Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

NHS 70 YEARS OF THE NHS 1948 - 2018

# Primary Care Commissioning Committee (PCCC)

**Date: Tuesday 30th October**
**Time: 9.00-11.00**
**Location: Vassall Centre, Gill Avenue, Bristol, BS16 2QQ**

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## Agenda number: 10

## Report title: Improved Access (IA) contracting. Engaging practices and locality boards

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**Report Sponsor:** Lisa Manson, Director of Commissioning

### 1. Purpose

NHS England has committed to the provision of additional funding, on top of existing Primary Medical Care allocations to enable Clinical Commissioning Groups to commission and fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services.

This paper sets out current and future provision of Improved Access (IA) services across BNSSG CCG's population.

### 2. Recommendations

PCCC is asked to recognise and agree the planned alliance contract engagement with stakeholders throughout November 2018.

### 3. Executive Summary

BNSSG CCG inherited a legacy contract with One Care from NHS England to provide Improved Access services until 31st March 2019.

From 1st April 2019, PCCC closed session has agreed to commission localities to provide Improved Access via an alliance contract which binds all parties together to deliver the contracted services, to share risk and hold responsibility for meeting the agreed outcomes.

The details of any alliance contract need to be considered and agreed with practices and their representative provider boards. This paper sets out how the CCG intends to consult with stakeholders being asked to deliver the unchanged service specification for Improved Access.

This paper sets out who, when and what the CCG is proposing to engage.

## 4. Financial resource implications

BNSSG CCG has received notification from NHS England that the allocation for Improved Access for 18/19 is £5,671,404. The total weighted population is 964,976. A proportion of this group (44,530) were assessed as being eligible for £3.34 per head rather than the expected £6 figure. This was unsuccessfully challenged by the CCG and therefore the total budget equates to £5.88 per head (weighted population).

Improved Access funding is allocated annually by NHS England. Therefore, based on 2018/19 allocation it is estimated that the annual contract value for each year will be around £5,700,000.

## 5. Legal implications

Legal advice will be sought dependent on the options chosen and the risks that present themselves over the course of the project.

## 6. Risk implications

Practices and their provider boards are not able to respond to co-ordinate provision of Improved Access. The engagement sessions should identify concerns and provide an opportunity for commissioners to respond ahead of 1st April 2019.

## 7. Implications for health inequalities

One of the core requirements for implementing Improved Access is to address issues of inequalities in patients' experience of accessing general practice, identified by local evidence with actions in place to resolve. The CCGs IA specification actively seeks new initiatives to reduce inequalities as well as improve access for all.

## 8. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

The improved Access specification is designed to mitigate inequalities through a locality response at scale.

## 9. Implications for Public Involvement

Commissioners will need to work to understand the needs and perspectives of those protected characteristics who do not currently experience easy access to general practice services, and subsequently do not experience the same health outcomes as the rest of the population.

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## 1. Introduction

NHS England has committed to the provision of additional funding, on top of existing Primary Medical Care allocations to enable Clinical Commissioning Groups to commission and fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services.

CCGs are required to secure services following appropriate procurement processes.

Bristol, North Somerset and South Gloucestershire CCG will receive recurrent funding of £6 per head of population (weighted) to commission Improved Access. In order to be eligible for recurrent funding, BNSSG CCG will need to commission and demonstrate the following:

Timing of appointments:

- Commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;
- Commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
  Provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week; and
- Appointments can be provided on a hub basis with practices working at scale.

Capacity:

- Commission a minimum additional 45 minutes per 1000 population.

Measurement:

- Ensure usage of a nationally commissioned new tool when introduced to automatically measure appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of high demand.

Advertising and ease of access:

- Ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community, so that it is clear to patients how they can access these appointments and associated service;

- Ensure ease of access for patients including: all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services and patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

Digital:

- Use of digital approaches to support new models of care in general practice.

Inequalities:

- Issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place.

Effective access to wider whole system services:

- Effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services.

## 2. Current Contractual Arrangements

The current contract holder is One Care (BNSSG) Ltd. The contract was incepted on 1 April 2016 following the completion of the Prime Minister's Challenge Fund phase 1 and 2 projects agreed for the BNSSG area.

Bristol, North Somerset and South Gloucestershire CCGs accepted the novation of the contract across from NHS England with effect from 1 April 2017. The current contract is due to end on 31 March 2019.

