<td>PDS contract</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If the contract is required to comply with legislation, then it must do so or the PCT will be contracting unlawfully. Even though some contracts are not the subject of legislation, DH guidance requires that they are in standard form unless changes are agreed by the SHA. The PCT has more flexibility in relation to the contracts that do not need to comply with legislation.

**Legislative Requirements and Understanding Limitations Around Primary Care Provision**

**Prohibition on combination of primary and dental/pharmacy services**
The 2006 Act prohibits the combination of contracts for primary care services with dental or pharmacy services. This means that dental or pharmacy services always have to be provided on separate contracts. This is mainly because different regulations apply to the regulation of each type of service (for example, only registered pharmacists dispense etc).

**Primary care legislation**
Primary care services may only be provided under the following three contracting regimes:
- GMS – General Medical Services
- PMS – Personal Medical Services
- APMS – Alternative Provider Medical Services

**GMS**
The GMS contract is a UK-wide contract between general practices and primary care organisations for delivering primary care services. The contract contains all of the mandatory terms for GMS contracts that are required by the Health and Social Care (Community Health and Standards) Act 2003 and the National Health Service (General Medical Services Contracts) Regulations 2004 (SI 2004/291) (as amended) (**GMS Regulations**). The contract also contains further terms that are strongly recommended to all primary care trusts (although they are not required by the Act or GMS Regulations).

The GMS Regulations may be found at: [http://www.opsi.gov.uk/si/si2004/20040291.htm](http://www.opsi.gov.uk/si/si2004/20040291.htm) (although please note that there have been amendments)

and the most recent version of the standard GMS contract may be found at: [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106968.doc](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106968.doc)

**PMS**
Personal medical services arrangements are an alternative to GMS, in which the contract is agreed locally between the contractor and the PCT.

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4 The White Paper contemplates some changes to the current legislation regarding primary care contracting.
The requirements for the contractual terms of PMS contracts are set out in the National Health Service (Personal Medical Services Agreements) Regulations 2004 (SI 2004/627) (as amended) (PMS Regulations) and, in many ways, reflect the content of the GMS Regulations. The PMS Regulations may be found at: http://www.opsi.gov.uk/si/si2004/20040627.htm (although please note that there have been amendments)

APMS
Under the terms of APMS (alternative provider medical services) contracts PCTs may engage with a wide range of providers to deliver primary care services tailored to local needs. APMS contracts must comply with the Alternative Provider Medical Services Directions 2010 (APMS Directions). The APMS Directions may be found at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_115584.pdf

A broad summary of the parameters of each contracting regime are set out in the table below:

<table>
<thead>
<tr>
<th>Primary Care Contract Regime</th>
<th>Features</th>
</tr>
</thead>
</table>
| **General Medical Services (GMS)** | • standard traditional GP contract  
• list based services  
• must include essential services (e.g. standard GP services)  
• lifetime contract and beyond (if practice merges)  
• only terminated if GP dies or poorly performs |
| **Personal Medical Services (PMS)** | • may be list based  
• may or may not include essential services  
• introduced to encourage GPs (with special interests) to provide specialist services to patients wider than the list  
• may be fixed term (i.e. not lifetime)  
• only terminated if GP dies or poorly performs but from 1 April 2010 may be terminated on 6 months notice  
• GP has right to convert the contract to a GMS contract (but only for the list based services) if essential services are provided (i.e. making it a lifetime right) |
| **Alternative Provider Medical Services (APMS)** | • may include essential services  
• may be list based  
• may include other services, even acute services and community services  
• the most flexible contract base  
• most easily changed and terminated  
• must comply with APMS Directions 2010 |

**Pharmacy Services**
Pharmacy services may only be provided under the contracting regime set out in the 2006 Act.

PCTs may choose to use the Local Pharmaceutical Services (LPS) model contract which may be found at: http://www.psnc.org.uk/data/files/LPS/lps_model_contract.pdf
The LPS model contract contains clauses required by the National Health Service (Pharmaceutical Services) Regulations 2005 (as amended) and other relevant legislation. Apart from these mandatory clauses, the parties are free to negotiate and agree such other clauses as they wish (provided they comply with relevant legislation and take account of any relevant guidance issued by the DH).

Dental Services
Dental services may only be provided under the following contracting regimes:
- GDS – general dental services
- PDS – personal dental services

The current standard GDS and PMS contracts may be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099946.

The standards contracts comply with the following regulations (as applicable):
- The National Health Service (General Dental Services Contracts) Regulations 2005 (SI 2005/3361) which may be found at: http://www.opsi.gov.uk/si/si2005/20053361.htm; and
- The National Health Service (Personal Dental Services Agreements) Regulations 2005 (SI 2005/3373) which may be found at: http://www.opsi.gov.uk/si/si2005/20053373.htm

Under the different rules, only certain providers may provide certain services (i.e. be the contractual party). The suitable providers for each service are set out in the table below:

<table>
<thead>
<tr>
<th>Services</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>• PMS – Persons and bodies listed in s 93 of the NHS Act 2006</td>
</tr>
<tr>
<td></td>
<td>• GMS – Individual GPs, medical partnerships and companies limited by shares which have at least one medical practitioner shareholder.</td>
</tr>
<tr>
<td></td>
<td>• APMS – any person unless excluded by the APMS Directions 2010</td>
</tr>
<tr>
<td>Dental services</td>
<td>• GDS – sole practitioner dentists or dentists in partnership with other dentists; dental corporations meeting the requirements of the Dentists Act 1984 (as amended)</td>
</tr>
<tr>
<td></td>
<td>• PDS – as above plus NHS trusts</td>
</tr>
<tr>
<td>Pharmacy services</td>
<td>• any pharmacy provider complying with the regulations and employing registered pharmacists</td>
</tr>
</tbody>
</table>

Possible solutions
Bearing in mind that an integrated care system will likely combine some or all of the above services, the PCT will need to consider the best outcome in each case.

Taking into account the points above, it is likely that if the PCT wishes to have one contract in place to deliver services in an integrated care system (rather than a separate contract with each provider) then:
• a contract compliant with the APMS Directions 2010 may need to be used; and
• dental and pharmacy services may need to be provided separately.

DH Standard Contracts for Mental Health, Learning Disability, Ambulance Services, Acute Hospital and Community Services and Related Guidance

NHS standard contracts for mental health, learning disability, ambulance services, acute hospital and community services were published by the DH in January 2010 (and revised from time to time). The NHS standard contracts cover agreements between PCTs and all types of provider delivering acute, community and mental health NHS-funded services.

The DH has published guidance relevant to each standard contract which helps the PCT determine when each contract should be used. It is important the PCT uses the correct standard contract and, if in doubt, the PCT should contact NHS London and/or seek legal advice.

The NHS standard contracts have a three-part structure:

• Elements which are mandatory;
• Elements which must be there, but the details of which are for local agreement or completion by the contracting parties; and
• Elements which can be added by local agreement.

The mandatory elements should be considered standard NHS terms & conditions. They cannot be altered or removed, even by agreement of the contracting parties. If a PCT believes that any aspect of the mandatory elements prevents the contract supporting a workable local agreement in the context of an integrated care system then this should be discussed with NHS London.

3.6.3. Making the changes – legal implications

Overview
In order to make changes to the current provision of clinical services, although there are likely to be many legal issues which will always depend on the circumstances, we anticipate that three key legal considerations are likely to be:

• the contractual provisions governing changes to existing service provision;
• the procurement implications of changing and awarding new contracts; and
• the consultation law implications of changing service provision.

These issues are considered in the following paragraphs.

Contractual Variations

General
In general, parties to a contract may vary its terms by mutual agreement, provided that consideration is given (or the variation agreement is executed as a deed) and any necessary formalities are complied with. Depending on the extent of the proposed changes to the PCT’s current contractual arrangements, the changes may give rise to procurement implications. In each case, the PCT will need to consider the relevant contract terms which apply.

Changes to the Standard Acute, Mental Health & Community Services Contracts
If an integrated care system is implemented, it is likely that certain parts of:

- the standard acute services contract; and
- the community services contract,

will need to be amended, including, by way of example, the services to be provided under those contracts, the Activity Plan and the expected Annual Contract Value (and therefore the monthly payments).

In particular, it will be important to amend the contract value of the community services contract (currently calculated on a “block” basis) to reflect any reduced amount to be paid.

**What type of change?**

Under the standard DH acute services contract and the standard DH community services contract, certain parts of the contract are to be “updated” every year (for example, Activity Plans, Commissioning for Quality and Innovation payment framework (CQUIN) and the service development and improvement plan).

However, many other parts of the contract may not be amended unless the variation procedure in Clause 38 and Schedule 6 is followed and the changes agreed by the parties.

Clause 38 sets out how the contract may be varied by the Parties. There are four types of variation:

1. a **national variation**, being a variation to implement the NHS Operating Framework or mandatory elements of the acute contract. This requires 3 months’ notice;
2. a **service variation materially affecting staff** (for example, redundancy or relocation). This requires 6 months’ notice;
3. a **service variation not materially affecting staff**. This requires 3 months’ notice; and
4. **other variations** not covered above have to be by agreement (You should note that only the provisions set out in Schedule 21 may be agreed to be varied and variations to any other provisions require the approval of the Secretary of State).

