

Board Meetings held in Common

Date: 27 June 2019

Agenda item: 6

Paper Title: Implementing the *Long Term Plan* in primary and community services

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Decision Making Responsibility:

NHS England	<input type="checkbox"/>
NHS Improvement	<input type="checkbox"/>
NHS England and NHS Improvement	<input type="checkbox"/>
N/A - joint discussion	<input checked="" type="checkbox"/>

Purpose of the paper

1. This paper: (a) explains the new primary and community services funding guarantee; (b) highlights the initiation of our new community services programme; (c) takes stock of the new GP contract implementation; (d) reports progress with primary care network formation, as the new network contract goes live on 1 July; (e) sets out plans to support PCN development; (f) recommends launching a new consultation of funding and commissioning rules for digital first primary care; and (g) publishes the findings of the GP premises policy review.

A. The new funding guarantee

2. The opening promise of the [NHS Long Term Plan](#) is to “boost ‘out-of-hospital’ care and finally dissolve the historic divide between primary medical and community-based services”.
3. **This is underwritten by the guarantee of a £4.5 billion real terms increase in primary medical and community health services from 2019/20 to 2023/24:** “the first time in the history of the NHS that real terms funding for primary and community services is guaranteed to grow faster than the rising NHS budget overall. And this is a ‘floor’ level of investment that is being nationally guaranteed, that local CCGs and ICS are likely to supplement further”.
4. The way the guarantee will be implemented is by setting a minimum cash spending requirement (a) at the level of every ICS in 2023/24, and (b) at the

NHS England and NHS Improvement



level of every region from 20/21. This approach should avoid unrealistic backloading, whilst giving regions some flexibility in the three years between 2020/21 and 2022/23. The £4.5 billion real terms increase equals £7.1 billion in cash over 2018/19 planned levels of expenditure.

5. **Every region will operate the guarantee for April 2020 onwards.** To meet its required share of the regional guarantee from April 2020, each CCG and STP/ICS will need to:
 - (i) fully honour 100% of the GP contract entitlements each year; plus
 - (ii) spend at least their agreed share of the remaining cash amount of the guarantee each year. This amount will include the baseline of pre-existing 2018/19 planned spending levels on primary care, community health and CHC services.
6. All CCGs – even those with the lowest growth – have been funded in allocations to deliver their share of this guarantee. As the Long Term Plan makes clear, this is floor not a ceiling: systems will also want to consider what additional further investment beyond the Guarantee they may wish to make as part of wider local decisions.

B. Building a new community services programme

7. **Working directly alongside our primary care teams, a new community health services programme and group is now being established, under the leadership of our first ever national Director of Community Services, Matthew Winn, CEO of Cambridgeshire Community Health Services NHS Trust.**
8. The programme will be co-designed with the sector, particularly the Community Network (hosted jointly by the NHS Confederation and NHS Providers), but also the Association of Directors of Social Services and the Local Government Association, and our national primary care organisations and voluntary sector partners such as Age UK.
9. Ageing well is core. Our clear focus is on four big priorities:
 - (i) **improve responsiveness of community health crisis services** to within two hours of referral in line with NICE guidelines, where clinically judged to be appropriate, and reablement care within two days of referral to those patients who are judged to need it. The target is to achieve these access standards across the country by 2023/24, helping to reduce unnecessary admissions to hospitals and residential care, as well as ensuring a timely transfer from hospital to community;
 - (ii) **guarantee NHS support to people living in care homes**, by implementing the [Enhanced Health in Care Homes \(EHCH\) vanguard model](#). A majority of CCGs self-assess good progress against the different components of the model. Primary Care Networks will take lead responsibility for delivery. We intend that the primary care elements are delivered in full in 2020/21, subject to developing and agreeing the national

service specification promised in the new GP contract deal. The intention is to help cut avoidable emergency admissions, ambulance conveyances, and sub-optimal medication regimes;

(iii) **implement ‘anticipatory care’ for complex patients at risk of unwarranted health outcomes** right across the country, building on the work of the Multi-Speciality Community Provider (MCP) and Primary and Acute Care Systems (PACS) new care model vanguards. We will target support for severely frail elderly patients as well as people of all ages living with multiple comorbidities. Anticipatory care can only be delivered as joint endeavour between primary and community services. It needs a single team of GPs, pharmacists, nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropractors, joined by social care and the voluntary sector. The new PCN service specification will describe the contribution from general practice defined alongside that also from community services. And so **for the first time we will create national service specifications for community services within their NHS contracts**, carefully phased in line with the extra investment they will be receiving under the new funding guarantee. We will explore with the sector how national community contract specifications might also work for crisis response, reablement, and care homes support;

(iv) **tackling the workforce challenges in community services.** The above goals – particularly (i) and (iii) - require a big workforce expansion. The programme will work with the Chief People Officer to contribute to the final People Plan, plus the Chief Nursing Officer and the Chief Allied Health Professions Officer. As well as training and employing more staff, solutions include implementing efficiency opportunities already identified in [Lord Carter’s review](#) supported by the Chief Improvement Officer and the Improvement Directorate, as well as developing and adopting digital innovations, supported by Matthew Gould and NHSX.

10. **Without the full input of community health services, primary care networks will not be able to deliver their forthcoming service requirements - and vice versa.** Alignment between primary and community is being reinforced from 1 July this year with the introduction of a new requirement in the [NHS Standard Contract](#) that community teams be configured in line with PCN footprints.
11. Building trusting relationships, and creating and running joint teams, including with local government and voluntary sector partners, will take commitment and time. Many good examples exist, for example those in annex B. The Community Network is developing case studies of where community services are embracing the potential of networks. PCNs have enormous potential for different parts of the NHS and our partners in local government to “dock” better than ever before with primary care provision.

C. GP contract implementation and development

12. NHS England's public board meeting launched the publication of the new five year [GP contract deal](#) on 31 January . It introduces the most significant changes since 2004. The executive summary is at annex A. In brief, the new contract:
 - has brought a permanent solution to the uncertainty and burden of rising indemnity costs. The new [NHS Resolution Clinical Negligence Scheme for General Practice](#) started on 1 April;
 - significantly reformed the GP Quality and Outcomes Framework (QOF) from 1 April, following an [NHS England review](#). This includes creating new Quality Improvement modules, developed jointly by the Royal College of GPs (RCGP), NICE and the Health Foundation. The first two focus on prescribing safety and end-of-life have gone live;
 - launched a practical, phased plan to help address the serious workforce shortfall in primary care. A major new reimbursement scheme at network level will bring in over 20,000 additional staff in five defined roles, for whom there is both available supply and practice demand (pharmacists and social prescribing link workers from now; physiotherapists and physician associates from 2020; and paramedics from 2021). The scheme starts as planned on 1 July;
 - introduced an automatic entitlement for practices to a new Primary Care Network Contract that builds on their existing Practice Contract;
 - set out plans to simplify and improves access, and deliver digital first;
 - committed to the phased introduction of seven new national service specifications. These implement different aspects of the Long Term Plan: (i) medication reviews, (ii) the care homes service, (iii) the anticipatory care service, (iv) the NHS comprehensive model of personalised care, (v) early cancer diagnosis, (vi) CVD prevention and diagnosis, and (vii) health inequalities. Metrics will be included within a new primary care network dashboard. A new Investment and Impact Fund will maximising benefits for patients and the wider NHS;
 - gave five-year funding clarity and certainty for practices for the first time in NHS history. This includes core practice funding for pay and expenses. To build and maintain public confidence to invest in the partnership model, we introduce greater pay transparency for high earning individuals and a balancing mechanism.
13. **The new contract has generally been well received.** In many parts of the country, general practice continues to face major workforce and workload challenges that cannot be solved quickly or easily. Simply agreeing a deal does not overnight change that reality. But it has brought some hope. We now have an agreed five year plan that will help solve the biggest problems facing the profession and improve care for patients.
14. 2019/20 implementation has been proceeding on track. Given the scale of the changes it has involved a lot of work, including by our Department of Health and Social Care and NHS Resolution colleagues who have led on creating the

new indemnity scheme as well as developing new arrangements for existing liabilities. **Improved indemnity arrangements are already being felt by general practice.** The new scheme covers clinical negligence liabilities arising in general practice for incidents that occur on or after 1 April 2019. Unlike the old scheme, the cover does not attach to individuals and covers all practice staff.

15. **Specifically on QOF, we today share our initial pipeline of planned Quality Improvement modules** agreed with GPC and RCGP: (i) early cancer diagnosis, (ii) CVD prevention and detection, (iii) supporting people with learning disabilities, (iv) shared decision making, (v) anxiety and depression, (vi) anti-microbial resistance including antibiotic prescribing, and (vii) wider primary prevention.
16. **The Long Term Plan committed to improving coverage of health checks for people with a learning disability. We have now agreed with the GPC to implement a wider package of measures to make faster progress:**
 - (i) improve the quality of registers for people with a learning disability;
 - (ii) concerted effort to increase the number of people receiving the flu vaccine, given the level of avoidable mortality associated with respiratory problems;
 - (iii) introduce the QOF Quality Improvement module for learning disability in 2020/21;
 - (iv) aim to achieve early delivery of the 75% target for comprehensive health checks, which already attract a £140 item of service fee. We would like to achieve the 75% goal in every primary care network; and
 - (v) later this year launch a national communications campaign to help get the messages across.

