GP Integration Agreement FAQs

NHS England and NHS Improvement

GP Integration Agreement FAQs

ICP Contract Package

Publishing approval number: **000502**

Version number: 1

First published: August 2019

Updated:

Prepared by: Primary Care Strategy and NHS Contracts Group

Classification: Official

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1. Introduction to the GP Integration Agreement

What is the purpose of a GP Integration Agreement?

In partially integrated models, GP practices continue to deliver primary medical services under existing contracts (GMS / PMS / APMS).

The Integrated Care Provider (ICP) Contract sets out requirements on the ICP, to integrate services with GP practices in order to deliver the whole care model with sufficient involvement of primary medical services. The GP Integration Agreement (GP IA) sets out how GP practices and the ICP will work more closely together with the necessary commitment for the integrated care model to succeed.

Who is the GP IA for?

It is expected that each individual GP practice in an area covered by the ICP Contract will be a signatory to a single GP IA alongside the ICP, demonstrating the commitment between the GP practices and the ICP.

A GP federation or similar body should not sign on behalf of any GP practices unless there is clear authority (e.g. a power of attorney) for it to do so and to bind the GP practices to its terms. In this situation, the GP federation or similar body would be signing the GP IA in the name of the GP practice (not in the name of the GP federation). If a GP federation holds a contract for a service that is in scope of the GP IA (e.g. for out-of-hours primary medical services) it may be appropriate for the GP federation to be a party to the GP IA as a Primary Medical Services Provider in its own right, alongside the GP practices.

2. Essential content of a GP Integration Agreement

What should the GP IA set out?

Given the need to ensure sufficient involvement of the providers of primary medical services, the current version of the template GP IA is focused on the primary medical services element of the care model. Parties may agree between them to amend any aspect of the template GP IA as necessary so that it meets their local requirements and sufficiently captures additional actions which the ICP will be committed to and through which it can support GPs in delivering the locally agreed care model. This would be over and above the integration requirements already set out in the ICP Contract for those ICPs.

The GP IA will perform two main functions:

1. To create a framework for **shared governance and decision making** between the GP practices and the ICP; and

2. To set out how the **integration of services** will be effected, setting out the primary medical services contribution to the ICP's care model. This element should be able to evolve as local circumstances change but will always need to mirror the ICP's obligations to integrate with providers of primary medical services, as set out in the ICP Contract.

What should the GP IA describe in relation to shared governance and decision making?

The template GP IA incorporates a range of suggested requirements to establish shared governance and decision-making. Parties should consider how they may wish to tailor these requirements to ensure they best fit their local needs.

Area	Suggested requirements of Parties to be captured in the GP IA
1. Shared vision and delivery of system outcomes	• Commit to delivery of system outcomes in terms of clinical matters, patient experience and resource allocation • Develop and participate in the risk reward scheme where all share in savings generated by reduction in acute activity • Commit to delivering the best possible care for the whole population • Adopt an uncompromising commitment to trust, honesty, collaboration, innovation and mutual support
2. Working together	• Commit to work together and to make system decisions on a Best for Service basis • Establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information, subject to competition law compliance • Adopt collective ownership of risk and reward, including identifying, managing and mitigating all risks in performing the parties' respective obligations in this agreement • Co-design with others, especially service users,

	families and carers, the delivery of the services
3. Decision making	• Take responsibility to make unanimous decisions on a Best for Service basis

How can the GP IA capture integration commitments?

The integration commitments set out in the template GP IA reflect NHS England's view of the level of integration which is required between providers of primary medical services and providers of other services in order to deliver the care model. Whilst the specific commitments set out in the template GP IA are not mandatory and can be amended,

the extent to which providers have come together to deliver an integrated care model will be tested through the Integrated Support and Assurance Process (ISAP) and the commitments in the template GP IA should therefore be seen as an indication of the level of commitment which is likely to be required to make the care model a success.

Alongside the integration commitments, it is likely that local schedules will need to be completed, setting out the specific contributions required of GP practices and of the ICP and referencing local systems, processes and protocols. The wording of any local schedules should dovetail with the existing wording of the GP IA. As with the terms of the main body of the template GP IA, the schedules are open to local adaptation.

Suggestions for the local detail that could be set out in these schedules are captured in the template GP IA. For example, clause 6.2(d) refers to the locally determined clinical hub model, and cross references Schedule 3 in which specific detail about the model can be included. Additionally, key performance indicators and corresponding reporting requirements can be set out in Schedule 5 of the template GP IA to enable the parties to monitor the extent to which commitments or integration objectives are achieved. Such indicators could be aligned to the developing incentives framework for ICPs to minimise reporting requirements.

While all content in the template IA can be tailored to local needs, the template also contains short drafting notes or optional wording in square brackets that may benefit from specific consideration by parties when finalising the agreement. Parties must weigh up the pros and cons of including additional wording. For example, clause 4.1(b) enables the parties to specify that commencement of the agreement is conditional upon the objectives of the agreement being included in the services contracts of the parties. This may result in more alignment of the parties to those objectives but may mean that a GP is in breach of its GMS/PMS/APMS contract if it breaches the relevant wording. Each party will therefore need to carefully consider the possible consequences of including any additional wording.

Requirements which reflect NHS England's expectation (and the suggested interface with locally agreed elements) are captured in the table below using a multispecialty community provider (MCP) as an example, and are included in the template GP IA. Parties may wish to insert the schedule from the ICP Contract that describes the care model into the GP IA so that it is made clear that the GP IA is linked to the overall aims of the integrated care model.