In these circumstances, it is unlikely that the change will be linked to an implementation of the NHS Operating Framework. It appears most likely that the changes will be a form of Service Variation. In each case, the nature of the variation must be reviewed in order to ensure that the correct procedure is followed. Alternatively, at the commencement of the new contract year, the amendments could be incorporated in any annual deed of variation or review of schedules, which are due to be updated annually.

**Procedure for Change**

The procedure for a change:

- to the standard DH acute services contract is set out in Clause 38 and Schedule 6 of the contract (set out in Appendix 1);
- to the standard DH community services contract is set out in Clause 38 and Schedule 4 of the contract (set out in Appendix 2); and
- to the standard DH mental health and learning disability services contract is set out in Clause 38 and Schedule 6 of the contract (set out in Appendix 3)
Any agreed variations must be recorded in the relevant schedule of the contract. If the parties fail to agree on a variation, then the PCT may need to rely on rights to terminate the contract.

**Termination of the contract**
If the parties do not wish to vary the contract, then the commissioner and/or provider may rely on rights to terminate parts of the contract. The rights to terminate the contract are set out in Clause 35 of the standard DH acute services contract, Clause 35 of the standard DH community services contract and Clause 35 of the standard DH mental health and learning disability services contract.

The rights to terminate the contract are limited in some circumstances. For example, the right to terminate is subject to the Provider’s obligation to supply Essential or Mandatory Services.

If part of the contract is terminated, then it will be important to review the provisions in the contract relating to the consequences of termination. The standard DH acute contract, the standard DH community services contract and the standard DH mental health and learning disability services contract include various obligations upon the provider, including obligations to co-operate with successor providers, provide information at a reasonable cost and comply with TUPE.

**Compensation upon termination**
In addition, it will be important to determine whether any compensation is payable for early termination of the services. Under the acute services contract, the community services contract and the mental health and learning disability contract, there is an ability to agree compensation on termination package for the early termination of the contract.

**Changes to Primary Care Contracts**

**APMS**
APMS contracts are likely to be used most commonly for the procurement of the provisions of primary care services and offer the greatest degree of flexibility to the commissioner. There is no mandatory standard form for an APMS contract although various forms have been published in the past for use in (for example) the Equitable Access in Primary Care program, and for Urgent Care Centres. Any terms may be included in an APMS contract provided that they require at least as high a level of performance from the provider as the position required by the APMS Directions 2010 (which import many of the requirements of the PMS Regulations 2004, as amended). Accordingly, there is considerable scope for a commissioner to set the terms particularly when approaching a new procurement.

**PMS**
PMS contracts are significantly more restrictive than APMS contracts in terms of the changes that are permitted to be made from the terms required by the PMS Regulations. These regulations require the terms of the PMS contract to have the same effect as the position set out in the regulations, thus removing a significant degree of flexibility that a PCT would enjoy in settling the terms of an APMS contract. Commissioners should note that where essential services are provided under a PMS contract, the provider has the right to require the PCT to enter into a GMS contract in respect of the same services. Recent updates to the regulations permitting the PCT to terminate the contract on 6 months’ notice are therefore of limited use where the provider is providing essential services.
GMS
GMS contracts are governed by the GMS Regulations 2004 which are even more restrictive than the PMS regulations, as the PCT is not presently able to terminate such contracts on notice at all.

Existing primary care contractors may of course agree to move their practices to a new facility. One way of managing the risk in importing an existing contract is to require the Super-contract to be entered into as a pre-condition of the move, thus at least ensuring the availability of contractual remedies should the practice fail to meet the expectations of the PCT regarding the integrated care system more broadly.

The Super-contract has a potentially wide application in integrated care systems, being a contract into which all providers at a particular facility would enter with the PCT. The terms of the Super-contract require each provider to co-operate with the others in providing a fully functional, seamlessly operated facility (from the patient’s perspective) and to give the PCT a coherent set of useful monitoring information in order to lessen the management burden on the commissioning PCT. In this way, existing contracts for services with which providers are already familiar may continue to be used as the additional requirements of them in each case will be set out in the Super-contract. It would be a requirement of any new provider entering the integrated care system to execute the Super-contract to ensure a consistent approach with the aim of seamlessly delivered patient services and equality of treatment between providers.

Procurement Implications

Introduction
Procurement law will be relevant in relation to changing existing contracts and awarding (entering into) new contracts for the provision of clinical services.

Relevant Legislation and Guidance
The EU Directives (Directives) have been implemented into UK law by the Public Contracts Regulations 2006 (Regulations) which require PCTs to take certain steps when procuring services exceeding a certain financial threshold.

PCTs must also have regard to any relevant guidance, including the most recent version of The PCT Procurement Guide for Health Services (currently dated March 2010) (PCT Procurement Guide), and the Principles and Rules for Cooperation and Competition (PRCC). PCTs will also need to consider their own Standing Orders and Standing Financial Instructions.5

PCTs need to determine when and how to use procurement within the umbrella of their overarching commissioning and procurement strategy. The onus is on PCT Boards to demonstrate a rationale for their decisions whether or not to procure certain services. Development of the PCT’s procurement strategy and decisions on procurement must be fully documented and justified, so that they are able to be audited.

5 Please note that the legislation and guidance referred to in this section pre-date the White Paper and will need to be considered in light of the impending changes (e.g. the interpretation of “preferred provider” may need to be reassessed in this context).
Part B Services: Health and Social Services
The Directives and Regulations divide services into two categories - Part A and Part B services. Contracts for “health and social services” constitute Part B services and most integrated care system contacts will fall within this category. Part B services are not subject to the full rigour of the Regulations and the procurement regime is much less prescriptive in terms of the process the PCT must follow. There is therefore some flexibility in the procurement processes that may be adopted and prior advertising and a competitive formal tender process may not necessarily be required for the procurement of health services to be provided from an integrated care system.

As nearly all integrated care system contracts will be classed as Part B services, the regime applicable to Part A services has not been considered in detail in this guidance. Part A services are subject to a much more rigorous procurement regime which mandates particular timescales and procures that must be followed (for example, the open, restricted, competitive dialogue or negotiated procedures).

Integrated care systems are multi-dimensional by nature and will involve a range of different health-related service from different providers. It is important the procurement issues are assessed in relation to each element of the integrated care system, and the Regulations and EU Principles (see below) must be applied to each element separately. Consequently, the procurement process used for one of the services provided from the integrated care system may not necessarily be appropriate for all the services.

Legal advisors should be involved early in the process and dialogue between the PCT and its legal advisors should be on-going, rather than legal input simply representing a ‘read through at the end of the process’. Legal advisors’ commercial as well as legal perspective can help the PCT shape procurements so that they most effectively meet the needs of each individual case.

Overarching EU Principles
When deciding whether or not to procure services, the PCT must also satisfy itself that its decision complies with the following general EU principles of:

- **Transparency**: requires a degree of advertising to allow the market to be opened up to competition, depending on the likely level of interest in the contract across the EU;
- **Proportionality**: requires the level of resources a PCT commits to the procurement process to be proportionate to the value, complexity and risk of the services contracted and the contractual framework must be appropriate to the services being commissioned. The demands placed on providers should be both relevant and directly related to the contract being awarded; and
- **Non-discrimination**: requires that the procurement process is non-discriminatory and transparent at all times, neither including, nor favouring, nor excluding any particular provider; and
- **Equality of Treatment**: requires that providers are given equal and fair treatment throughout the procurement process. This includes ensuring there is no direct or indirect discrimination caused by the conditions of the procurement and all providers have access to the same information; and
- **Mutual Recognition**: requires that the standards, specifications and qualifications in use throughout the EU receive equal recognition to ensure services are suitable for their intended purpose,
(together, the EU Principles). There is a risk of potential challenge from an aggrieved bidder if the procurement process adopted by the PCT does not accord with EU Principles. More details regarding the application of the EU Principles may be found in the PCT Procurement Guide.

If the PCT decides to procure a new contract, the application of the EU Principles in practice means that the contract needs to be “adequately” advertised and some form of fair competition run thereafter. An open process, with transparent and objective rules for the process and award of contracts is very often the preferred procurement approach, whichever form the process may take.

**Implications on Varying Existing Contracts**

The PCT may choose to vary its existing contracts (instead of entering into new contracts with the providers). In certain circumstances, variations to an existing contract may amount to a new award of that contract and trigger the application of the Procurement Regulations. In the event of a challenge the Courts will look at whether the change to the contract is, in effect, a new contract and therefore, whether there is an obligation to carry out a whole new competitive tendering procedure for that ‘new contract’.

Recent European case law has set out a two part legal test to be applied in determining whether a change to an existing public contract constitutes a new contract. The test to apply is whether the amendments made to the contract are:

- Materially different in character from the original contract; and thus
- Demonstrate an intention of the parties to renegotiate the essential terms of the contract.