Filling gaps in our future work programme

17. **The 5 year deal set out a broad and comprehensive future work programme**, to inform phased annual contract changes through to 2023/24. It includes for example: the Access Review; creating the new digital first supply framework for existing practices alongside the forthcoming new *GP IT Futures* programme; the Vaccinations and Immunisations Review; implementing further phased of QOF reform including developing a suite of new QI modules; progressing work on training hubs and the fellowship scheme; developing the seven Primary Care Network service specifications; developing the new Primary Care Network dashboard and then laying it on to PCNs through the Commissioning Support Units; designing and implementing the new PCN Investment and Impact Fund; developing and implementing the PCN support offer; and introducing the new testbed programme.
18. **Our 'to do' list now expands following the publication of the [Interim People Plan](#) , and the *GP premises policy review*.**

GP and nurse numbers

19. Thanks to the [GP Forward View](#), we are in a better position than we would have otherwise been with GP and practice nurse numbers but we still need more. **We will now boost our national work on GP and practice nurse numbers in time for inclusion in the final People Plan.** Our ambition is sufficiency of supply to meet expected service needs. We will work with the Chief People Officer and her team, partnering with stakeholders including Health Education England and the RCGP, who recently set out their vision for the profession, [Fit for the Future](#).
20. Continuing our existing recruitment and retention programmes will help. Working as part of a PCN and its bigger multi-disciplinary team can also create a wider variety of more attractive roles. For nursing, we will reap benefits from the CNO's rapid expansion programme to increase clinical nurse placement capacity, which includes placements in community and primary care. In the contract deal we explicitly asked the Government to consider partial pension changes, and a consultation has been launched (reference weblink). Process redesign is another part of the answer. In early adopter sites, the [Time to Care](#) programme of 10 high impact changes has already saved an estimated 330,096 annual hours of administrative time and 205,157 annual hours of clinical time. This proven programme will be rolled out right across England, supported by the Improvement Directorate. And our consultation on digital first, covered in section F of this paper, sets out how we might harness the opportunity of digital to increase workforce participation, with a particular focus on our most under-doctored areas in order to tackle the inverse care law.
21. Taken together, all of these steps may not prove sufficient. And so we will additionally:
 - (i) **explore how best to make it more attractive for existing qualified GPs, including sessional GPs, to choose to increase their time commitment**, e.g. through closer mutually beneficial association with individual PCNs, or clusters of PCNs working together;
 - (ii) **look at the potential to create a more managed and nationally consistent 'glide path' through post-graduate qualification and beyond, to build confidence and support and offer experiences in a range of different practices**, including through the way we conceive and operationalize the new planned fellowship programme for GPs and nurses; and
 - (iii) **re-examine our previous assumptions and plans on future training numbers and clinicians from abroad**, given the scale of the gap. HEE spend beyond 2019/20 is subject to the Spending Review.

Fit-for-purpose premises

22. The GP premises policy review covers policy questions about the reimbursement model and is covered in section G of this paper. Amongst its recommendations is for **additional work to answer the question of what it would take to achieve a fit-for-purpose estate, that supports PCNs and**

integrated primary and community teams. We have a revenue guarantee for primary and community services, but like the rest of the NHS we are missing the capital story for 2020/21 and beyond, which is contingent on the Spending Review. In the meantime, we encourage PCNs to start thinking now about their future premises needs, working in tandem with their community partners, so that these can be fed into emerging STP/ICS capital prioritisation plans in a timely manner.

D. Forming Primary Care Networks

23. **Well-supported and flourishing primary care networks provide the essential foundations for every successful ICS.** Covering around 30-50,000 patients in a neighbourhood, the network is a group of separate GP practices choosing to join forces: (i) with each other to address the challenges faced by general practice, and (ii) with other community-based services to enable integration of care for patients. The network list size is the sum of its constituent practice members.
24. Some have suggested that PCNs might assume CCG statutory functions, such as population need assessment, or can be the reincarnation of the GP multi-fund or Total Purchasing Pilots. This is neither our intention nor legally possible. **The primary care network is not about commissioning. Instead, PCNs are about collaborative provision.** In this they draw more on the tradition of the out-of-hours cooperative movement that flourished after the 1995 development fund deal.
25. **A Primary Care Network is not a new structure, a new organisation, or an NHS management tier. Instead, its core is simply an extension of the existing independent GP partnership model.** The general practice element of the PCN is given legal effect through the entitlement to the new network contract Directed Enhanced Service (DES). This flows from the existing individual practice contract. The PCN contract is held jointly and severally, under the legal binding Network Agreement. Those constituent practices then work together with wider community-based partners. Networks have flexibility as to how they organises including working with GP federations and other partners, within the constraints of the legal framework, VAT rules (on which we have published a guidance note), and lag involved in updating NHAIS payment information. Every Network must have its own named accountable Clinical Director drawn from its constituent practices.
26. Participation in the Network Contract is not mandatory. NHS England and the BMA agreed to aim for comprehensive voluntary coverage of Primary Care Networks (PCNs) by 1 July 2019. The architecture of the deal makes opting out an unattractive proposition.
27. **For some, the pace has felt fast.** Partnering with other practices under the Network Contract is a big decision. It means sharing some staff, accountability for service delivery, and funding arrangements. But most of the country had already been developing networks, albeit in a softer form. An October 2019 start would have cut 2019/20 network funding down to 6 months from 9 months.

And a longer deadline would have meant more time in meetings discussing network formation, but not necessarily led to a different or better result.

Current position

28. **Unsurprisingly, we have seen mass GP engagement right across the country, including most notably all the practices that hitherto had been least engaged.** Nationally we have prioritised communication: roadshows in every region; joint NHS England/BMA events and materials; webchats and WhatsApp groups. **A large number of new and younger clinical leaders have come forward.** Not all are GPs; we also have some nurses and pharmacists. PCN leaders are bringing huge energy.
29. The most significant engagement has been happening at local level, aided by CCGs and Local Medical Committees (the statutory local representative committees of the GPC). They have been holding myriad events as well as dealing with complex local issues. **NHS England and Improvement appreciate the leadership, commitment and sensitivity that LMCs have brought.**
30. **PCN configuration is not always straightforward.** A PCN must synthesise two different and sometimes competing demands: the bonds of affiliation between practices on the one hand; sufficient scale, sensible cartography and community partnering on the other. A PCN cannot function if it does not work sufficiently well for its constituent practices. But it also has to make sense for the community partners, and the sum total of all PCNs in a CCG must include all willing practices, irrespective of natural ties. This is why CCGs have not been approving any PCN in their area without approving all PCNs.
31. In the vast majority of systems, combining these objectives has not been overly problematic, but **the last pieces of the jigsaw have been the hardest.** The fuller engagement and voice of all practices has sensibly led many systems to rethink and sometimes adjust previous network plans. The benefit is that these are no longer just the CCG or local STP's network plans; they are genuinely practice-led, with stronger leadership and fuller participation. The biggest issues have arisen where relationships have historically been weak or poor between existing practices, particularly where the relationships with CCGs/STPs have also been poor.
32. The difficult issues fall into three main categories: (i) helping networks that do not meet the 30k minimum 'sustainable size' rule or key exception criteria of rurality and cannot therefore be approved; (ii) helping practices who have wanted to form part of a network, but did not form a natural alliance with other emerging PCNs; and (iii) working with practices who have had significant concerns and been unsure whether or not to participate.
33. **A national and regional group has met on four occasions to support progress and ensure that all sub-30k applications have been considered on a case-by-case basis in a fair and consistent way across the country.** This has led to a number of putative networks being asked to reconsider. As of

last Friday, all but eight such PCNs had been resolved, and that number will reduce further this week. We have also been working closely with the GPC to solve issues, without need for formal escalation to the joint NHSE/GPC national team.

34. Our current expectation on numbers is set out in the table. 1259 networks is almost exactly as modelled in the January contract deal:

NETWORK NUMBERS AND MINIMUM SIZE - EXPECTED 1 JULY POSITION

SUBJECT TO CHANGE

	TOTAL	<30k	<27k	<20k
North East and Yorkshire	185	14	5	1
North West	164	19	4	1
Midlands	226	15	5	0
East of England	145	7	3	0
South West	128	9	5	0
South East	208	16	4	0
London	203	3	0	0
ENGLAND	1259	83	26	2

35. **Over the past month we have seen the number of practices not wishing to join reduce steadily.** As of last Friday, only 26 practices out of nearly 7000 were in this position. We do not expect the number to change. The reasons vary and include: (i) unwillingness to end half-day closing, which is a core requirement for all come 1 July; (ii) unwillingness to partner; (iii) not wanting to grow their business and take on associated responsibility; and (iv) major concern about the level of additional future workload. Alternative arrangements are now being put in place for their patients during 2019/20, and where non-participation continues, we expect those to be made permanent from April 2020. A further 10 current practices are not participating because of a change of contract holder, but their successors will all be included in a PCN.
36. As of last Friday, 34 practices were in the position of wanting to join a network, but where their inclusion had not been confirmed; we expect this will reduce to just a handful by 30 June. Some of these have been wicker cases, e.g. where there had been an acrimonious partnership split in the past; where one of the practices is still involved in a legal dispute with its only obvious network partners; another where the practice is currently under investigation.
37. Inclusion of GP at Hand within a Hammersmith PCN has been particularly complex given that most of its patients are distributed outside Hammersmith CCG in many different boroughs. The proposal in our consultation of digital first primary care would help solve this problem for April 2020 onwards, by disaggregating the patient list once a threshold level is reached of patients by CCG. And so as a strictly temporary arrangement for nine months only, it will form a separate Hammersmith CCG PCN network, pending implementation of changes arising from our consultation. We have discussed and agreed this approach with our GPC colleagues.

38. **The latest CCGs projections lead us to anticipate 99.7% of all practices being covered from 1 July.** This is better than we had expected and the exceptions are set out in the table by region:

PRACTICE PARTICIPATION – EXCEPTIONS AND UNRESOLVED ISSUES

SUBJECT TO CHANGE

	Opted out	Wanting to participate but not yet included	Of previous column, expected to be unresolved by 30 June
North East and Yorkshire	4	3	0
North West	6	2	0
Midlands	1	5	1
East of England	1	9	0
South West	3	5	0
South East	5	7	0
London	6	3	1
ENGLAND	26	34	2

39. Regions have also conducted an exercise to confirm that each and every STP/ICS has been engaged and is content with the proposals. **We encourage all local systems to engage and communicate widely with their communities given the strategic significance of PCNs.** Nationally we are working with one system where the CCG and the constituent practices had agreed proposals in line with their interpretation of the rules, but where the ICS has sought to reverse the decision because it did not match the previous neighbourhood boundaries.