The contract is an NHS Standard Contract (short form). BNSSG CCG hold contract management meetings with One Care (BNSSG) Ltd on a monthly basis. These meetings discuss any current issues affecting the contract and hold oversight of performance against Key Performance Indicators contained within the contract.

Overall delivery of the contract is reliant on sub-contracting arrangements managed by One Care (BNSSG) Ltd. Sub Contracts are in place with individual GP practices as well as third party providers who contribute to the overall delivery of Improved Access.

The provisions relating to sub-contracting in the shorter-form Contract are very much shorter than those in the full-length version. NHS Standard technical guidance suggests that the 'expectation is that sub-contracting of material elements of the services will typically not be a feature of the type of commissioning arrangements which are to be governed by the shorter-form Contract'. 'If there is expected to be extensive reliance on sub-contracting, the full-length Contract should be used'. Therefore, it is felt that should the existing arrangement continue a switch to the NHS Standard Contract (full length) will need to be made. This will allow for more detailed terms and conditions to support commissioner assurance as to the identity, level of competence and experience of the sub-contractor and the terms on which they have been appointed.

## 3. Contracting 19/20 Onwards

To support the collaboration between providers to deliver Improved Access while also supporting the development and resilience of general practice it has been established that Alliance Contracting would be a progressive step in collaboration between provider partners to deliver Improved Access.

Alliance contracting brings a set of providers into a single agreement with commissioners to deliver specified services. All parties are bound together to deliver the contracted services, to share risk and hold responsibility for meeting the agreed outcomes. Other models of contracting at a cluster level cannot be used as the practices have not formed formal registered organisations that the CCG could contract with. Alliance contracting does not require changes to organisational forms.

Alliance contracting involves an arrangement whereby a number of parties enter into an agreement to work cooperatively and to share risks and rewards. Performance is measured against a common set of performance indicators. Commissioners and providers work together as a single 'integrated' team in order to deliver a specific integrated service or project under a contractual framework that seeks to align their financial interests with the achievement of the agreed aims and objectives of the integrated service or project. Alliance contracting aims to offer a more collaborative and collegiate approach than traditional contracting: it seeks to create cooperation between providers and commissioners with a mutual obligation (and incentive) to act in a way that is 'best for service/project' and not necessarily best for individual organisations.

An alliance contract seeks to create this collaborative environment without the need for new forms or structures. By having a single alliance contract, the intention is that all parties work to the same outcomes and are committed to the same success measures. There is a strong sense of 'your problem is my problem, your success is my success'.

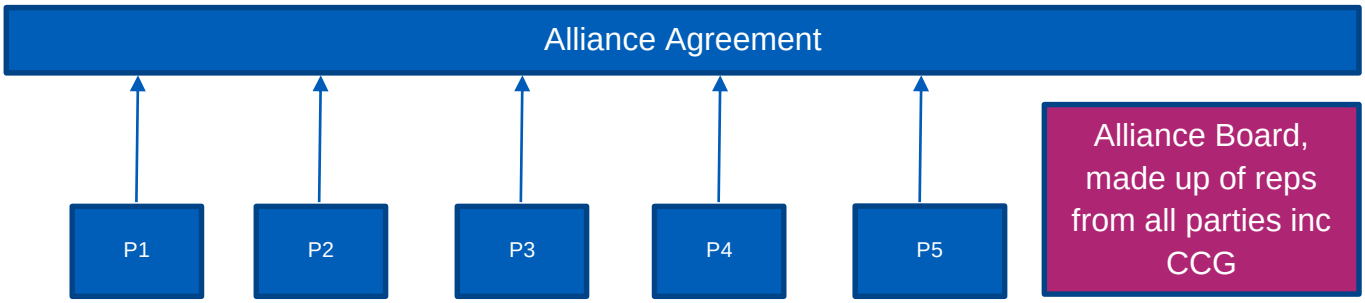
Alliance contracts are typically characterised by a number of key features including:

- Risk and opportunity sharing
- A commitment to 'no disputes'
- A best for service, unanimous decision making process

- A culture of 'no fault – no blame'
- A commitment to act in good faith
- Transparency between parties including open book principles and reporting
- A joint management structure

The Alliance Agreement is underpinned by individual NHS Standard contracts being held by each GP provider. This can be a service specific contract, or the service specification can be added to an existing contract. The contract management is then held at cluster level across providers, with the CCG being a core member of the Alliance Board.

Alliance contracts encourage collaboration and innovation across providers for the delivery of services. The model allows for additional services and partners can be added to an alliance contract, if localities identify opportunities to deliver some services and functions at scale, the contracting model can allow for this as appropriate.