The European Court has also provided examples of where changes to existing public contracts would be materially different and therefore satisfy the test:

- where conditions are introduced which, had they been part of the initial award procedure, would have allowed for admission of other tenderers or acceptance of other tenders;
- where the changes extend the scope of the contract considerably to encompass services not initially covered; and
- where the changes alter the economic balance of the contract in favour of the contractor in a manner not provided for under the original contract.

If the PCT meets the requirements of the test in altering the terms of an existing public contract, it will be required to award a ‘new contract’ by carrying out a whole new tender process, or risk a claim being made against it for breach of the Procurement Regulations. If the Courts were to assess an award, it is likely the Courts will look at the impact and extent of the changes as a whole, in determining whether the test has been satisfied.

Some of the factors likely to be of relevance that the PCT ought to consider in each individual case include whether there is to be a change:

- to the provider of the services;
- in the scope of the services to be provided;
- in the location from which the services are to be provided; and
- to the value of the contract.
In practice, it tends to be the case that when a variation results in: (i) a lengthening of the contract term; (ii) an increase in service lines; (iii) an increase in the price paid for the services; or (iv) another significant change in favour of the service provider, then it is more likely a variation may be considered to form a new contract.

Legislative Framework

Any duty to consult under section 242, and possibly section 244, of the 2006 Act will therefore arise in relation to implementing an integrated care system.

Section 242(1)(b) of the 2006 Act states that:

- Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in:
  
  (a) the planning of the provision of those services;
  
  (b) the development and consideration of proposals for changes in the way those services are provided; and
  
  (c) decisions being made by that body affecting the operation of those services.

- these requirements only arise where the proposals or decisions would have an impact on:

  (a) the manner in which the services are delivered to users of those services; or
  
  (b) the range of health services available to those users.

The reference to delivery of services in these sections refers to their delivery at the point where they are received by users.

Section 244 of the 2006 Act requires formal consultation with the relevant overview and scrutiny committees (OSCs) where integrated care system proposals represent a substantial variation or development in services. The term “substantial” is not defined. While the overall impact of any potential change upon patients, carers and the public who use, or might need to use, a service need to be considered, the following particular factors are relevant to them:

- changes in the accessibility of the services – with reduced access to services more likely to be considered a “substantial” change than improved access;

- the number of patients affected – although a change that affects only a small group may still be regarded as “substantial”, particularly if patients need to continue accessing that service for many years.

Practical Steps

Any engagement/consultation process will need to be compliant with NHS London and other relevant guidance, and particular care will need to be taken with forthcoming changes. The following tips may be useful:

- involve GPs and patient/public representatives from the very start of your planning process: agree a programme of stakeholder involvement with the PCT’s LINks, and possibly other patient/public representative groups. (Note
that the LINks is a body with a statutory responsibility to satisfy themselves about the adequacy of the consultation process, so they must be involved;
• have similar discussions with the relevant OSCs, especially if the PCTs proposals do (or might) amount to a substantial variation to challenge its services;
• keep a good paper trail so that you the PCT can prove what steps have been taken, if necessary; and
• if in doubt about the PCT’s legal obligations or if the PCT is concerned that there is a real risk of legal challenge for whatever reason, consider getting early legal advice.

Integrated care system proposals will be expected to meet clear standards in the following four key areas as plans for significant service change are developed and consulted upon:

• support from GPs will be essential (as noted above);
• arrangements for public and patient engagement, including local authorities should be further strengthened;
• there should be greater clarity about the clinical evidence base underpinning proposals; and
• proposals should take into account the need to develop and support patient choice.

All business cases for integrated care system developments that relate to substantial service changes should be submitted to the SHA or DH for approval and will need to include assurance that the required standards have been met and be supported by evidence. A letter of support from the Sector Chief Executive will be required, in addition to the approval of the PCT Board.

3.6.4. Forms of provider joint venture and possible vehicles

Overview
Generally, joint ventures or partnering arrangements involve two or more parties who agree to work together, committing defined resources to achieve common objectives. In the context of establishing an integrated care system, the various providers may form a joint venture to deliver various health services commissioned by the PCT.

One of the first considerations for providers will be to decide whether or not to establish a separate legal entity as the vehicle for the joint venture. If a separate legal entity is not established, the joint venture arrangement will be known as a contractual joint venture. If a separate legal entity is established, the joint venture will be known as a corporate joint venture.

This Chapter/s addresses some of the key issues associated with these two joint venture structures.

Any decision about the best joint venture model will be very closely linked to the type of contracting solution which will be adopted for the integrated care system. Please see earlier in this section about the contract that may be required to be used for certain services. The contracting solution may take various forms, for example, the commissioning PCT may contract for all the services in an integrated care system under one contract or the commissioning PCT may, instead, have a separate contract with each provider.
**Contractual Joint Ventures**

Under a contractual joint venture arrangement, no new legal entity will be created. Instead, direct contractual relationships will be put in place between the various providers and they will set out their governance arrangements in an agreement between them. As noted, the nature of the contractual joint venture is dictated by the number of contractual relationships that the commissioner wishes to have. The following options are possibilities:

- **All parties are counterparties**, for example, the commissioner has one contract but each party is responsible for some or all of the obligations.
- **One party is the lead contractor**, for example, the commissioner has one contract with a lead contractor (selected by the other providers to contract on behalf of the providers).
- **All parties have a separate contract and interface/governance arrangements**.

**Benefits and Disadvantages**

Some of the key benefits of a contractual joint venture arrangement are set out below:

- The parties will not have legal responsibility for the liabilities and obligations of the joint venture and for acts and omissions of each other. The extent to which a party will be responsible for the actions of another will mainly hinge on the authority given to bind the other party, on the indemnities in the joint venture agreement and the extent to which obligations are jointly and severally expressed.
- There is flexibility in a contractual joint venture arrangement as the governance and terms of the agreement between the parties may be changed (by consent) at any time to suit changing conditions.
- If any of the providers are PCTs or NHS Trusts, there may be limitations on the ability to form companies or separate legal entities. Further details are set out on page 37 and in Chapter 20 of the DH Transactions Manual.
- There are no formal registration requirements and the joint venture agreement may expire on a given date without the need to formally dissolve a joint venture company.
- The contractual joint venture will not be a separate legal entity requiring administrative and company services. In addition, the taxation and VAT implications may be simpler (although financial advice should be sought on this structuring element).

Some of the key disadvantages of a contractual joint venture arrangement are set out below:

- A contractual joint venture wholly lacks legal personality and is not wholly integrated.
- The providers may seek to limit their liability to the distinct and separate obligations that they are undertaking. This may mean that liability “falls” between the providers.
- If separate integrated care system contracts are used (with interface/governance arrangements between the providers), then this may require the commissioner to monitor the performance of different providers under different performance regimes. This will mean that it is important to
ensure a coherent set of performance monitoring and payment systems that incentivises the providers to act in a “joined-up” manner.

**Corporate Joint Ventures**

If a corporate entity is the chosen vehicle for a provider joint venture, the various provider organisations will join together to form a single new entity. This newly formed joint venture entity may commonly be referred to as an “integrated care organisation” (ICO). The key legal forms that may be adopted for the ICO are outlined below. Depending on the form adopted, the governance arrangements between the various providers may be set out in a shareholders agreement and/or articles of association.

![Diagram of Corporate Joint Ventures]

**Figure 4: Care providers uniting to form a new integrated healthcare organisation**

The new corporate JV/ICO (illustrated above) will take on the contractual obligation to the PCT to supply the services on behalf of the original provider organisations.\(^6\) To this end, the PCT will sign a new integrated care system contract with the ICO and the ICO will be held to account through this contract. The ICO may choose to fulfil these contractual obligations by providing the services directly. Alternatively, the ICO may choose to sub-contract the provision of certain services to another independent organisation that will provide the services on behalf of the ICO.

**Legal form of the new ICO**

There are a range of corporate vehicles open to the provider organisations to adopt for the new ICO. The options include:

- Company limited by shares;
- Company limited by guarantee;
- Limited liability partnership or legal partnership; and
- Not-for-profit social enterprises (for example, Community Interest Company (CIC))

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\(^6\) The changes to commissioning responsibilities proposed in the White Paper should be considered in this context. Please refer to the overview of these changes on page 6.
Some of the key features of these corporate vehicles are set out below. The providers will then need to agree on appropriate governance arrangements for the selected corporate vehicle. Most commonly the new ICO will be a form of company, although if any of the providers are NHS Trusts or PCTs then they will need to have regard to the vires issues (See page 37 below and Chapter 20 of the DH Transactions Manual).

Company Limited by Shares
If a company limited by shares is the chosen corporate vehicle for the new ICO, then the original health organisations will take shares in, and (more likely) contract with, the new ICO.

Governance arrangements (in particular relating to the control of the business of the new ICO and the way it is managed) will need to be agreed between the relevant parties and set out in a shareholders’ agreement and articles of association.