E. PCN development and delivery

40. Forming PCNs is a key moment, but the real work and potential benefits follow. **For patients an immediate patient benefit is the end of half-day closing and improvement in extended hours.** As of 2018, 75.7% of practices were already participating in the Extended Hours Access DES, which requires an end to half day closing. By participating in the PCN, the requirement extends to all practices from 1 July. And a network with a population of 50,000 will need to provide 25 hours extended access per week, shared between morning, evening and weekends.
41. Looking ahead to 2023/24, our ambition is that PCNs will have done five things:
- (i) **stabilised the GP partnership model.** Through the Network Contract, we have given the independent contractor model a major shot in the arm. It is now down to PCNs to decide their own long-term future: take

- responsibility for securing a new generation of partners, or by default (rather than choice) become salaried to other NHS providers;
- (ii) **helped solve the capacity gap and improved skill-mix by growing the wider workforce by over 20,000 wholly additional staff.** We are undertaking a baseline exercise now, and have issued guidance designed to protect additionality and taxpayer investment. NHS England and Improvement will take a zero tolerance approach to any attempts to shunt existing staff costs from CCGs or practices into the additional roles reimbursement funding, including issuing directions or launching fraud investigations;
 - (iii) **become a proven platform for further local NHS investment, including in premises;**
 - (iv) **dissolved the divide between primary and community:** ‘the twins separated at birth’. The necessary inwardness of practice-to-practice discussions right now will increasingly be replaced by full engagement with community partners with whom they will jointly be delivering services. If PCNs are to thrive, they need to look out as well as in;
 - (v) **having done (i) to (iv) first, achieved clear quantified impact for patients and the wider NHS.** This means delivering the seven new national service specifications well, and making progress against the new PCN dashboard – including lives saved from earlier diagnosis. We also want PCNs to have demonstrated that the primary and community funding guarantee has been the right investment decision for the NHS. The case for investing disproportionately in primary and community was that over five years they would help moderate demand on A&E, reduce avoidable admissions, help the redesign of outpatients, support reductions in hospital length of stay, and reduce avoidable medicines spend. Success means we will be in a position to seek to extend and potentially increase the scale of the guarantee for the second five years of the Long Term Plan.
42. PCN development is mission critical for ICSs and STPs to implement the Long Term Plan. We need to avoid overburdening PCNs with expectations that are unrealistically phased, given their differing maturity. **STPs/ICSs, supported by Regional teams, have a core role in supporting PCNs – not just CCGs.** We have committed to providing extra development funding of around £1m/system on a weighted capitation basis. This is on top of existing allocations and the money announced in January for the GP contract. It comes out of the centrally held NHS England allocation for primary care. The funding will flow through ICSs/STPs from the end of June. The amount will also be higher than listed: we will increase the total by a further £2.8million, instead of supporting a small number of PCN accelerators.
43. Regions will work with their systems to get a good understanding of the range of maturity of their PCNs to agree the most effective way to ensure PCNs can easily access good development support, ensuring that this funding is used both wisely and to make rapid progress. **We have developed a support offer comprising: i) set up support, ii) PCN development support and iii) PCN clinical director leadership development support.**

44. For those PCNs in STPs that are at the very beginning of their development journey, we aim to provide fast track support. **We have developed a draft PCN development support prospectus on the back of extensive system engagement, and intend to publish later this summer.** The prospectus will provide the context for Regions to work with their ICSs/STPs to develop local specifications that drive the delivery of high-quality development support. On this it will be vital for ICS/STPs to work closely with LMCs, PCN Clinical Directors as well as community providers. We expect the funding to be used to help PCNs prepare for implementing known future service improvements, building their confidence and relationships. **And to support the specific development of PCN clinical directors, we are setting out a development specification.** This is being co-produced with key stakeholders including the NHS Leadership Academy, Kings Fund, a range of PCN clinical directors, multi-professional clinical advisors and Regional Directors of Primary Care and Public Health.

F. Digital first primary care consultation

45. **The Board is asked to approve the launch of the attached consultation on digital first policy funding and contracting arrangements, inviting responses by 23 August.** As part of the consultation process we will seek to hold roundtable discussions including with the BMA, the RCGP, under-doctored CCGs, patients and industry.
46. The context is our commitment that by April 2020 all patients should have online access to their full record and by April 2021 all patients should have the right to online and video consultations. These could be enshrined in the NHS Constitution.
47. **The most important way in which this will be achieved is by helping existing practices digitise their offer.** NHS England has already committed to creating a new framework for digital suppliers to offer their platforms and products to primary care on standard NHS terms for use from 2021. We intend to set out further details in 2019. **We suspect this will be the bigger opportunity for digital first providers than directly registering patients in competition with existing practices.**
48. Our consultation seeks to solve four main additional specific questions:
- should we reform out-of-area registration rules to fit better with the world of digital first providers and primary care networks, and if so, how?
 - linked to this, should we also improve the responsiveness of CCG allocation adjustments to reflect in-year patient flows, and if so how?
 - should we change current premium for new patient registration?
 - should we allow patients choice to register with a wider array of new digital first providers, and if so, could we do so in a way that helps under-doctored areas and tackles inequalities, and also avoids current and future transaction costs of local APMS procurements?

49. We propose to:

- (i) **amend the out-of-area registration rules so that where a practice exceeds a threshold number of out-of-area patients in any CCG (we propose to fix this somewhere between 1,000-2,000 patients in any CCG, subject to views from consultees), then their main contract will be automatically disaggregated.** They would separately be awarded a local APMS contract in that CCG, through which to serve those patients, meeting all normal requirements including access to physical premises where required. Those patients would no longer be out-of-area patients;
- (ii) **change the allocations system to enable quarterly recalculation of CCG funding to reflect patient movements** of the sort which have been stimulated by registration with digital-first practices in London;
- (iii) **not make further changes to the GP payment formula for newly registered patients at this point.** We conclude that scrapping the premium would be unfair given the extra work as well as undesirable given the huge redistribution effect it would have in practices with highly transient populations. **But we do propose to pay it only if a patient remains registered with a practice for a defined period.** We are inviting views on that period, and suggest somewhere between six to twelve months;
- (iv) **use practice entry rules to address the inverse care law in general practice. We suggest allowing new digital first practices to register patients in our most under-doctored geographies– for example, CCGs in the bottom 10 or 20%. And require these new practices to meet three strict criteria:** (i) demonstrate that the GPs they will be bringing into the local community are wholly additional; (ii) ensure the physical part of their service also covers the most deprived areas of the CCG; and (iii) actively promote their service to the most deprived communities, so that their lists properly reflect the make-up of the local population. In this way, the NHS could harness the potential of digital-first providers to reduce health inequalities. We propose to do this through national rules rather than local commissioning;
- (v) **we also suggest that as part of these potential new national rules, we could remove the need for most local APMS procurements by looking to PCNs as the default mechanism for maintaining primary care provision.**

G. Premises policy review

50. **We are also publishing today the findings of the premises policy review.** This involved considerable engagement and exploration of the problems and potential solutions. The review was a staging post rather than a full answer to the problems faced, given NHS capital for 2020/21 onwards is contingent on the Spending Review and the new context of PCN development. Nonetheless, we reach conclusions that could have far-reaching effects. It is also important to

note that this is an NHS England and Improvement only document; and any of the changes we propose that lead to new financial commitments could well require government approval, as well as negotiation with the GPC on the details.

51. Our conclusions have been discussed and agreed with our finance and estates teams. We propose to:

- (i) **assign existing practice leases to NHS bodies where they are of strategic importance, and where their length and liabilities prevent the healthy renewal of partnerships and the estate.** The detail of which leases are of strategic importance will be subject to further detailed discussions with GPC and within NHS England and Improvement during 2019. The capital DEL cover which would be required to enable this will be dependent on discussions with HM Treasury, the outcome of the government's spending review, and a relative prioritisation process;
- (ii) support the availability of an ownership model which continues to make sense for GP practices, but **over time we expect more practices to want to separate the decision to enter premises ownership from the operation of primary medical services.** We will develop best practice guidance on this for all property-owning GPs. Future NHS capital investment would come with a requirement to demonstrate robust governance around property ownership
- (iii) **provide clearer guidance on the expectations of owners and occupiers around maintenance and standards,** as part of professionalising property ownership and management
- (iv) **pilot alternative premises reimbursement arrangements at network level,** to give networks greater autonomy to manage and minimise their costs relating to estates across their premises
- (v) **pilot a simpler model of premises provision in which the NHS directly bears the cost of premises in multi-use new build premises,** removing the need for bureaucratic premises reimbursement systems, promoting integration of service delivery and optimal use of space
- (vi) **develop a package of support relating to primary care engagement in STPs' and ICSS' capital strategies** and the capital allocations process
- (vii) **encourage networks to start now working out their future estates needs,** taking into account joint working and the estate of their community partners
- (viii) **focus our primary efforts on understanding what it would take to ensure we have premises that are fit for purpose,** as part of the Spending Review

(ix) following the Spending Review, develop and publish a premises implementation framework.

**IAN DODGE
NATIONAL DIRECTOR, STRATEGY AND INNOVATION**

Investment and evolution: a five-year framework for GP contract reform to implement The NHS Long Term Plan

FOREWORD AND SUMMARY

General practice is the bedrock of the NHS, and the NHS relies on it to survive and thrive.

This agreement between NHS England and the BMA General Practitioners Committee (GPC) in England, and supported by Government, translates commitments in The NHS Long Term Plan¹ into a five-year framework for the GP services contract. We confirm the direction for primary care for the next ten years and seek to meet the reasonable aspirations of the profession.