Area	Suggested requirement of Parties to be captured in the GP IA
1. Agreement of common protocols	• Work towards reducing variation and unnecessary admissions (where appropriate) • Develop simplified, integrated and coordinated routes into unplanned care, including through the use of clinical hubs where agreed • Adhere to local transfers of care protocols
2. Identification of Service Users	• Apply stratification approaches at practice level **[specific requirements set out in relevant schedule]** • Identify Service Users with potential acute illness enabling provision of anticipatory care
3. Participation in and signposting to core ICP services	• Commit to the preventative initiatives within the ICP care model **[specific requirements set out in relevant schedule]** • Subject to any requirements relating to patient choice, support signposting to services made available by the ICP as part of the care model
4. Shared systems and access to information	• Be a party to agreements to share data with each other setting out how all key data will be available to inform decision-making • Adhere to data quality standards in line with local agreement **[refer to relevant schedule]** • Contribute to summary care record **[the detailed requirements are set out in relevant schedule]** and

	ensure the information they provide is kept up to date • Comply with the local protocols thus ensuring access by the ICP to the Practice's booking system **[specific practice requirements set out in relevant schedule]** • Agree to strategic alignment in terms of the approach to systems and technology **[specific practice requirements set out in relevant schedule]** • Supply business intelligence for ICP care model as key to enabling analysis to improve efficiency **[specific practice requirements set out in relevant schedule]**
5. Estates plan	• Contribute towards and agree a shared estates strategy, setting out how the current premises will be used to support delivery of the care model
6. Workforce	• Contribute towards and implement a shared workforce development strategy and workforce plan whereby resources are utilised effectively as set out in the relevant schedule • Contribute to and participate in joint organisational development, workforce and training and education strategies
7. Access	• Work together to achieve local primary medical services access requirements

3. Developing a GP Integration Agreement

Who should be involved in the development of a GP IA?

For the GP IA to be successful in enabling integration, the prospective ICP and GP practices should be engaged in a collaborative co-design process to develop, agree and finalise the terms of the GP IA thus reflecting their

shared commitments to each other. As the integration of primary medical services is crucial to the ICP care model, engagement between the parties should also occur during the development of the vision and the local integrated care model. The engagement activities are essential for building trust between the parties and, consequently, ensuring effective collaboration and integration during the delivery of the care model. Given the importance of effective engagement, sites should consider the time and resources that may be needed in their area.

The GP federation could represent the GP practices in engagement and negotiation, and in the day-to-day operation of the GP IA, but the GP federation and the GP practices would need to ensure there are robust 'behind the scenes' arrangements outlining the extent to which a GP federation can represent the views of the GP practices.

A CCG may be involved in the engagement to develop the terms of a GP IA, particularly in advance of an ICP Contract being awarded, but ideally the focus of engagement would be between the (prospective) ICP and GP practices – as parties to the GP IA. To the extent that CCGs are involved, all parties should be mindful of and take steps to mitigate any potential conflicts of interest that may arise in relation to the CCG's involvement in any procurement process to award the ICP Contract and that may arise from the fact that GP practices make up the membership of the CCG.

4. GP Integration Agreements in practice

How would the terms of the GP IA be monitored?

It is important to monitor the delivery of commitments set out in the GP IA, given the crucial role of GP practices in delivering integrated care models to the population.

Generally, the ICP will be required under the ICP Contract to fulfil certain integration commitments. The ICP will therefore want to ensure the GP practices are performing the integration commitments in the GP IA in a way that enables the ICP to evidence fulfilment of the integration commitments in the ICP Contract. It is envisaged that the ICP will agree with GP practices the appropriate type and extent of monitoring of activity undertaken pursuant to the GP IA.

Commissioners would not monitor delivery of commitments in a GP IA directly, but would instead monitor the ICP's overall performance according to the requirements set out in the ICP Contract. Where delegated responsibility, or co-commissioning, for primary medical services is in place, CCGs may have a role in overseeing the GP practices' fulfilment of their contracts for essential primary medical services commissioned via their GMS/PMS/APMS contract; however, this should remain separate to their monitoring of the ICP Contract.

5. GP Integration Agreements in relation to other agreements

How does a GP IA relate to subcontracts?

The aim of a GP IA is to set out the ways of working and specific activities that will be undertaken to achieve integration between an ICP and GP practices including outlining governance mechanisms and the integration commitments of each party. It should be noted that the GP IA is not a contract with GP practices for the delivery of specific services. It is not a form of subcontract for GP practices to deliver the ICP's obligations under the ICP Contract.

If an ICP wishes to put in place agreements with other organisations for the provision of specific elements of the services provided under the ICP Contract that it is commissioned to provide, this should be through separate subcontracts.

How does the GP IA relate to a local authority IA (LA IA)?

A LA IA is intended to be used to for ICPs and local authorities to work collaboratively to enable the health and/or care services provided by each organisation to be delivered in an integrated way (see the LA IA FAQs for more details). Depending on the particular ICP care model, an ICP could be party to both an LA IA and a GP IA.

In such circumstances, local sites may want to include wording in the LA IA stating the intent for the LA to work closer with GPs and in the GP IA stating the intent for the GPs to work closer with the LA. The agreements could also set out how this intent be actioned. An example is for any meeting under the agreements to include observers, i.e. GP representatives attend Integration Board meetings held under the LA IA, and LA representatives attend the Integration Leadership Team meetings held under the GP IA.