Company Limited by Guarantee
A company limited by guarantee is a form of company that has members (not shareholders). Members do not need to make any contribution to the company's capital for so long as the company remains. The legal liability of each member is limited to such amount as the parties guarantee to contribute to the assets of the company in the event of it being wound up. A company limited by guarantee tends to be the most appropriate structure when there is no immediate need for capital to carry out the objects of the company and, accordingly, are often incorporated for non-profit making functions.

The governance arrangements for a company limited by guarantee will be set out in its articles of association. If the ICO is a company limited by guarantee (and does not have a share capital), then it may adopt the set of model articles of association for companies limited by guarantee. Alternatively, the members of the ICO may prefer to set out the governance arrangements in bespoke articles of association. In the absence of bespoke articles being registered for the newly formed ICO, the model articles will apply in default. Providers considering adopting bespoke articles of association may wish to use the model articles as a guide to understanding the types of governance issues that could be addressed.

A Partnership or Limited Liability Partnership (LLP)
If the providers choose to form an ordinary (unlimited) partnership, then:

- every partner will be jointly liable with all the partners in the partnership for all the debts and obligations of the partnership incurred during the period of membership; and
- every partner is jointly and severally liable for any loss or damage arising from the wrongful acts or omissions of any of the partners done in the ordinary course of the partnership business or with the authority of the partners.

Generally speaking, if the providers form an LLP, they will not personally be jointly liable for contracts entered into by the LLP or personally jointly and severally liable for any torts committed by the LLP. As with directors of companies, however, members of an LLP may be personally liable for their own negligence if they have assumed a personal duty of care and have acted in breach of that duty.

Members of an ordinary partnership or an LLP are not legally obliged to enter into any formal agreement governing the relationship between them. However, there are obvious advantages to clarifying the rights and duties of the members as between
themselves. Any such LLP agreement is a private document which is confidential to the members.

Social Enterprise (e.g. a CIC)
A social enterprise is a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than distributing profit to shareholders and owners.

A social enterprise may take a variety of legal forms including:

- **Community interest company (CIC):** A CIC is a legal form created specifically for social enterprises. It has a social objective that is "regulated" and its assets are protected. A CIC is governed by its memorandum and articles of association and there are models that may be adopted. More information about a CIC may be found on the CIC Regulator’s website: [http://www.cicregulator.gov.uk/](http://www.cicregulator.gov.uk/)

- **Industrial and provident society (IPS):** This is the usual form for co-operatives and community benefit societies. Is democratically controlled by their members in order to ensure their involvement in the decisions of the business.

- **Companies limited by guarantee or shares:** the features of a company limited by shares or guarantee are noted above. A social mission may be written into the memorandum and articles of association of a social enterprise company, although this is not regulated (unlike a CIC).

- **Group structures and charitable status:** For organisations that need to retain surpluses, tax is often an important consideration and the tax breaks associated with charitable status can be an important factor in the selection of this form.

**Benefits and Disadvantages**

Some of the **key benefits** of a corporate joint venture arrangement are set out below:

- A corporate joint venture entity will have its own separate legal personality and will represent greater integration of the parties.
- A corporate joint venture company may have more flexible financing options. For example, if a company limited by shares is created, the corporate structure allows equity to be raised and can generally accommodate shareholders with different equity interests. A company can borrow in its own name, secure the borrowing and generally issue loan stock.
- From the provider’s perspective, a corporate joint venture vehicle (for example, a company) will mean that the shareholders are able to limit their liability to the investment in the company.
- The shareholders/members of a corporate joint venture have the flexibility to agree on appropriate arrangements to govern their relationship.

Some of the **key disadvantages** of a corporate joint venture arrangement are set out below:

- There are a number of administrative steps that need to be completed if establishing or dissolving a corporate joint venture entity such as a company.
- The separate corporate entity may require a separate CQC registration.
- If any of the providers are PCTs or NHS Trusts, there may be limitations on the ability to form companies or separate legal entities. For further details, please see page 37 below and Chapter 20 of the Transactions Manual.
The newly formed corporate entity may lack financial muscle which may mean that commissioners are forced to seek performance guarantees from shareholders or members (as the case maybe).

There may be particular taxation and VAT issues associated with a corporate joint venture entity and PCTs should seek separate financial advice to address these issues.

If staff transfer (by operation of TUPE) to the corporate vehicle, then unless the corporate vehicle satisfies certain tests under NHS pension rules, the NHS Pension scheme may no longer be available to such transferring staff. In that event, the obligation to provide broadly comparable pension benefits (which are set out below) must be met by the new provider.

**Vires issues relating to providers who are NHS Trusts or PCTs**

If any of the potential providers wishing to form an ICO are PCTs and/or NHS Trusts, then, as creatures of statute they must only act in accordance with the 2006 Act. Under the 2006 Act, PCTs and NHS Trusts have limited vires and statutory powers to form and invest in companies. They may only form a company in the following circumstances:

- For the purposes of income generation;
- For public private partnerships; or
- If to do so falls within the general power to do anything necessary or expedient for the purposes of, or in connection with, its functions.

NHS Foundation Trusts are not bound by the same restrictions as NHS Trusts and PCTs. Accordingly, a provider that is an NHS Foundation Trust does not need to rely on any of the circumstances set out above.

For more information on the vires powers of PCTs and NHS Trusts, please see Chapter 20 of the DH Transactions Manual.

**Staffing issues relating to choice of corporate vehicle**

There are three potential staffing issues that may arise from the corporate vehicle which is selected to provide services in an integrated care system arrangement:

- TUPE obligations;
- Pension issues; and
- Obligations to new recruits under the Code of Practice on Workforce Matters in Public Sector Service Contracts (the Two Tier Workforce Code).

**TUPE**

Where the award of the contract results in a transfer of the obligation to deliver services from an existing provider, that transfer can result in the application of TUPE. When TUPE applies, the obligations with respect to the continuation of employment of transferring employees on existing terms and conditions of employment (and the resulting limitations on the ability to vary employment contracts post-transfer) must be considered.

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7 The changes to commissioning responsibilities proposed in the White Paper should be considered in this context. Please refer to the overview of these changes on page 6.
Pension Issues
In addition to obligations under TUPE, when the transfer of employment affects existing NHS staff, the pension obligations which are due to those employees must be considered. While TUPE does not require new employers to continue benefits for old age, invalidity or survivors in employees' occupational pension schemes, the general rules in relation to pensions do not apply to transfers of employment of NHS employees.

Four potential options exist in relation to the pension obligations due to NHS staff:

- where the transfer of employment is to another NHS employer, membership of the NHS Pension Scheme will continue;
- where the new provider meets the statutory or regulatory requirements to be an “employing authority” the new provider can offer the transferring employees continued membership of the NHS Pension Scheme;
- if the new provider is granted “direction employer” status, it will be able to offer the transferring employees continued membership of the NHS Pension Scheme with certain limitations; or
- where the new provider cannot continue the transferring employees’ membership of the NHS Pension Scheme, they will instead be required to provide former NHS staff with pension benefits the new employer offers transferring staff membership of a pension scheme which, although not identical, is ‘broadly comparable’ to the NHS Pension Scheme. To determine whether the new provider’s scheme meets this criteria a certificate of broad comparability must be obtained from the Government Actuary's Department which requires a determination that there are no identifiable employees who will suffer material detriment overall in terms of their future accrual of pension benefits under the alternative scheme. Such schemes can result in significant additional costs which must be incurred by the new employer.

Two Tier Workforce Code
Integrated care system service providers may also be required to take note of the Two Tier Workforce Code where the service provider recruits new staff to work alongside staff transferred from the NHS. In such circumstances, the provider is required to offer employment on fair and reasonable terms and conditions which are, overall, no less favourable than those of transferred employees. The service provider must also offer reasonable pension arrangements.

3.6.5. Provider delivery models for integrated care systems

Overview
To establish an integrated care system, the PCT may choose to enter a single contract with a group of providers (one contract approach) or, alternatively, enter a number of contracts with separate providers (multi contract approach).

This chapter illustrates some contractual models that the PCT may put in place with providers and highlights the key factors to consider when considering each model.

Four of the proposed contractual models that were consulted on as part of the development of this guidance have been set out in section 3.1.
One Contract Approach
There are a few ways to contractually implement the ‘one contract approach’ as outlined below. Whether or not this approach is suitable for a PCT will depend on the provisions of the contracts that the PCT currently has in place with its providers and the extent to which the providers are willing to fit within the PCT’s preferred contractual structure.

It would be advisable for the PCT to seek legal advice to assist the PCT in selecting the most suitable contractual structure in its circumstances.  

PCT contracts with JV which sub-contracts services to other providers
One option is for the PCT to contract with corporate joint venture company established by a group of providers. Regardless of the corporate joint venture form selected by the group of providers, the joint venture entity would sub-contract the provision of the services to other providers. This contractual structure may or may not involve an interface agreement and include direct agreements with the PCT and the various sub-contractors.

In the illustration below, the PCT is directly contracting for pharmacy and dental services.  

In addition to the key benefits and disadvantages of a provider corporate joint venture set out above, the following additional factors should be considered:

- If the ICO will be providing the services to the PCT via sub-contractors, the parties will need to ensure the obligations set out in the sub-contract arrangements reflect the obligations owed by the ICO to the PCT as set out in the new integrated care system contract.