In our discussions we shared five main goals:

- secure and guarantee the necessary extra investment;
- make practical changes to help solve the big challenges facing general practice, not least workforce and workload;
- deliver the expansion in services and improvements in care quality and outcomes set out in The NHS Long Term Plan, phased over a realistic timeframe;
- ensure and show value for money for taxpayers and the rest of the NHS, bearing in mind the scale of investment;
- get better at developing, testing and costing future potential changes before rolling them out nationwide.

Specifically, this agreement:

1. Seeks to address workload issues resulting from workforce shortfall. Through a new Additional Roles Reimbursement Scheme, Primary Care Networks (PCNs) will be guaranteed funding for an up to estimated 20,000+ additional staff by 2023/24. This funds new roles for which there is both credible supply and demand. The scheme will meet a recurrent 70% of the costs of additional clinical pharmacists, physician associates, first contact physiotherapists, and first contact community paramedics; and 100% of the costs of additional social prescribing link workers. By 2023/24, the reimbursement available to networks amounts to £891 million of new annual investment. Practices will continue to fund all other staff groups including GPs and nurses in the normal way through the core practice contract, which grows by £978 million of new annual investment by 2023/24 and will support further expansion of available nurse, GP and other staff numbers. NHS England will also create and part-fund a new primary care Fellowship Scheme² aimed at newly qualifying nurses and GPs, as well as Training Hubs. Current NHS England recruitment and retention schemes under the General Practice Forward View will be

extended. Rises in employer superannuation contributions will be fully funded. We have asked the Government to introduce a partial pension scheme.

2. Brings a permanent solution to indemnity costs and coverage. The new and centrally-funded Clinical Negligence Scheme for General Practice will start from April 2019. All of general practice will be covered, including out-of-hours and all staff groups. Membership will be free. The scheme is funded through a one-off permanent adjustment to the global sum. Practice contract funding nonetheless rises in 2019/20 by 1.4%, as a result of the overall investments agreed. Future costs of NHS practice under the scheme will be funded centrally, not met individually by practices.

3. Improves the Quality and Outcomes Framework (QOF). We are implementing the findings of the QOF Review⁴. 28 indicators, worth 175 points in total, are being retired from April 2019. 74 points will be used to create a new Quality Improvement domain. The first two Quality Improvement Modules for 2019/20 are prescribing safety and end-of-life care. 101 points will be used for 15 more clinically appropriate indicators, mainly on diabetes, blood pressure control and cervical screening. The current system of exception reporting will be replaced by the more precise approach of the Personalised Care Adjustment. This will better reflect individual clinical situations and patients' wishes. In 2019, we will review the heart failure, asthma and chronic obstructive pulmonary disease domains. In 2020, we will review the mental health domain for change in 2021/22. Long term Quality Improvement module and indicator development will benefit from the new primary care testbed programme.

4. Introduces automatic entitlement to a new Primary Care Network Contract. In The NHS Long Term Plan, Primary Care Networks are an essential building block of every Integrated Care System, and under the Network Contract Directed Enhanced Service (DES), general practice takes the leading role in every PCN. The Network Contract is a DES established in accordance with Directions given to NHS England. Eligibility depends on meeting registration requirements. The Network Contract DES supports practices of all sizes, working together within neighbourhoods. Like existing GMS, the Network Contract DES will be backed by financial entitlements. If every network takes up 100% of the national Network Entitlements we intend, including a recurrent £1.50/patient support, plus a new contribution to clinical leadership, £1.799 billion would flow nationally through the Network Contract DES by 2023/24. CCGs could also add local investment through Supplementary Network Services. We expect 100% geographical coverage of the Network Contract DES by July 2019, so that no patients or practices are disadvantaged. Each network must have a named accountable Clinical Director and a Network Agreement setting out the collaboration between its members. Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System and dissolving the historic divide between primary and community medical services. A new Primary Care Network development programme will be centrally funded and delivered through Integrated Care Systems.

5. Helps join-up urgent care services. The NHS Long Term Plan envisages Primary Care Networks joining up the delivery of urgent care in the community. Funding and responsibility for providing the current CCG-commissioned enhanced access services transfers to the Network Contract DES by April 2021 latest. From July 2019, the Extended Hours DES requirements are introduced across every network, until March 2021. Following an Access Review in 2019, a more coherent set of access arrangements will start being implemented in 2020 and reflected in the Network Contract DES with coverage everywhere in 2021/22. 111 direct booking into practices will be introduced nationally in 2019. As part of these access arrangements, £30 million of additional annual recurrent funding will be added to the global sum from 2019/20. Working with NHS Digital, GP activity and waiting times data will be published monthly from 2021, alongside hospital data. Publication of the data will expose variation in access between networks and practices and we will include a new measure of patient-reported experience of access.

6. Enables practices and patients to benefit from digital technologies. NHS England will continue to ensure and fund IT infrastructure support including through the new GP IT Futures programme, which replaces the current GP Systems of Choice5. Additional national funding will also give Primary Care Networks access to digital-first support from April 2021, from an agreed list of suppliers on a new separate national framework. All patients will have the right to digital-first primary care, including web and video consultations by April 2021. All patients will be able to have digital access to their full records from 2020 and be able to order repeat prescriptions electronically as a default from April 2019. A Review of Out-of-area Registration and Patient Choice will start in 2019. The rurality index payment and London adjustment will be changed from April 2019 to avoid unwarranted redistribution between different types of provider. To safeguard the model of comprehensive NHS primary medical care, from 2019 it will no longer be possible for any GP provider either directly or via proxy to advertise or host private paid-for GP services that fall within the scope of NHS-funded primary medical services. NHS England will consult in 2019 on expanding this ban on private GP services to other providers of mainly NHS services. In recognition of income loss and workload from subject access requests, £20 million of additional funding will be added to the global sum for the next three years.

7. Delivers new services to achieve NHS Long Term Plan commitments. The scale of the investment in primary medical care under this agreement was secured for phased and full delivery of all relevant NHS Long Term Plan commitments. The annual increase in funding for the Additional Roles Reimbursement Scheme is subject to agreeing seven national Network Service Specifications and their subsequent delivery. Each will include standard national processes, metrics and expected quantified benefits for patients. The specifications will be developed with GPC England as part of annual contract negotiations and agreed as part of confirming each year's funding. Five of the seven start by April 2020: structured medication reviews, enhanced health in care homes, anticipatory care (with

community services), personalised care and supporting early cancer diagnosis. The other two start by 2021: cardio-vascular disease case-finding and locally agreed action to tackle inequalities. A Review of Vaccination and Immunisation arrangements and outcomes under the GP contract will take place in 2019 and also cover screening. Available by 2020, a new Network Dashboard will set out progress on network metrics, covering population health, urgent and anticipatory care, prescribing and hospital use. Metrics for the seven new services will be included. A national Network Investment and Impact Fund will start in 2020, rising to an expected £300 million in 2023/24. This is intended to help networks make faster progress against the dashboard and NHS Long Term Plan goals. Part of the Investment and Impact Fund will be dedicated to NHS utilisation, which could cover: (i) A&E attendances; (ii) emergency admissions; (iii) hospital discharge; (iv) outpatients; and (v) prescribing. The Fund will be linked to performance and its design will be agreed with GPC England and Government. We envisage that access to the Fund becomes a national network entitlement, with national rules as well as locally agreed elements. Networks will agree with their Integrated Care System how they spend any monies earned from the Fund.

8. Gives five-year funding clarity and certainty for practices. Resources for primary medical and community services increase by over £4.5 billion by 2023/24, and rise as a share of the overall NHS budget. This agreement now confirms how much of this will flow through intended national legal entitlements for general practice under the practice and network contracts. GPC England and NHS England have agreed that we do not expect additional national money for practice or network contract entitlements, taken together, until 2024/25. Funding for the practice contract is now agreed for each of the next five years, and increases by £978 million in 2023/24. As a result, DDRB will not make recommendations on GP partner net income. Under this agreement, we assume that practice staff, including salaried GPs, will receive at least a 2.0% increase in 2019/20, but the actual effect will depend on indemnity arrangements within practices. NHSE and GPC have asked the government to ask the DDRB not to make recommendations for salaried GPs for the 2019 pay round. We have further asked the Government to continue to include recommendations on the pay of salaried GPs in the DDRB remit from the 2020 pay round onwards. Recommendations will need to be informed by affordability and in particular the fixed contract resources available to practices under this deal and will inform decisions by GP practices on the pay of salaried GPs. We have asked the Government to ensure that DDRB continues, as usual, to recommend on GP trainees, educators and appraisers. As now, the Government will decide how to respond to DDRB recommendations. A new Balancing Mechanism will, if required, adjust between the global sum and the workforce reimbursement sum in the Network Contract DES, depending on real terms partner pay levels. This will be designed by NHS England and GPC England in 2019. As a corollary of major investment, and to safeguard public trust in the GP partnership model, pay transparency will increase. GPs with total NHS earnings above £150,000 per annum will be listed by name and earnings

in a national publication, starting with 2019/20 income. The Government will look to introduce the same pay transparency across other independent contractors in the NHS at the same time.

9. Tests future contract changes prior to introduction. A new testbed programme will be established to provide real-world assessment. Under this, different clusters of GP practices in Primary Care Networks will each develop or test a specific draft contract change such as a service specification, QOF indicator or QI module. Some clusters will work with innovators to discover promising approaches and develop prototypes. Testing is likely to include rapid cycle evaluation, with assessment of costs and benefits. Each cluster will be commissioned nationally, topic by topic, normally through open calls for practice or network participation. Network participation in research will also be encouraged from 2020/21, given the proven link to better quality care.

This document marks the expansion of a major programme of collaboration between NHS England and the BMA over the next five years. We include a schedule of planned work. We now need to get the further design work and implementation detail right. The profession and patients expect the benefits we intend to bear fruit.