The Primary Care Commissioning Committee (PCCC) agreed in September for an Alliance Agreement to be put in place with the 6 localities with each practice holding an individual NHS Standard Contract. Localities will decide which third parties to engage in their alliance to deliver the service specification. PCCC also asked the CCG contracts team engage with localities on the arrangement.

## 4. Engagement

This section sets out who, when and what the CCG proposes to engage stakeholders. PCCC is asked to consider the engagement plan to ensure it is robust.

### a. Who

Stakeholders are identified as: -

- 6 Locality Boards
- 6 membership meetings
- Avon Local Medical Committee (LMC)
- One Care ltd

## b. When

CCG contract team want to engage stakeholder between October and the beginning of December on the details of a proposed Alliance contract and the supporting NHS standard contracts.

Dates of provider boards are

- Woodspring locality board - 14th November between 1 – 3pm.
- Weston Worle and Villages locality board – 28th November – 1.30- 3.30pm
- ICE locality board – 6th November from 12:30 -14:30
- South locality board - 28th November from 2pm – 4pm
- South Glos locality board – 13th November 2pm
- N&W locality board – 12th November

## c. What

The engagement to date and CCGs research into alliance contracting has identified a need to consult on the following: -

- NHS Standard contract
    - Service specification
    - Finance schedule
    - Information schedule
        - 7 core requirements for IA
        - Satisfy CCG reporting to NHS England
    - Exit arrangements i.e. notice requirements
    - Schedule 4 – delivery requirements
    - Schedule 9; general conditions i.e. contract levers

- Alliance contract
    - Risk
    - Payment
    - What is defined by the CCG and what provider board would have the autonomy to decide

- Indemnity cover

- How non-GP providers will be commissioned to form part of the alliance.

- Whether the CCG will be part of alliance or alliance contract holder

- Current Memorandums of Understanding (MOU's) for joint working of provider boards were not designed to lead and make contractual decisions. Therefore the ask of provider boards to lead a contract will require localities to review and update MOUs to ensure fit to lead alliance contracting for the locality.

- To develop FAQs for wider membership e.g.

    i. What is the CCGs positon on practices that do not want to provide IA?
    ii. What is the CCGs approach to phased activity i.e. minimum of 30 minutes in summer and increased minutes in winter i.e. profile activity over a year

- Understand any legal considerations

## Glossary of terms and abbreviations

| | |
|---|---|
| 5YFV | 5 Year Forward View |
| APMS | Alternative Provider Medical Services |
| CCG | Clinical Commissioning Group |
| CQC | Care Quality Commission |
| GMS | General Medical Services |
| GMS Regulations | The National Health Service (General Medical Services Contracts) Regulations 2015 |
| GMS SFE | General Medical Services Statement of Financial Entitlements Directions 2013 |
| GP | General Practitioner |
| GPVF | General Practice Forward View |
| LMC | Local Medical Committee |
| PCSE | Primary Care Support England (delivered by Capita on behalf of NHS England) |
| PMS | Personal Medical Services |
| PMS Regulations | The National Health Service (Personal Medical Services Agreements) Regulations 2015 |

**Appendix 1 - Questions raised and responses following August PCOG**

**A FAQ to practices to state why alliance contracting is chosen model would be useful should this approach be agreed**

*These can easily be produced should alliance contracting be agreed by PCCC as the optimal model for contracting Improved Access*

**It would be useful for practices to see draft contract forms**

*below are links to further information on the Alliance Contract and NHS Standard Contract forms: -*

*Standard NHS contract: -*
https://www.england.nhs.uk/wp-content/uploads/2017/10/contract-technical-guidance-25oct17.pdf

*Standard NHS contract technical guidance: -*

*https://www.england.nhs.uk/wp-content/uploads/2016/11/7-contract-tech-guid.pdf*

*NHS Alliance Contract: -*

*https://www.england.nhs.uk/wp-content/uploads/2017/08/3b.-170802-Alliance-Agreement.pdf*

*Alliance Contract technical guidance: -*
https://councilfordisabledchildren.org.uk/sites/default/files/field/attachemnt/Alliance%20Agreement%20Guidance.pdf

*Further guidance reference alliance contracting: -*
http://lhalliances.org.uk/frequently-asked-questions/

*Alliance contracts allow local agreement of key performance indicators (Schedule 3) and the Risk/Reward Mechanism (Schedule 4). As stated in this paper the standard NHS contract is the relationship with each provider covering everything you might expect in any bilateral arrangement. The alliance contract then sits on top of these contracts setting out shared working noting there is not legal entity.*

**What is the role of the lead practice in any alliance arrangement?**

The lead practice will need to be defined fully in any next steps should alliance contracting be agreed the optimal model for Improved Access (IA). What can be said is a lead practice of any alliance would the point person for the CCG to engage the alliance on transactional matters and it is envisaged that the lead practice could rotate over time.