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8 The changes to commissioning responsibilities proposed in the White Paper should be considered in this context. Please refer to the overview of these changes on page 6.
9 The changes to commissioning responsibilities proposed in the White Paper should be considered in this context. Please refer to the overview of these changes on page 6.
The PCT may wish to ensure it has appropriate guarantees and indemnities (or direct agreements) from the ICO and any material sub-contractors relating to the provision of services.

The contracts must comply with the appropriate legislation and guidance, where applicable (please see section 3.6.2 for further details).

If the ICO sub-contracts its obligations, the PCT may have a lack of communication with the sub-contractors and may wish to have additional information reporting obligations and/or have the ability to meet with the sub-contractors from time to time regarding service provision.

The PCT will wish to ensure the contractual arrangements provide a mechanism for continuity of service provision in the event any of the sub-contractors are replaced for any reason.

The PCT and providers may wish to ensure that any interface agreement between them is robust.

The PCT may wish to ensure that there are appropriate payment incentives included in the contracts between the ICO and the providers.

If the contractual arrangements result in the potential for a transfer of employees from a current provider of services, the obligations of TUPE (both with respect to the continuation of employment of transferring employees on existing terms and conditions of employment and limitations on the ability to vary contracts post-transfer) must be considered.

**PCT contracts with lead contractor which sub-contracts services to other providers**

Another option is for the PCT to sign a single contract with a lead contractor (selected by the providers to contract on their behalf). The lead contractor would then sub-contract the provision of the services to the other providers. This contractual structure may or may not involve an interface agreement between the providers and include direct agreements with the PCT and the various sub-contractors.

In the illustration below, the PCT is again contracting directly for pharmacy and dental services.\(^\text{10}\)

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\(^\text{10}\) The changes to commissioning responsibilities proposed in the White Paper should be considered in this context. Please refer to the overview of these changes on page 6.
In this diagram, the relationship between the lead contractor and the providers represents a contractual joint venture arrangement. In addition to the key benefits and disadvantages of a provider contractual joint venture arrangement set out in paragraph 3.5.4, the following additional factors should be considered:

- As the lead contractor will be providing the services to the PCT via subcontractors, the parties will need to ensure the obligations set out in the subcontract arrangements reflect the obligations owed by the lead contractor to the PCT as set out in the new integrated care system contract.

- The providers will need to have appropriate governance arrangements in place to ensure there are systems and processes for ensuring there is proper accountability and openness between them. In this example, the governance arrangements and the rights and liabilities of each provider (as between them) may be set out in an interface agreement between the lead contractor and each of the providers. The PCT may also be a party to this interface agreement.

- The PCT may wish to ensure it has appropriate guarantees and indemnities from the lead contractor relating to the services and be sure the lead contractor will be liable for any contractual failures.

- The providers will need to select one lead contractor and the arrangements between the lead contractor and providers will need to be clearly defined, particularly in respect of liability.

- The contracts must comply with the appropriate legislation, where applicable (please see Section 3.6.2 for further details).
- Given the sub-contractor arrangements, the PCT will have a lack of communication with the sub-contractors and may wish to have the ability to meet with the sub-contractors from time to time regarding service provision.

- The PCT will wish to ensure the contractual arrangements provide a mechanism for ensuring there is continuity of service provision in the event any of the sub-contractors is replaced for any reason.

- Will the integrated care system contracts result in the change in identity of any existing providers, which may result in the application of TUPE and the potential that alternative pension arrangements may be required for employees who transfer from the NHS.

- The PCT and providers may wish to ensure that any interface agreement between the providers is robust.

- There are appropriate payment incentives included in the contracts between the lead contractors and the sub-contractors.

**PCT has one contract with a variety of providers (each signing same contract)**
The PCT may sign one contract with a variety of providers. This may take the form of an APMS contract (particularly if the contract will cover the provision of primary care services). The contract will list the various services provided by each provider along with any jointly provided services.

In the illustration below, the PCT is again contracting directly for pharmacy and dental services.\(^\text{11}\)

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1 APMS contract (because primary care)
- 4 providers
- Each provider to provide a “list” of services and a “list of joint services”

Acute Provider
Community Provider
Mental Health Provider
Primary Care Provider (GP)

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\(^\text{11}\) The changes to commissioning responsibilities proposed in the White Paper should be considered in this context. Please refer to the overview of these changes on page 6.
The following factors should be considered in respect of this contractual model:

- The selected contract that will be signed by a few providers must comply with the appropriate legislation and guidance governing the relevant services. For example, if any of the services are primary care services then the single contract will need to meet the requirements of the APMS Directions 2010 in respect of those services.

- The termination provisions will need to be carefully considered and the PCT may wish to allow for partial termination of the single contract (e.g. termination of a particular service line due to poor performance or otherwise) and may like the ability to ‘step-in’ and either perform that particular service itself or contract with an alternative service provider to perform the service.

- The PCT will wish to ensure the contract includes a mechanism for ensuring there is a continuity of service provision in the event there is a change of one of the service providers.

- The obligations of each provider will need to be set out and reflect the services being provided by that provider. As noted above, the regulations may require more stringent obligations to be placed on some providers (e.g. primary care provider) than others (e.g. acute providers).

- The liability of each provider to the PCT will need to be addressed and the PCT may wish to ensure that the contract includes appropriate guarantees and indemnities from each of the providers in relation to the services they are providing.

- If the new single contract results in the change in identity of any existing providers, this may result in the application of TUPE and there is the potential that alternative pension arrangements may be required for employees who transfer from the NHS.

Multi Contract Approach
Alternatively, the PCT may choose to enter a number of contracts with providers. Some illustrations of some possible contracting models are set out below.

**PCT has one identical contract with a variety of providers – 5 separate contracts**
Another option is for the PCT to hold one identical contract with a variety of providers. The PCT could achieve this result by either:

- varying its existing contracts with each provider; or
- putting in place a new “integrated care system” contract with each provider.

If the contractual structure set out below adopted, the PCT will enter six separate “integrated care system” contracts – one with each provider. Alternatively, the PCT may wish to amend its existing contracts with those providers.¹²

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¹² The changes to commissioning responsibilities proposed in the White Paper should be considered in this context. Please refer to the overview of these changes on page 6.
As noted above, the ‘multi-contract approach’ may be achieved in two ways. If the PCT decides to put in place new integrated care system contracts, then the following factors should be considered:

- Whether or not separate contracts will achieve ‘integration’ and meet the objectives of the integrated care system.

- PCT and providers to consider whether to agree the terms of a joint working/interface agreement to govern the relationship between them and whether to include payment incentives or deductions to compensate if joint working is not achieved.

- If the integrated care system contract results in the change in identity of any existing providers, this may result in the application of TUPE and there is the potential that alternative pension arrangements may be required for employees who transfer from the NHS.

If the provider decides to vary its existing contracts, then please see the relevant factors set out in respect of paragraph 3.6.5.

**PCT continues with existing contracts with existing providers**

If this option is selected by the PCT, the PCT will continue with its existing contracts with its existing providers. In this model, there is no separate contract for the integrated care system services. Instead, each of the existing contracts are varied to accommodate the changes for the integrated care system. The providers may will sign up to an interface agreement (to which the PCT may, or may not, be a party) to cover the joint working arrangements. Payment incentives and/or deductions may be included in the interface agreement to compensate if joint working is not achieved.

As set out in Section 3.6.4, varying existing contracts may or may not trigger the procurement rules. PCTs should seek legal advice early in the process when
considered varying any existing contracts to ensure the appropriate variation procedure is followed.¹³

The following factors should be considered in respect of this contractual model:

- Need to consider the variations that will need to be made to each of the existing contracts to accommodate the changes that need to be made for the integrated care system. In particular:
  
  (i) Services to be provided by each provider;
  (ii) Activity Plan;
  (iii) Annual Contract Value;
  (iv) Service Development and Improvement Plan; and
  (v) CQUIN

- Providers to consider whether to sign up to a joint working/interface agreement to govern their relationship and whether to include payment incentives or deductions to compensate if joint working is not achieved.

- In respect of the acute, community services and mental health contracts, the procedure for change set out in the contract needs to be considered.

- Consider any procurement implications and consultation requirements resulting from the changes.