DR RICHARD VAUTREY

IAN DODGE

GPC ENGLAND CHAIR
CHAIR

NHS ENGLAND NEGOTIATING TEAM

CASE STUDIES

North Cumbria: Integrated Care Communities

North Cumbria is a mixed geography, with huge diversity in urban and rural populations, with patients often noting that it is a long distance to travel anywhere. Whilst historically general practice services in the area scored highly on the General Practice Patient Survey, with patient access and experience of primary care doing well, recruitment in the area has been a problem, with only one permanent GP covering three practices.

In order to transform services and encourage recruitment and retention of primary care staff, North Cumbria CCG set a proposal to build a fully integrated health and care system, working alongside community services and involving patients and secondary care in their decision making. This included transforming mental health services, looking at creating a sustainable secondary care offer, developing digital health and promoting self-care and prevention.

Practices in North Cumbria now work as part of an “Integrated Care Community” and offer rapid response and enhanced community services, education programmes, frailty co-ordinators and first contact physiotherapy. Health and social care professionals, GPs, the voluntary and third sector along with the community all work as one team to support the health and wellbeing of local people.

Bradford: Building our Community Partnership model

In August 2017, Bradford City and Districts CCGs began a journey and initiated conversations with system leaders to look at how to develop their community model. Over the next few months, 59 GP practices aligned to 10 communities across the 2 CCGs covering a patient population of 470,000.

A ‘youth parliament’ was established to provide opportunities for children and young people to inform future initiatives, and an enhanced community support programme for people living in care homes was developed to enable these people to feel part of the wider community. Drop in sessions were arranged to support carers and provide advice and information about local community services, as well as offering the opportunity for a flu jab.

Other initiatives currently running include:

- Proactive multi-disciplinary community support for people with frailty to ensure their needs are understood so future support packages can be tailored to meet this
- Projects with local community pharmacies to support people to manage respiratory conditions

- 'Living Well' events supporting people in the community to live well and maintain their independence through signposting and promoting self care and prevention
- Establishment of a community respiratory physiotherapy service
- Lifestyle coaching for people with chronic respiratory conditions
- Expansion of community physiotherapy service to support people with chronic muscular skeletal conditions

Feedback to date has been good, with community staff commenting that this programme has “created opportunities for discussions to develop joint solutions” and “the best thing is being able to work across professional boundaries”,

A selection of community partners they're working with:

- Community Pharmacy West Yorkshire
- Bradford District Care Foundation Trust
- Bradford Care Alliance
- Local Care Direct
- Bradford VCS Alliance
- Five Lane Community Partnership

Digital-First Primary Care

Policy consultation on patient registration, funding and contracting rules



Digital-First Primary Care

Policy consultation on patient registration, funding and contracting rules

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Preface

All around us, a new generation of technology is changing our lives. Each year more of us choose online routes to book GP appointments, order repeat prescriptions or view personal health records. Online and video consultations are available in a growing number of practices.

Digital innovations have the potential to support and empower patients, helping people to remain healthy and independent for longer. Used well, new technologies can also help to alleviate workload challenges in practices, ensuring appropriate use of appointments that will best address patient need and free up clinicians' time to support more complex patients and deliver continuity of care.

But the current contract rules weren't designed for digital-first services, and cause problems for the existing practices, the NHS and new providers alike.

The NHS is short of GPs. We know it can be attractive for some GPs to work for digital-first services, which have the potential to help increase overall GP numbers. And we also know that there are problems with the distribution of GPs, with some parts of the country much more under-doctored than others.

The NHS Long Term Plan commits that every patient in England will have access to digital GP services. We need to make it easier for existing GP surgeries to expand and improve their own digital services.

We need to change how the system works so we can ensure that the money continues to follow the patient - a long standing principle of NHS general practice.

And we need to ensure that digital-first providers can register new patients in areas where people can't currently access digital GP services.

This document therefore describes proposals to reform patient registration, funding and contracting rules to ensure patients have both choice as well as access to integrated care; and to harness the potential of digital providers to help with our workforce shortages in a way that helps our most under-doctored and deprived communities. It sets out options and proposals for reform and invite views.

Beneficiaries of these changes would include people in remote or deprived areas, people who don't live near a GP surgery, or don't have enough GPs in their area, and people with long-term health conditions, who need regular contact with a GP.

Executive Summary

1. The NHS Long Term Plan commits that every patient will have the right to be offered digital-first primary care by 2023/24.¹ The new five-year framework for GP contract reform describes the areas in which we expect early progress to be made in general practice.² For example, by April 2020 all patients should have online access to their full record and by April 2021 all patients should have the right to online and video consultations.
2. One important step is to help existing practices digitise their offer. NHS England has already committed to a programme to support practices and commissioners to do that via a framework for digital suppliers to offer their platforms and products to primary care on standard NHS terms for use from 2021. The creation of Primary Care Networks (PCNs) will see them play an essential role in supporting practices and other partners to deliver a comprehensive digital offer for their patients and integrating these services across a local area.
3. Recently there has been a growth in new digital GP providers offering a model which allows patients to register with them directly and contact the practice through an app. The app enables patients to check their symptoms, message the practice, monitor their health and undertake video consultations with GPs. These models are proving convenient and popular with some patients.³ It is important to support patients' active choice of a new service.
4. Under the current arrangements, the expansion of these models has taken place by registering patients across wide geographies from a single GP practice. The most significant example of this is the likely expansion of a practice in Hammersmith and Fulham to register patients in Birmingham, as it is permitted to do under longstanding GMS regulations.
5. However:
 - If large numbers of patients are registered with a practice that is unnecessarily miles away from their home, it will be more challenging to

¹ "The NHS Long Term Plan"; available from:

<https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

² "Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan"; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

³ "Evaluation of Babylon GP at hand. Final evaluation report"; available from:

<https://www.hammersmithfulhamccg.nhs.uk/media/156123/Evaluation-of-Babylon-GP-at-Hand-Final-Report.pdf>

deliver integrated local health services. It also creates complexities for delivering screening arrangements;

- Because of the way NHS funding currently flows following a patient's registration with a GP, Clinical Commissioning Groups (CCGs) with high numbers of out-of-area registrations become responsible for the healthcare costs of patients registering with a digital provider in their area in advance of the adjustment which is then made to funding allocations. In the example above, the patients in Birmingham with a GP practice in London would under current arrangements be funded by Hammersmith and Fulham CCG even if they live in Birmingham.

6. We need to address these issues to ensure:
 - General practice providers remain connected, as far as practicable, to wider local services, including the new primary care network services that will be introduced from April 2020;⁴
 - CCG allocations and the distribution of general practice funding are fair.
7. Given our need for more GP capacity, we also need to make best use of all available tools which could reduce GP workload and maximise the participation of trained GPs in the workforce. New digital models offer further opportunities to improve access to services and bring additional capacity from part time GPs willing to work additional sessions from home.
8. This document sets out proposals and options to:
 - Change how the system works so we can ensure the money follows the patient;
 - Make it easier for existing GP surgeries to expand and improve their own digital services;
 - Ensure that digital-first providers can register new patients in areas where people can't currently access digital GP services.
9. **Chapter one concludes that the current out-of-area registration rules need to change, and in a way that maintains patient choice. It therefore proposes to amend the out-of-area registration rules so that where a practice exceeds a threshold number of out-of-area patients in any CCG (we propose to fix this somewhere between 1,000-2,000 patients in any CCG, subject to views from consultees), then their main contract will be automatically disaggregated. They will separately be awarded a local primary medical care contract in that CCG through which to serve those patients.** This solves the problems identified whilst protecting the active choice being made by patients for a different service.

⁴ "Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan"; available from: <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

10. **Chapter two sets out how we propose to change the allocations system** to enable quarterly recalculation of CCG funding to reflect patient movements of the sort which have been stimulated by registration with digital-first practices in London.
11. **Chapter three considers further changes to the GP payment formula** to ensure resources are distributed fairly. This builds on the changes introduced this year to the London adjustment and rurality index payment⁵. We have specifically considered whether we need to make changes to the new patient registration premium since digital-first providers typically see a higher number of patient registrations and de-registrations⁶. Given that new patients generate extra work for practices, it is proposed to maintain the premium but only pay it if a patient remains registered with a practice for a defined period. We are inviting views on that period, but propose six to twelve months.
12. **The fourth chapter considers whether we should allow other digital providers to set up and start registering patients in any part of England.** This could help increase overall GP capacity as well as increase the choices available to patients.
13. **It could also help address the inverse care law in general practice.** We could allow new digital-first practices into our most under-doctored geographies – for example, CCGs in the bottom 10% or 20%. And require these practices to meet key criteria: (i) demonstrate that the GPs they will be bringing into the local community are additional; (ii) ensure that the physical part of their service also includes the most deprived areas of the CCG; and (iii) actively promote their service to the most deprived communities, so that their lists properly reflect the make-up of the local population. In this way, the NHS could harness the potential of digital-first providers to reduce health inequalities.
14. **We also suggest that alongside national rules, we could remove the need for most local APMS procurements by looking to PCNs as the default mechanism for maintaining primary care provision. In chapter four we invite views on these propositions.**
15. We would welcome your feedback on the proposals set out in this document by **Friday 23 August 2019. Chapter five outlines how you can share your feedback, as well as the next steps we propose to take.**

⁵ “Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan”; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

⁶ Based on internal NHS England analysis.