**A legal view from practices would be beneficial before enacting any change**

*The CCG recognises any contractual changes would benefit from a legal assessment of any final alliance contract proposal.*

**Are there examples of where others are using alliance contract model?**

*The CCG contracts team have contacted NHS England's national team and await a response. We know our local neighbouring CCGs are using alternative modes and are at different stages of procurement.*

**Procurement – if there is a competitive process how can practices bid, noting any one group of practices are not a legal entity**

*Individually practices are legal entities and can be contracted to provide Improved Access. An alliance contract would be a form of Memorandum of Understanding between parties. The CCG is assured by procurement advised that groups of practices could bid and further to that supported to bid should this be required. Should alliance contracting be the preferred model more thorough detail of a procurement processes can be development and shared.*

**Reporting arrangements across localities would need to be the same, but localities may want to agree different terms of risk share.**

*If alliance contracts are agreed as the optimal model for IA, a process will be pulled together to set out how the CCG intends to recognise BNSSG standards to ensure parity in services for its population and what might be open for localities to negotiate/define.*

**General Practice has agreed for One Care to be representative voice of primary care in the system. What are the benefits of moving away from this arrangement?**

*As set out in the paper, alliance contracting would:-*

- *Provide a contractual vehicle to provide primary care at scale*
- *Support localities to contract with commissioners directly at scale*
- *Allow localities to define their partners in the delivery of services through alliance arrangements (GP and others)*
- Provide a contractual platform to mobilise Locality Transformation Plans (LTP)

**What training will be provided by the CCG to support practices understand what is required of them individually and collectively?**

*If alliance contracts are agreed as the optimal model for IA, a robust plan to roll out the model with full briefings and support will be provided.*

**What is the proposed process for agreeing and completing the alliances contract schedules describing approach to both risk and reward?**

*If alliance contracts are agreed as the optimal model for IA, a process will be pulled together to set out how the CCG intends to recognise BNSSG standards to ensure parity in services for its population and what*

*might be open for localities to negotiate/define.*

**How will practices who do not wish to partake be addressed**

*The CCG would be looking to commission services for a population. Which providers in any alliance actually deliver the activity will be a decision for those providers within the alliance.*

**What is the governance for provider boards/alliance boards?**

**And**

**Partners typically have equal voting rights in decision making concerned with their practice. How is it proposed each provider is represented with regard the proposed alliance?**

**And**

**Provider board representatives were not elected to oversee an alliance with material decisions. Will/can attendance be reassessed to ensure appropriate and supported by general practice**

*If alliance contracts are agreed as the optimal model for IA, a proposal for the future status, governance and process to make any changes of provider boards will need to be drafted in light of their proposed new remit of alliance contract boards.*

**The alliance technical guidance describes an alliance programme manager role. Who will employee and fund this role?**

*If alliance contracts are agreed as the optimal model for IA, how alliance contract boards are constructed, run and supported will need agreeing within the context of both improved access and locality transformation schemes.*

**What are the arrangements concerning indemnity cover when medical staff are providing services to other populations? Has the CCG tested this with the medical defence organisations (MDDUPS and MDS)?**

*If alliance contracts are agreed as the optimal model for IA, formal advice concerning indemnity will need to be sought.*

**Practices will always want to ensure their business as usual is staffed and delivered over supporting services for other populations. Therefore there is a risk Improved Access will be the first shifts/cover to be pulled if staffing issues occur. How will this be mitigated and managed?**

*The CCG will be seeking alliances to agree continuity plans to ensure delivery of standards set out in the specification i.e. 45 mins per 1000 head of population. The details of which will need finalising through*

*agreeing the terms of the alliance contract.*

**It would be useful if practices could have a proposed model for delegation of authority to the proposed alliance board**

*The CCG can support alliances to develop a standard protocol to support partnerships to understand, recognise and agree the parameters of delegated authority for their representative members to an alliance board/provider board, should this be deemed useful.*