¹³ The changes to commissioning responsibilities proposed in the White Paper should be considered in this context. Please refer to the overview of these changes on page 6.
### 3.6.7. Steps to take when implementing an integrated care system

<table>
<thead>
<tr>
<th>STEP</th>
<th>ACTION</th>
</tr>
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| 1    | Consider what existing contracts are in place and whether the contracts are subject to legislative requirements. In particular, consider:  
  - payment  
  - termination  
  - variation  
  - current status of service provision  
  - information provision |
| 2    | Consider what changes need to be made to the existing contracts  
  In particular, consider:  
  - Services to be provided  
  - Activity Plan  
  - Annual Contract Value  
  - Service Development and Improvement plan  
  - CQUIN  
  - Impact that the reduction of services or amounts paid to existing providers may have on the local health economy or the sustainability of other services. |
| 3    | Set out the desired procedure for making the changes to the contracts |
| 4    | Consider any procurement implications arising from changing the contract terms and procuring “new” services |
| 5    | Consider any consultation law requirements relating to changes to provision of healthcare |
| 6    | Consider any staffing and pensions issues in relation to transfers of staff (and possibly redundancy). |
| 7    | Consider any property law issues relating to occupation of premises and ownership of assets. |
| 8    | Providers to consider the preferred form of provider joint venture, liaising with the PCT where necessary |
| 9    | PCT and providers to select the preferred contracting model for the integrated care system |
| 10   | Make any necessary amendments to the contracts and implement the integrated care system |
Making it happen  Taking the right steps to implement change and connecting with the enablers – IT, workforce, estates – that will make that change happen

THIS SECTION WILL BE FURTHER DEVELOPED FOLLOWING TESTING WITH PARTNER SITES

4.1. Lessons learnt to date (to be continued with learning from pilots)

Implementing new delivery/ contractual models
This should incorporate lessons learnt from CSL polysystems first wave evaluation report, desktop research and from initial testing with partner sites:

- Clinical leadership is needed to ensure that clinicians, in particular GPs, lead the development of new, integrated pathways and the case for change is driven by clear clinical benefits
- Providers can’t operate in a vacuum. Commissioners need to be clear about the scope of any integrated care contract/ model and the objectives of integration
- Crucial and consistent message is that form must follow function. Successful integrated systems tend to grow organically
- Challenges are likely to be encountered in bringing together different organisational cultures
- Potential economies of scope and scale are likely to take time to achieve and much evidence from the US suggests integration alone has seldom increased efficiency

Learning from PACE
All parties who operated at both strategic and implementation levels during the pilot phase were invited to evaluation workshops to capture learning. The following themes were drawn out by a neutral moderator and approved by the participants:

Generic Principles

- **Field Your Best Team:** the scale of success resulted from committing the best people to the start-up. Their positive, solution-oriented attitude ensured a rapid project was delivered efficiently with benefits for patients.
- **Communicate! Communicate!** even with a formal plan driven diligently we still struggled to keep everyone informed. Inadequate communication is immediately apparent and affects delivery. Reaching everyone affected by the service is
exceptionally difficult. Indeed, some groups complained of not being informed even after having been sent details in several formats.

- **Lobby for Senior Support**: sustaining a piloted service can be achieved by ensuring that success is understood and discussed where change is enabled. PACE was actively promoted to senior groups, committees and individuals.

- **Empower Teams to Respond Quickly and Appropriately**: PACE works when staff make appropriate decisions throughout the process. Governance should ensure safe and correct clinical decision are made by the appropriate practitioners but beyond this team members should be free act on what they feel most benefits the patient.

- **Evolve don’t revolve**: The pilot approach offered a perfect environment for continuous learning, skills development and rapid implementation of lessons learned. Clinical practice was adapted throughout the pilot. This approach should be adopted as an ongoing principle in any PACE scheme to ensure high-performing teams and services.

- **Consultant Advocate for a New Service**: success depended upon hospital doctors and therapists believing the service will meet their patients’ needs safely. The Hospital Geriatrician understood both acute and intermediate care services so could speak to colleagues with knowledge and confidence.

- **Rapid Access to Senior Clinical Support**: this type of working requires staff to accept greater responsibility than traditional intermediate care. Access to immediate and senior support (from acute or CPU) is essential to maintain confidence and safety.

**Strategic Considerations**

- **Alignment to Local Organisation Objectives**: close working relationships were facilitated by the alignment of PACE to the three organisations’ objectives and goals. It was common to hear that PACE “is high on our agenda” in all partner organisations. Senior members of services that had been trying to work across boundaries commented that doors were being opened through PACE that had previously been firmly closed.

- **Alignment to Regional & National Strategies**: PACE aligned to *A Picture of Health; Healthcare for London, Transforming Community Services and Transforming Social Care*. It addressed components of all four strategic drivers providing the leverage to open doors that have traditionally remained close.

- **Funding**: It was necessary to underwrite the risk of collaboration between health and social care – values and aspirations were not enough. The CPU funded the cost of domiciliary care provided by ASC teams whilst the patient is medically unwell.

- **Rotational Roles**: Posts that rotate through all intermediate care functions (and possibly acute care) have been discussed and are thought to be well worth pursuing as a means of promoting collaboration and personal competency development.

**Tactical Challenges**

- **Inter-organisational Issues**: Staff were seconded into the PACE from three organisations. This presented a number of challenges:
  - Contrasting terms and conditions: Each organisation offers staff different terms and conditions of employment eg: some staff had substantive contracts; others were paid hourly. These differences had to be managed with sensitivity but also had practical implications for the organisation of
the staff rota.

- **Honorary Contracts**: community staff assessing patients in the hospital were required to have an honorary contract. These had to be arranged at short notice and gathering the required documentation and paperwork was time-consuming.

- **Organisational boundaries between support services**: To function, the team needed computers able to access community systems whilst via the hospital’s network. Establishing responsibility for implementing and troubleshooting this system proved a significant challenge.

- **Documentation/Record Keeping**: Each organisation had different documentation requirements and additional information was also collected for the purposes of the evaluation. The LMT ultimately agreed a data set and process that satisfied all organisations.

- **Risk and Governance**: Each organisation had different risk and governance procedures for a new service. Contact was made with the risk and governance leads at each organisation and a risk and governance framework and guidelines developed that were acceptable to all.

- **Duplication**: The PACE service was perceived as a potential competitor to some of the acute services with discharge functions.

- **Releasing Staff Quickly From Mainstream Services**: staff were drawn from existing services to support rapid start and to ensure the team had local knowledge. This required existing services to be backfilled to avoid destabilisation.

- **Accommodation and Furnishing for PACE Team**: the PACE team needs a lockable base of operations in the hospital with desks, computers, white boards and a filing cabinet. Pressure on space in the hospital made this challenging.

- **Team Induction and Unity**: PACE required individuals from different services employed by different organisations to come together as a team more or less immediately. The team has demonstrated a very positive ‘can do’ approach and a willingness to support one another throughout the pilot. However, with more time we would have preferred a more structured induction and warm-in.

- **Seven Day Contracts**: existing intermediate services in Bromley operate a reduced weekend service. To support weekend discharges PACE needs to be a seven day service. Whilst the pilot staff were willing to ensure rotas were covered, as the pilot progressed it became clear that any substantive appointments should be on the understanding that this is a seven-day service.

- **Adjusting to Working in an Acute Environment**: many members of the PACE team were accustomed to working in the community. A new base in the hospital required adaptation to a range of policies from staff car parking to an awareness of the 4-hour target in A&E and its implications for Case Finding and discharge.

- **Changing Practices**: the PACE criteria requires a Specialist Registrar (SpR) or Consultant to record ‘medically stability’ in the patient notes. This step is not required on referral to other community services. Case Finders worked to ensure ‘stability’ was documented. This had to be handled delicately since PACE had been praised by acute staff for ease of access and no need for a written referral.

- **Patient Choice**: the pilot began by offering patients the choice of staying or transferring to PACE but this was at odds with the hospital's discharge policy. Following discussions with acute matrons PACE changed its criteria to no longer offer the choice.

- **Integration with Social Care**: ASC trusted the PACE team to assess and prescribe social input directly. This created a direct and rapid pathway for patients enhancing care and the relationship between health and social services.

- **On-going Social Need**: where there is a need for care beyond the PACE horizon, referral and assessment needs to be swift with arrangements in place.
from the outset of PACE care. On occasion, patients were taken under-care by PACE only to have a social assessment delayed requiring an unfunded extension to the PACE episode.

- **Junior Doctor Changeovers:** this stalls referrals and delays medical sign off needed for discharge until the doctors have become comfortable with PACE.
- **Seasonal Demand Variation:** during August the acute trust slowed its surgical activity and medical demand was low. As winter approaches, demand for PACE is rising.
- **Acute Reconfiguration:** when two acute wards were merged into a 48-hour assessment unit demand for PACE dropped as staff concentrated on moves rather than patients.
- **Medication:** the PACE team needs to be across discharge details like take home drugs lest this delay the transfer to PACE care.