1. Out-of-area registration

16. English GP practices have traditionally operated on the basis of a ‘catchment area’ from which their list of registered patients has been drawn. In January 2015, out-of-area registration rules were introduced to allow patients the choice to register with a practice in a more convenient location for them than near their home address. They were intended to enable commuters to register with a practice near their place of work, parents to register with a practice near their child’s school, a GP practice to continue to care for a patient who has moved into a care home or new house outside the practice boundary etc. We know many patients have benefitted from this flexibility and it is important we maintain and protect this. **There is no intention to restrict the choice exercised by these patients.**
17. But the out-of-area rules need revisiting. Out-of-area registrations have risen, partly as a result of the expansion of new digital-first primary care models.⁷ On 1 April 2019, there were 126,821 patients recorded as out-of-area registrations, a rise of over 53,000 over the past two years, and this trend is likely to continue.⁸

Date	# Out-Of-Area Registrations
1 April 2015	7,065
1 April 2016	50,103
1 April 2017	73,573
1 April 2018	98,755
1 April 2019	126,821

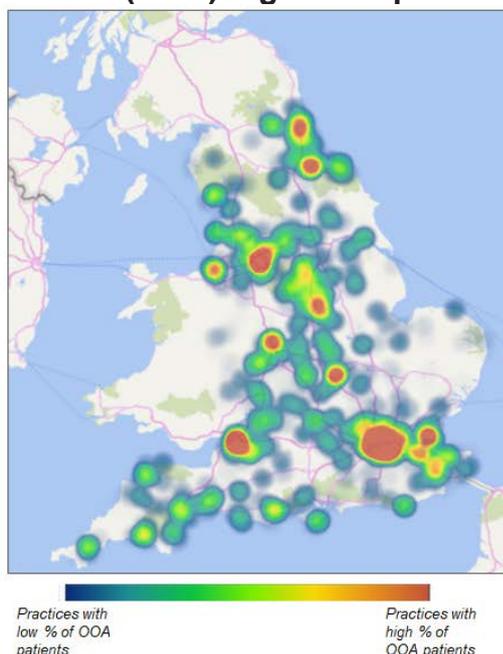
18. We also know, because of the manual processes in use by practices to record out-of-area status, that these figures will be higher in reality, reflecting patients who do live outside the catchment but are not formally recorded as such; the extent of this issue is not precisely known.
19. The majority of practices (73%) still have no recorded out-of-area patients, with only six practices having more than 10% and one practice more than 20%.⁹

⁷ Based on an internal NHS England analysis.

⁸ Based on an internal NHS England analysis.

⁹ Based on an internal NHS England analysis.

Figure 1: Geographical and numerical distribution of general practices by % out-of-area (OOA) registered patients, April 2019



% OOA registered patients	Practices [#]	Practices [%]
0%	5,098	73%
>0% and <=5%	1,883	27%
>5% and <=10%	27	0.4%
>10% and <=15%	4	~0%
>15% and <=20%	1	~0%
>20%	1	~0%
(all)	7,014	100%

20. The out-of-area system has been used and is likely to be further used by some providers to register increasing numbers of patients across vast geographical areas. However:
 - It is challenging to deliver integrated services and population-based care to patients who are registered with a practice at significant distance from their other local health and care services;
 - Though a solution is available as a workaround, the current system risks creating complexities in delivering reliable screening arrangements;
 - It makes it challenging for commissioners to plan and budget for local services because of the interaction between arrangements for charging costs to responsible commissioners and flows of funding allocations and the speed at which they reflect movements in GP registration.

21. Some digital-first models also rely on sub-contracting to expand into new areas. Commissioners currently have limited and different ability to object to sub-contracting of clinical matters (services) under a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract. For GMS contracts, the only grounds to object are if:
 - The sub-contracting arrangement puts the safety of the contractor's patients at serious risk;
 - The sub-contracting arrangement puts NHS England at risk of material financial loss; or
 - The sub-contractor would be unable to meet the Contractor's obligations under the Contract.

22. This means that commissioners have very little influence over sub-contracting from primary medical care contracts in their area, even if it is not in the best interests of patients and the local health and care system. This is very different to the position in other areas of the NHS.
23. We have therefore considered:
 - Abolishing out-of-area registration but this would unjustifiably limit patient choice of GP, which has been a defining attribute of the NHS since 1948. We therefore reject this possibility;
 - Option A: Limiting the number of patients that practices can register as out-of-area; or
 - Option B: Using the automatic award of new, local contracts: a forced disaggregation of the list.

Option A: Limiting the number of patients which practices can register as out-of-area

24. Limiting the number of out-of-area registrations could address the issues with expansion under the current rules whilst maintaining flexibility for those patients for whom the original out-of-area rules intended to support. It could be achieved by:
 - Preventing practices from registering patients who live more than a given distance away. However, catchment areas vary and this approach could penalise (as an example) commuters in a relatively arbitrary way;
 - Preventing practices from registering patients who reside outside their CCG or Sustainability and Transformation Partnership (STP)/Integrated Care System (ICS). However, some practice areas naturally span the boundaries of multiple STPs/ICS and this approach could penalise (as an example) those patients who live a short distance from a neighbouring STP/ICS;
 - Setting a cap on the proportion of patients who can be registered as out-of-area. Any cap could be relatively arbitrary and curtail the speed and agility by which digital-first models spread, leaving legacy issues to resolve.
25. Implementing these approaches would be challenging given the known issues in the recording of out-of-area registration status. Practices do not systematically collect data on the reasons why patients choose to register out-of-area. For all these options to work, particularly the cap, practices would need to undertake a significant administrative exercise to improve recording which would be time-consuming and burdensome. All variants of this option potentially involve some restriction of patient choice. We have therefore ruled this option out.
26. Even though this is not our preferred option, we intend to put steps in place to help practices to improve the recording of patients' registration status by:
 - Changing IT systems to make it easier to record out-of-area patients;

- Amending the new patient registration form to make it simpler to identify out-of-area patients and their rationale for registering with the practice;
- Issuing further communications to remind practices of the need to accurately record out-of-area patients; and
- Reminding the system about the processes around practice boundaries.

Option B: Disaggregating the patient list to create new, local practice contracts, linked to local CCGs and Primary Care Networks

27. We have considered whether there is a better way to reflect the fact that patients choosing new digital-first providers are almost certainly opting for the different service, rather than making an active choice to be registered as ‘out-of-area’; the conflation of these two concepts is an artefact of the current system. Instead of limiting out-of-area registration, we propose to take steps to support patients’ choice whilst addressing some of the issues identified in the current system.
28. For that reason, our preferred option is to determine a threshold number of patients who could be registered by a provider ‘out-of-area’ in any one CCG area before a new, local contract was awarded to the provider in question. That would mean:
- Where small numbers of patients were registered, the system of out-of-area registration would continue as it does currently;
 - But if the number of out-of-area patients registered with the provider hit the threshold, the provision of services for those patients would automatically be transferred into a new contract held locally by the relevant CCG. This would ensure that contractual arrangements with the provider follow the flow of commissioner funding and local management;
 - We would ensure that the right to register truly out-of-area would always continue to exist for patients who wanted it, for example commuters.
29. As an illustrative example:
- In July 2019, a number of patients who are resident in CCG X are registered out-of-area with a practice in CCG Y. They are patients of CCG Y. The practice may hold any type of primary medical services contract (GMS/PMS/APMS);
 - By April 2020 the number of patients resident in CCG X but registered with the provider in CCG Y reaches the agreed threshold for contract conversion;
 - The provider is automatically awarded a new contract in CCG X to which its patients resident in CCG X are transferred. These patients become patients of CCG X (again) rather than out-of-area patients;

- The provider continues to operate as before in CCG Y but its practice list does not include patients in CCG X, who from this point onwards would be registered to the new contract.
30. The key decision is the choice of threshold at which to trigger the creation of a new APMS contract. Set too low, the danger would be a series of contracts serving very few patients. Set too high, the danger is that the detractions of the current model are perpetuated for too many patients. We are therefore consulting on the correct threshold, but our starting proposition is that a threshold of between 1,000 and 2,000 patients might be used.
 31. To avoid bureaucracy and uncertainty for GPs, CCGs and patients, the establishment of new contracts by this route would be an automatic process involving default bulk and automatic re-registration of patients with the same provider under its new contract.^{10 11} We propose that this is applied to all current and future GMS, PMS and APMS contracts (i.e. all providers). This may require changes to the Regulations and Directions governing them, made by the Department of Health and Social Care.
 32. These changes would oblige the commissioner and provider to undertake this process. There is a precedent for conversion between different contract types serving the same patients in the existing right of PMS providers to request a GMS contract.¹² New APMS contracts established via this route would be on terms that ensured there was no advantage to the provider in this conversion; a digital-first provider would simply serve the same patients as before but in a more sustainable contract structure. Existing rules would apply with regards to contract transfers and sub-contracting. We propose that providers would not have the right to register out-of-area patients from these new APMS lists – otherwise we risk perpetually reintroducing the same problem we will have been seeking to solve.
 33. We could require the physical premises established under new APMS contracts to be established in deprived areas of the relevant CCG and compel providers under the contract terms to take steps to ensure its list represents the cross-section of the local population in that area, with the aim of reducing inequalities. We would apply the Market Forces Factor for the new contract area. See chapter four for further discussion on proposed terms.

¹⁰ The APMS contract would remain in place even if the number of registered patients with the provider subsequently fell below the threshold after the contract was awarded. Any removal of the contract would be on prevailing national terms.

¹¹ The new patient registration premium would not apply to patients who are automatically re-registered under the new APMS contract.

¹² “The National Health Service (Personal Medical Services Agreements) Regulations 2015 Part 7, Right to a General Medical Service Contract”; available from: <http://www.legislation.gov.uk/ukxi/2015/1862/contents/made>

34. Chapter four also explores whether there are also other circumstances in which new contracts should be available to digital-first primary care providers to further enable patient choice and tackle wider issues in the provision of primary medical services.

Amending the out-of-area registration payment level

35. When we engaged on digital-first primary care payments in 2018, some argued it was unfair that practices received the same payment for out-of-area patients as in-area patients.¹³ This is because practices are under no obligation to deliver home visits for out-of-area patients or urgent care during core hours. CCGs have to ensure urgent care arrangements are in place for out-of-area patients, which has a financial cost and requires careful commissioning to take account of the potential impacts on quality of care and patient safety.
36. This is not an issue when rates of out-of-area registration are low, as they have been historically. But as the use of out-of-area registration grows, it could become unsustainable.
37. We estimate that it might be reasonable for practices to receive somewhere between 72p and £2.93 less than the average global sum payment of £89.88 for an average out-of-area patient than an “in-area” patient, on the basis that practices are not required to deliver home visits for out-of-area patients:
- 72p is based on the actual cost to CCGs for 2017/18 for the formal provisions made to deliver services to out-of-area patients via the “Out of area registration: In hours urgent primary medical care (including home visits) Enhanced Service” - £80,516.¹⁴ But this calculation does not take account of other types of arrangements put in place locally to support out-of-area patients and the wider impact of out-of-area registrations on other local open-access services, particularly urgent care.
 - £2.93¹⁵ is an estimate based on the current ratio of home visits to total appointments. 1 in 20 out-of-area registered patients have a home visit annually at an estimated cost of £60 per visit. However, this calculation has not been adjusted for patient characteristics.

¹³ “Digital-first primary care and its implications for general practice payments” public engagement report; available from:

https://www.engage.england.nhs.uk/survey/digital-first-primary-care/user_uploads/digital-first-access-to-gp-care-engagement-v2.pdf

¹⁴ Internal NHS England analysis based on “Payments to General Practice - England, 2017/18”; available from: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/england-2017-18>

¹⁵ Internal NHS England analysis based on “Appointments in General practice, October 2018”; available from: <https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/oct-2018>

38. Given the proposed reduction in global sum is so small (78p would be a 0.8% reduction to global sum, whilst £2.93 a 3.2% reduction), we do not propose to change the payment level at this time. This is because it would require all practices to comprehensively review their patient lists to ensure accurate recording of out-of-area patients and we cannot justify the time practices would need to spend.
39. Further, in our recent engagement on digital-first primary care and its implications for general practice payments¹⁶, some respondents raised concerns that lowering the payment would discourage practices from accepting out-of-area patients. If the preferred option above is taken forward, patients could move between out-of-area and in-area status. Therefore, we propose to maintain the same payment level for out-of-area registered patients as in-area ones.

Consultation questions

- Q1a.** Do you agree with the principle that when the number of patients registering out-of-area reaches a certain size, it should trigger those patients to be automatically transferred to a new separate local practice list, that can be better connected with local Primary Care Networks and health and care services?
- Q1b.** Are there any factors which you think should be taken into account if this option were to be implemented?
- Q1c.** Please provide any views you may have about the proposed threshold of 1,000-2,000 patients for the triggering of this localisation.
- Q2.** Do you agree that, although the service obligations are not identical, given the small scale of any possible change and the burden of its implementation, payments for out-of-area patients should remain the same as those for in-area patients?

¹⁶ “Digital-first primary care and its implications for general practice payments” public engagement report; available from: https://www.engage.england.nhs.uk/survey/digital-first-primary-care/user_uploads/digital-first-access-to-gp-care-engagement-v2.pdf

2. CCG allocations

40. Because of the way NHS funding currently flows following a patient's registration with a GP, CCGs with high numbers of out-of-area registrations become responsible for the healthcare costs of patients registering with a digital provider in their area in advance of the additional population being reflected in their funding allocations.
41. The increased volume, concentration and rate of out-of-area registrations described in chapter one can magnify the impact of the lag in funding adjustments and lead to a financial pressure. Though chapter one describes a mechanism by which this impact would be reduced by conversion of out-of-area registrations back to the 'right' CCG through APMS contracts, significant financial pressures could still arise for CCGs hosting a digital-first provider. It is right that the resources for out-of-area patients should flow as soon as is practicable from the CCG they were part of, and which no longer bears the financial responsibility for them, to the CCG they are now registered with.
42. The process for making this adjustment should be timely, perhaps once per quarter, prospective and proportionate, with a materiality threshold avoiding reopening allocations for all CCGs because of movements in registrations between a small number of practices.

Making the ongoing adjustment

43. Where the numbers of out of-area registrations are low and so the threshold to convert them back to the 'right' CCG has not been triggered we propose an adjustment using registration data to find the net flow of people registering with each digital practice from practices in other CCGs. The data are derived from the same datasets that underpin payments for primary medical care services and so are generally held to be of high quality.
44. We would then determine the financial value of the adjustment per patient. We propose that this should be based on the per capita allocation made to the original CCG, adjusted for the age and gender of the patients. From this, we would calculate a financial adjustment to be made from the subsequent quarter onwards. Considering the net flow would allow resources to flow back to the original CCG should the "pull" of the digital practice fluctuate, or should the threshold be breached, requiring the digital practice to operate through the originating CCG.
45. This capitation-based approach may not be sufficient to address concerns that digital-first models will attract patients with lower health needs (and hence costs).

46. We will explore two further options to address this concern. Firstly, using the practice-specific need indices; or, secondly, using the need indices of the digital practice itself. Using the originating practice would assume that people from each of its age-gender groups are attracted uniformly to the digital offer, which may not be the case. The latter will require the digital practice itself to have a sufficiently stable profile that its need indices can be robustly calculated. This is unlikely to be the case in the short term for a fast-growing practice, and the additional analysis required would take time to complete. In the context of a capitation-based approach, we will also consider whether the adjustments made should relate only to a subset of services, such as those to which pure activity-based payment applies under terms set in the National Tariff or prescribing costs, and not to other services such as community services which tend to be commissioned and paid for on a place basis.
47. An alternative approach to estimating the financial impact which takes account of the characteristics of the individual patients would be to use the actual costs incurred by the transferring individuals in the previous quarter and apply those to the forthcoming quarter. However, this would mean that fluctuations in usage by individuals will drive fluctuations in the resources transferred and result in greater financial uncertainty for CCGs affected by the adjustments. It is also inconsistent with the fairness principle of needs-based allocations. We therefore do not propose to take this approach.
48. There is a risk that small-scale registrations of out-of-area patients, in line with the original intention of the policy, could be affected by this policy and drive many burdensome low-value financial adjustments. This would be inefficient and risk deterring practices from accepting out-of-area registrations, and thus limit patient choice. We therefore propose to disregard patient flows where the accumulated flow to the CCG registering the out-of-area patients falls below a threshold. We would welcome views on where this threshold should be set.

Baseline adjustments

49. For patients moving during 2019/20, we propose to follow the process outlined above. However, we also need to make a baseline adjustment to take account of very rapid growth in Babylon GP at Hand (BGPaH) in 2018/19, from around 5,000 to around 33,000 registered patients, that has not been accompanied by an explicit adjustment to the funding allocations of the affected CCGs. We propose that a similar adjustment, based on registered patient flow and an age-gender adjusted capitation payment, should also be made for this baseline impact.
50. This will have a financial impact for CCGs whose patients have moved to register with BGPaH. However, we believe that in the context of material and rapid movements in registered population it is important that the resources follow the patient.

Consultation questions

- Q3a.** Do you agree with the principle that resources should follow the patient in a timely way where there are significant movements in registered patients between CCGs as a result of digital-first models?
- Q3b.** For these purposes, how do you think “significant” movements in registered patients should be defined?
- Q3c.** What threshold, if any, do you think should be applied to the flow of out-of-area patients to a CCG before this adjustment is applied?
- Q3d.** Do you think it is necessary to cap or restrict the maximum deduction from any one CCG on an in-year basis?
- Q4.** Do you agree that a capitation-based approach is the best way to determine the size of the adjustment required per patient or do you have other proposals?

3. New patient registration premium

51. This section considers whether we need to make any changes to the new patient registration premium, to ensure fairness in the distribution of resources. This builds on the public engagement we undertook last year on digital-first primary care and its implications for GP payments.¹⁷ This review led to the introduction of changes to the rurality index and London adjustment¹⁸ and highlighted the need to further consider the out-of-area registration payment (dealt with in Chapter 2) and the new patient registration premium.
52. When the current GP payment formula was established in 2004, the new patient registration premium¹⁹ was introduced to recognise the additional workload new registered patients generate, since they tended to be associated with a higher workload, including having more consultations in the first year than other patients with similar characteristics. Last year 10.7 million patients registered with a new practice (18%).²⁰ Based on patient turnover data from Jan 2015 to Dec 2018, 13% of newly registered patients leave the practice before completing a full year, while 6% do so within six months of registering.²¹
53. We need to review the premium in light of the expansion of digital-first primary care models because:
 - Digital-first providers have had a high number of new patient registrations in the past two years.²² This trend is likely to continue and could increase, particularly with any expansion of digital-first provision;

¹⁷ “Digital-first primary care and its implications for general practice payments” public engagement report; available from:

https://www.engage.england.nhs.uk/survey/digital-first-primary-care/user_uploads/digital-first-access-to-gp-care-engagement-v2.pdf

¹⁸ “Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan”; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

¹⁹ Also known as list turnover adjustment.

²⁰ Based on internal NHS England analysis.

²¹ Figures are derived from NHS England internal analysis of patient registration data and are gross figures, which include patient registrations and de-registrations for any reason, e.g. where patients need to move to a new practice following the closure or merger of GP practices.

²² Based on internal NHS England analysis.

- Digital-first providers have a higher rate of registration and de-registrations (patient churn). We know that the proportion of patients in London practices returning to their original practice within one year of moving to a new practice is 12%, while for digital models it is more than three times that rate.²³ The premium does not fully account for patient churn. This is because it is calculated at the end of each quarter, based on the proportion of a practice's registered list that joined during the previous twelve months;
- We know that those registering with some digital-first providers are more likely to be younger and healthier.²⁴ We therefore need to consider whether it is still right to distribute funding towards new patient registrations rather than existing patients with co-morbidities and more complex needs.

54. We have considered several options including:

- Option A - Abolishing the new patient registration premium;
- Option B - Retaining the new patient registration premium;
- Option C - Keeping the new patient registration premium but setting stricter criteria for its payment.

Option A - Abolishing the new patient registration premium

55. When the Carr-Hill Formula was established, a 46% premium was considered to be about the right amount to pay practices for the additional workload a new patient generates over the course of a year. Abolishing the new patient registration premium would affect all practices but particularly those with naturally high list turnover rates (university practices, practices in urban areas or those with transient populations). It could also act as a disincentive for practices to register new patients or accept patients following practice closures, which could have a negative impact on patient choice and access. For these reasons, we do not propose to abolish the premium.