**Opportunities for Further Alignment**

- **Equipment:** length of stay with the PACE service was artificially lengthened by difficulties obtaining equipment for the home.
- **Medication Records (NOMADS):** Although PACE patients no longer needed acute care it was common for the team to identify medical issues once they were home. This most often involved medication management where new drugs prescribed in hospital were not in the patient’s NOMAD or other system. In some cases it took two weeks to obtain the NOMAD record. The team kept these patients as they had a duty of care to ensure that the patient was adequately instructed and checked in their ability to use the NOMAD safely.
- **Existing Medication:** we found hoards of unused drugs, sharing of medication between family members and instances where patients had not been taking medication for many weeks. Some of these issues undoubtedly contributed to the patient’s admission to hospital. This has led us to explore inclusion of a dedicated pharmacy technician in the team. To respond to some of the medical monitoring issues, all team members have been trained in basic medical monitoring. It is hoped to do further training in medicines administration and wound and catheter care.
- **Weekend transfers to PACE:** these depend upon strong weekend discharge arrangements in the hospital eg nurse-led discharges; weekend rounds and pharmacy support. During the pilot admissions to PACE over the weekend were slow so the team spent its weekends making sure that patients could go home under PACE care without delay on Monday morning. It was felt by the team that with an appropriate hospital weekend discharge planning the potential to discharge more people under PACE would rise.
- **Work May Be Required to Clarify PACE Pathways Inside the Hospital:** On occasion, normal hospital events compromised the ability of the PACE team to take-on patients. These types of minor glitches need to be logged and addressed as they arise. Examples included:
  - An end of life patient placed on a surgical ward since medical wards were full – surgeons did not feel competent to discharge the patient to PACE and the medics did not regard the patient as under their care.
  - A doctor on-call at the weekend felt unable to write a take-home drug prescription – this was because the patient did not have a care plan in their notes from the speciality and the on-call doctor did not feel able to take ownership of the patient’s care.
38 VARIATIONS

38.1 This Agreement may not be amended other than in accordance with this clause 38 (Variations).

38.2 The Parties:

38.2.1 subject to clause 49.4 may agree to vary the provisions of this Agreement and its Schedules that are set out in Schedule 21 (Provisions that may be varied);

38.2.2 shall not vary any provision of this Agreement or its Schedules that is not set out in Schedule 21 (Provisions that may be varied) without the approval of the Secretary of State or the Department of Health.

38.3 Subject to clauses 38.2 and 49.4, the provisions of this Agreement and its Schedules may be varied by agreement in writing, signed by the Co-ordinating Commissioner’s representative on behalf of the Commissioners, and by the Provider’s representative on behalf of the Provider.

38.4 Subject to clause 49.4, where any Party, with a view to reaching agreement on a proposed Variation requests that it be considered in detail, then the provisions of Schedule 6 Part 1 shall apply.

38.5 All requests for Variations shall be made in writing and all Variations shall be recorded in Schedule 6 Part 2.

38.6 Each Party that requests a Variation shall have regard to its impact on the other Services, and in particular the Mandatory Goods and Services and the Essential Services.

38.7 Where a Co-ordinating Commissioner proposed Variation would have the effect of increasing the Annual Contract Value, then that increase shall be in line with the Prices agreed under clause 7 (Prices and Payment). In all other circumstances agreement over such Variation must include agreement in respect of the costs associated with implementing it.

38.8 Where a Variation would have a cost implication for the Commissioners, including for the avoidance of doubt and without limitation, additional activity, new treatments, drugs or technologies, then:

38.8.1 the Provider shall provide a full and detailed cost and benefit analysis of the requested or proposed Variation; and

38.8.2 the Co-ordinating Commissioner shall, after consultation with the Provider, in its absolute discretion have the right to refuse or withdraw the requested or proposed Variation; and

38.8.3 the Commissioners shall have no liability to the Provider for any costs arising from the requested or proposed Variation should the Provider implement it other than in accordance with this Agreement.

38.9 Where a Service Variation is agreed which involves the withdrawal of a Service and the Provider withdraws the Service prior to the date agreed for such withdrawal then the Provider shall be liable to the Commissioners for all reasonable costs and losses directly attributable to the early withdrawal of such Service. Where a Service Variation is agreed which involves the withdrawal of a Service and a Commissioner ceases to commission the Service prior to the date agreed for such withdrawal then the Commissioner shall be liable to the Provider for all reasonable costs and losses directly attributable to the early cessation of such commissioning.

38.10 Where the Parties fail to agree a National Variation, having followed the procedure in Schedule 6 Part 1, the Provider may terminate this Agreement in accordance with clause 35.1.2 or the Co-ordinating Commissioner may terminate this Agreement in accordance with clause 35.2.2.
38.11 Where the Parties fail to agree a Service Variation, having followed the procedure in Schedule 6 Part 1, the Provider may terminate this Agreement in accordance with clause 35.1.3 or the Co-ordinating Commissioner may terminate this Agreement in accordance with clause 35.2.3.

SCHEDULE 6 – VARIATIONS

Schedule 6 Part 1: Variation Procedure
1. Where clause 38.4 applies, the Parties shall follow the procedure set out in this Schedule 6 Part 1.
2. The Party proposing the Variation (“the Proposer”) shall make a proposal in writing to the other Party (a “Variation Proposal” or “VP”) setting out the Variation proposed and the date upon which the Proposer requires it to take effect.
3. Upon receipt of a VP, the receiving Party (“the Recipient”) shall respond to it in writing within 10 Operational Days from the date of the VP, or if it is marked “urgent” within 5 Operational Days of the date of the VP.
4. The Parties shall then meet within 10 Operational Days of the date of the Recipient's response to discuss the VP and acting reasonably and in good faith shall use reasonable endeavours to agree the Variation.
5. If, notwithstanding paragraph 4 above, the Recipient does not agree the Variation, the Recipient shall give notice in writing to the Proposer that the Variation is refused and shall set out reasonable grounds for such refusal. The Proposer may then:
   5.1 withdraw the VP; or
   5.2 refer such refusal to dispute resolution under clause 28 (Dispute Resolution); or
5.3 serve notice to terminate this Agreement in accordance with clause 35.1 or 35.2, as appropriate.

Schedule 6 Part 2

Schedule 6 Part 2: Recorded Variations and Dispute Resolutions
38 VARIATIONS
38.1 This Agreement may not be amended other than in accordance with this clause 1 (Variations).
38.2 With the exception of any provision of this Agreement specified to be for local agreement or local determination and/or which may be highlighted in amber or green, the Parties shall not vary any provision of this Agreement without the approval of the Secretary of State or the Department of Health.
38.3 The provisions which may be varied in accordance with clause 1.1 must be agreed in writing, signed by the Commissioner’s representative on behalf of the Commissioner, and by the Provider’s representative on behalf of the Provider.
38.4 Subject to clause 49.4, where any Party, with a view to reaching agreement on a proposed Variation requests that it be considered in detail, then the provisions of Schedule 4 Part 1 (Variation Procedure) shall apply.
38.5 All requests for Variations shall be made in writing and all Variations shall be recorded in Schedule 4 Part 2 (Recorded Variations and Dispute Resolutions).
38.6 Each Party that requests a Variation shall have regard to its impact on the other Services, and in particular the Mandatory Goods and Services and the Essential Services.
38.7 Where a Commissioner-proposed Variation would have the effect of increasing the Annual Contract Value, then that increase shall be in line with the Prices agreed under clause 7 (Prices and Payment). In all other circumstances agreement over such Variation must include agreement in respect of the costs associated with implementing it.
38.8 Where a Variation would have a cost implication for the Commissioner, including for the avoidance of doubt and without limitation, additional activity, new treatments, drugs or technologies, then:
   38.8.1 the Provider shall provide a full and detailed cost and benefit analysis of the requested or proposed Variation; and
   38.8.2 the Commissioner shall, after consultation with the Provider, in its absolute discretion have the right to refuse or withdraw the requested or proposed Variation; and
   38.8.3 the Commissioner shall have no liability to the Provider for any costs arising from the requested or proposed Variation should the Provider implement it other than in accordance with this Agreement.
38.9 Where a Service Variation is agreed which involves the withdrawal of a Service and the Provider withdraws the Service prior to the date agreed for such withdrawal then the Provider shall be liable to the Commissioner for all reasonable costs and losses directly attributable to the early withdrawal of such Service. Where a Service Variation is agreed which involves the withdrawal of a Service and the Commissioner ceases to commission the Service prior to the date agreed for such withdrawal then the Commissioner shall be liable to the Provider for all reasonable costs and losses directly attributable to the early cessation of such commissioning.
38.10 Where the Parties fail to agree a National Variation, having followed the procedure in Schedule 4 Part 1 (Variation Procedure), the Provider may terminate this Agreement in accordance with clause 35.1.2, or the Commissioner may terminate this Agreement in accordance with clause 35.2.2.
38.11 Where the Parties fail to agree a Service Variation, having followed the procedure in Schedule 4 Part 1, the Provider may terminate this Agreement in
accordance with clause 35.1.3 or the Commissioner may terminate this Agreement in accordance with clause 35.2.3.

SCHEDULE 4 – SERVICE VARIATIONS, NATIONAL VARIATIONS AND OTHER VARIATIONS

Schedule 4 Part 1: Variation Procedure
1. Where clause 38.4 applies, the Parties shall follow the procedure set out in this Schedule 4 Part 1.
2. The Party proposing the Variation (the “Proposer”) shall make a proposal in writing to the other Party (a “Variation Proposal” or “VP”) setting out the Variation proposed and the date upon which the Proposer requires it to take effect.
3. Upon receipt of a VP, the receiving Party (the “Recipient”) shall respond to it in writing within 10 Operational Days from the date of the VP, or if it is marked “urgent” within 5 Operational Days of the date of the VP.
4. The Parties shall then meet within 10 Operational Days of the date of the Recipient’s response to discuss the VP and acting reasonably and in good faith shall use reasonable endeavours to agree the Variation.
5. If, notwithstanding paragraph 4 above, the Recipient does not agree the Variation, the Recipient shall give notice in writing to the Proposer that the Variation is refused and shall set out reasonable grounds for such refusal. The Proposer may then:
   5.1 withdraw the VP; or
   5.2 refer such refusal to dispute resolution under clause 28 (Dispute Resolution); or
   5.3 serve notice to terminate this Agreement in accordance with clause 35.1 or 35.2, as appropriate.

Schedule 4 Part 2: Recorded Variations and Dispute Resolutions
Contract variation in the DH standard form mental health and learning disability services contract 2010/11

38. VARIATIONS
38.1 This Agreement may not be amended other than in accordance with this clause 38 (Variations).
38.2 The Parties:
   38.2.1 subject to clause 49.4, may agree to vary the provisions of this Agreement and its Schedules that are set out in Schedule 21 (Provisions that may be varied);
   38.2.2 shall not vary any provision of this Agreement or its Schedules that is not set out in Schedule 21 (Provisions that may be varied) without the approval of the Secretary of State or the Department of Health.
38.3 Subject to clauses 38.2 and 49.4, the provisions of this Agreement and its Schedules may be varied by agreement in writing, signed by the Commissioner’s representative on behalf of the Commissioner, and by the Provider’s representative on behalf of the Provider.
38.4 Subject to clause 49.4, where any Party, with a view to reaching agreement on a proposed Variation requests that it be considered in detail, then the provisions of Schedule 6 Part 1 (Variation Procedure) shall apply.
38.5 All requests for Variations shall be made in writing and all Variations shall be recorded in Schedule 6 Part 2.
38.6 Each Party that requests a Variation shall have regard to its impact on the other Services, and in particular the Mandatory Goods and Services and the Essential Services.
38.7 Where a Commissioner-proposed Variation would have the effect of increasing the Annual Contract Value, then that increase shall be in line with the Prices agreed under clause 7 (Prices and Payment). In all other circumstances agreement over such Variation must include agreement in respect of the costs associated with implementing it.
38.8 Where a Variation would have a cost implication for the Commissioner, including for the avoidance of doubt and without limitation additional activity, new treatments, drugs or technologies, then:
   38.8.1 the Provider shall provide a full and detailed cost and benefit analysis of the requested or proposed Variation; and
   38.8.2 the Commissioner shall, after consultation with the Provider, in its absolute discretion have the right to refuse or withdraw the requested or proposed Variation; and
   38.8.3 the Commissioner shall have no liability to the Provider for any costs arising from the requested or proposed Variation should the Provider implement it other than in accordance with this Agreement.
38.9 Where a Service Variation is agreed which involves the withdrawal of a Service and the Provider withdraws the Service prior to the date agreed for such withdrawal then the Provider shall be liable to the Commissioner for all reasonable costs and losses directly attributable to the early withdrawal of such Service. Where a Service Variation is agreed which involves the withdrawal of a Service and the Commissioner ceases to commission the Service prior to the date agreed for such withdrawal then the Commissioner shall be liable to the Provider for all reasonable costs and losses directly attributable to the early cessation of such commissioning.
38.10 Where the Parties fail to agree a National Variation, having followed the procedure in Schedule 6 Part 1 (Variation Procedure), the Provider may terminate this Agreement in accordance with clause 35.1.2, or the
Commissioner may terminate this Agreement in accordance with clause 35.2.2.

38.11 Where the Parties fail to agree a Service Variation, having followed the procedure in Schedule 6 Part 1 (Variation Procedure), the Provider may terminate this Agreement in accordance with clause 35.1.3 or the Commissioner may terminate this Agreement in accordance with clause 35.2.3.

SCHEDULE 6

SERVICE VARIATIONS, NATIONAL VARIATIONS AND OTHER VARIATIONS

Schedule 6 Part 1: Variation Procedure

1. Where clause 38.4 applies, the Parties shall follow the procedure set out in this Schedule 6 Part 1.

2. The Party proposing the Variation (“the Proposer”) shall make a proposal in writing to the other Party (a “Variation Proposal” or “VP”) setting out the Variation proposed and the date upon which the Proposer requires it to take effect.

3. Upon receipt of a VP, the receiving Party (“the Recipient”) shall respond to it in writing within 10 Operational Days from the date of the VP, or if it is marked “urgent” within 5 Operational Days of the date of the VP.

4. The Parties shall then meet within 10 Operational Days of the date of the Recipient’s response to discuss the VP and acting reasonably and in good faith shall use reasonable endeavours to agree the Variation.

5. If, notwithstanding paragraph 4 above, the Recipient does not agree the Variation, the Recipient shall give notice in writing to the Proposer that the Variation is refused and shall set out reasonable grounds for such refusal. The Proposer may then:

5.1 withdraw the VP; or

5.2 refer such refusal to dispute resolution under clause 28 (Dispute Resolution); or

5.3 serve notice to terminate this Agreement in accordance with clauses 35.1 or 35.2 as appropriate.

Schedule 6 Part 2: Recorded Variations and Dispute Resolutions
Appendix 4: General principles for successful contractual arrangements for providers within an integrated care system

- Each provider is willing and able to provide its own services which are clinically safe
- Patient feedback is good with minimal complaints and new registration is maximised
- Providers do not suffer reputational damage for the poor performance of others
- Providers have a line of communication with the commissioner even if they are not the lead provider
- Transparent information and performance data sharing between providers.
- Providers are not penalised for the failure of others nor do they blame each other for failures
- Providers need to make a profit and not a loss, are financially stable with a workforce capable of delivering high quality care
- Penalties do not outweigh the benefits of putting wrongs right

From a commissioner perspective, successful arrangements mean:

- Objectives for service redesign are met
- Patients receive a safe, high quality service
- The arrangement is best value for the taxpayer
- The service feels seamless even though it is delivered by multiple providers.
- Certainty about what is being paid for and double payment is avoided. Services do not cost more than we budget.
- A single set of coherent monitoring data
- Ability to incentivise but also to performance manage
- Ability to terminate different providers
- Good communication and an early understanding of the issues likely to arise.
### Appendix 5: PACE governance and documentation model overview

#### OVERARCHING GOVERNANCE
- **Hospital Trust**
- **Community Provider**
- **Community Provider unless readmission required.**
- **GP or other continuing or social care provider**

#### OWNING CLINICIAN
- **Acute Team**
- **PACE team leader / deputy**
- **PACE team leader / deputy unless readmission**

#### DOCUMENTATION
- **1.1 FACEFreeNet Referral**
  - Emailed to XXX@nhs.net account by acute team or case-finder and emailed to XXX@nhs.net account
- **1.2 Community Care Record**
  - collated by case-finder
- **2.1 Agreed Management Plan**
  - including risk decisions
- **2.2 XXX drug chart**
- **2.3 Hospital D/C summary**
- **2.4 Patient consent**
- **2.5 PACE Acceptance letter**
- **2.6 Letter updating GP**
- **2.7 Risk Assessment**
- **3.1 Updated mgmt. plan**
- **3.2 Updated drug regimen**
- **3.3 Escalation referral**
- **3.4 Readmission referral**
- **4.1 Updated PACE notes**
- **4.2 Updated RIO record**
- **4.3 PACE D/C summary to MDT**
- **4.4 PACE D/C Letter to GP**
- **4.5 Referral to oncology**

#### Clinical Measures
- **1.3 Combined Assessment**
  - completed by case-finder
- **Appropriate clinical measures:**
  - 2.8 Modified Barthel Index
  - 2.9 POS Staff Assessment
  - 2.10 Early warning score
  - 2.11 Observations
- **3.4 XXX early warning score**
- **Appropriate clinical measures:**
  - 4.6 Modified Barthel Index
  - 4.7 POS Staff Assessment
  - 4.8 POS Patient Assessment
  - 4.9 Satisfaction Questionnaire
  - 5.0 Acute Monitoring Referrals

#### PROCESS
- **Accept referral; consultation with acute team and patient; complete assessment; joint decision; logged at MDT**
- **Review at MDT and risk evaluated; transfer arrangements coordinated by case-finding team.**
- **Virtual round of PACE patients by PACE team leader.**
  - Any changes discussed with acute consultant by phone or at MDT.
- **Update to MDT; normal referral process to ICT, continuing care or social care;**

#### TRACEABILITY HOSPITAL
- **All referrals in nhs.net inbox**
  - Patient’s hospital record
- **Documentation in hospital and PACE patient records:**
  - 2.1 – 2.7
  - **3.5 Reciprocal Fax of Patient record**
  - **PACE patient records 3.1 – 3.4**
  - **PACE records 4.1 – 4.9**
  - **Hospital record 4.3**

#### TRACEABILITY PACE
- **Assessment in patient’s hospital record**
- **2.112 Patient on RIO**
- **3.6 Patient on RIO**
- **3.5 Patient on RIO**