Option B - Retaining the new patient registration premium

56. Retaining the new patient premium in a world of increasing digital-first primary care risks diverting increasing levels of activity and funding to younger working age patients, rather than those with long term conditions, co-morbidities etc. It is conceivable that two practice moves within a few months might become

²³ Based on internal NHS England analysis.

²⁴ "Digital-first primary care and its implications for general practice payments" public engagement report; available from: https://www.engage.england.nhs.uk/survey/digital-first-primary-care/user_uploads/digital-first-access-to-gp-care-engagement-v2.pdf

more common and there is a need to ensure that the funding formula takes account of this.

57. One option would be to vary the premium level in a more dynamic way to take account of potential or actual churn, ensuring spend on the premium is more predictable overall. But given the uncertainties and complexities, it would be difficult both to make these calculations and to determine a fair value. We therefore think the best option would be to maintain the premium but set stricter criteria for payment.

Option C - Applying new criteria for payment of the new patient registration premium

58. We propose that the new patient registration premium is only paid **if a patient remains registered with a new practice for an agreed period**. This approach would ensure that practices which spend more time seeing newly registered patients will be duly recompensed. We would welcome your views on the exact time period we should set, but propose this be between six and twelve months.

Consultation questions

- Q5a.** Do you agree that we should only pay the new patient registration premium if a patient remains registered with a practice for a defined period?
- Q5b.** What do you consider to be the right period of time for a patient to be registered with a practice for the practice to be paid the new patient registration premium? Six months, nine months, twelve months or other?

4. Harnessing digital-first primary care to cut health inequalities

59. The NHS Long Term Plan commits that all patients will have the right to digital-first primary care over the next five years.
60. A key way this will be achieved is by supporting existing general practice to expand and develop its digital-first offer, as some practices are already doing by partnering with suppliers of digital technology to deliver a digital offer to their patients. A new programme will be introduced in 2019/20 to support ICSs, STPs, CCGs, PCNs and practices to develop an integrated digital-first offer that supports both patients and staff. The programme will ensure a new framework is available for digital suppliers to offer their platforms on standard NHS terms.
61. But we recognise that change takes time and this approach alone is unlikely to maximise take-up and innovation in digital-first services at pace, ensuring delivery of The NHS Long Term Plan commitment. We also need to continue to improve access to general practice services in some geographies, and digital-first providers could help achieve this.
62. Chapter one has already proposed a mechanism to convert lists of out-of-area patients held by existing providers into a separate, local contract. But this only applies where a digital-first provider already holds a local contract and may not fully honour the principle in The NHS Long Term Plan that patients should be able to choose to register with a digital-first practice.
63. In this chapter, we consider whether we could go further to facilitate new digital and physical services to be set up via an APMS contract in a way that would help to address issues in access to services.
64. This chapter also sets out further details of the possible terms of future APMS arrangements of both sorts.

Overview of proposed service model for new APMS contracts

65. Before a new APMS contract for digital-first provision is established, any provider would need to:
- Offer a full primary medical care service (i.e. essential services as defined under GMS Regulations) throughout core hours from a zero-based list²⁵. This would include both digital and face-to-face services as patients will always need some physical contact with practices, even if more and more patients opt for digital consultations in future;
 - Establish physical premises from which to offer face-to-face services in the CCG area in which the contract is held - we propose that this includes areas identified as deprived to help reduce health inequalities and improve access to services;
 - Provide services for all cohorts of patients so no groups are disadvantaged. We want to ensure that digital services are promoted and accessible to all patients. We expect the provider to take steps, making every effort to ensure that its list reflects the demographics of the local population;
 - Integrate with other local services;
 - Co-operate with the relevant local PCN;
 - Become a member of the local CCG as the Health and Social Care Act 2012 (as amended) requires all GP practices to be members of a CCG;
 - Agree to APMS contract terms, specification and pricing. In the case of APMS contracts created under the proposals in chapter one particularly, this would be on terms no more generous than the contract from which the conversion occurred.
66. In addition, we expect the provider to offer comprehensive digital offer including, for example:
- The ability for patients to book appointments online;
 - An evidence-based symptom checker;
 - Video consultations;
 - Asynchronous (online) consultations e.g. via text, email;
 - Management of repeat prescriptions online;
 - Full and integrated access to a GP medical record and personal health record.
67. We would expect providers to commit to working with other parts of the local health and care system to provide streamlined digital access for patients to all relevant services. We would also expect providers to innovate for the benefit of patients.

²⁵ This means that practices would not have any patients on their list until they register them.

68. The APMS contract would be offered on a rolling basis without a fixed length, subject to acceptance that the provider would deliver against prevailing national APMS terms which could be amended by commissioners.²⁶ The burden of the costs of set up would be for the provider to meet. Funding for each practice would otherwise mirror that for existing practices, be based on patient registrations with capitated payments using the Carr-Hill Formula. APMS providers would not as a default have access to funding through the Premises Costs Directions.²⁷

Where should we create new opportunities?

69. Except where indicated, the rest of this chapter applies only to possible opportunities for new providers to set up, rather than the proposals set out in chapter one.
70. In this regard, we have considered whether we should:
- Allow providers to set up anywhere in England from April 2020;
 - Restrict new entry to only those areas facing the greatest GP capacity gaps.

Option 1: Enable expansion anywhere

71. One option would be to create new opportunities for providers to set up new services anywhere in England. This approach could help to expand the digital-first offer quickly. It could bring more capacity into the system and encourage a greater number of GPs into the workforce; who may want to work part-time or more flexibly as the BGPaH evaluation has shown.²⁸
72. But it marks a fundamental shift in how we commission services. Provider appetite would need to be tested, but it is possible that the approach would lead to an unequal spread of providers with providers more likely to be attracted to specific areas (such as urban areas) and not those in need of capacity. As such, it could lead to over-provision in some areas and potentially exacerbate the issues of under-doctoring in other areas.
73. There is also a risk, depending on patient appetite for new services, that the approach could:

²⁶ If the APMS contract was offered, by conversion, under the scheme set out in chapter one and the provider's original contract was a time-limited APMS contract, the new contract would need to be limited to the same term as the original contract

²⁷ Premises Cost Directions do not apply to APMS contracts.

²⁸ "Evaluation of Babylon GP at hand. Final evaluation report"; available from: <https://www.hammersmithfulhamccg.nhs.uk/media/156123/Evaluation-of-Babylon-GP-at-Hand-Final-Report.pdf>

- Destabilise existing providers if new providers attracted their patients or staff. This could lead to an increase in the rate of closure of existing practices;
- Be inefficient when first established if new providers struggle to attract sufficient patients to be viable. This could lead to workforce inefficiencies at a time when general practice is stretched.

74. For these reasons we think it could be more beneficial to target any opportunities in areas of identified need, balancing the risks against the opportunity to tackle health inequalities and testing the real-world effects of the new model before further decisions are made.

Option 2: Restrict expansion to areas which lack GP capacity

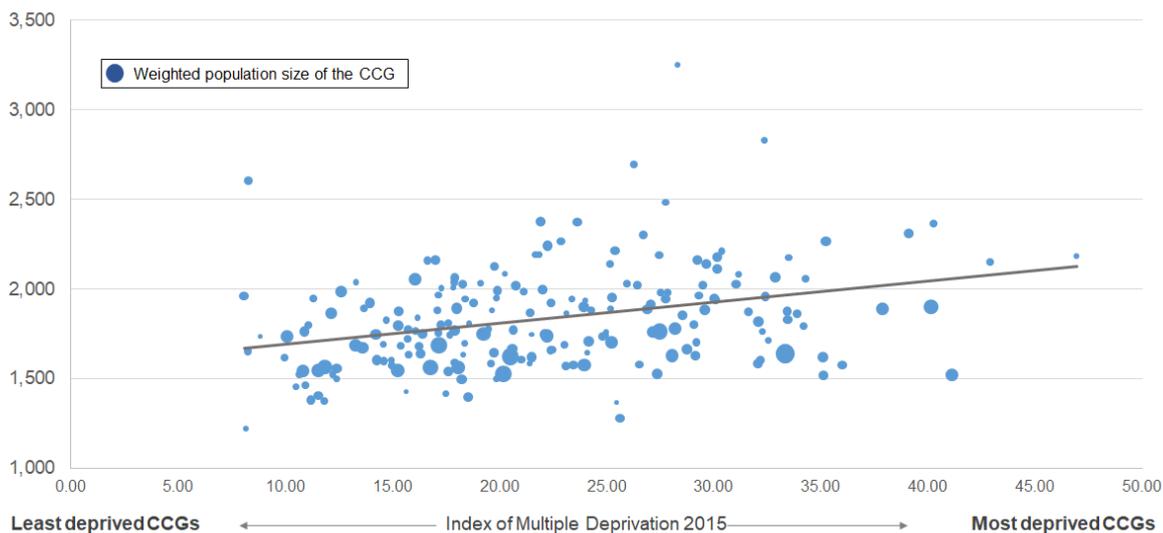
75. Numerous studies in recent years have highlighted a shortage of GP workforce as a result of population growth and increased need for care due to an ageing population.²⁹ Recent research suggests this issue disproportionately affects areas of deprivation, as GPs tend to care for more patients in areas of high deprivation.³⁰

76. This can be seen in the analysis we have undertaken of the number of registered GP Full Time Equivalents (FTEs) per weighted population. See Figure 2.

²⁹ “Securing the future: funding health and social care to the 2030s”; available from: <https://www.ifs.org.uk/uploads/R143.pdf>

³⁰ “Are parts of England 'left behind' by the NHS?”; available from: <https://www.nuffieldtrust.org.uk/news-item/are-parts-of-england-left-behind-by-the-nhs>

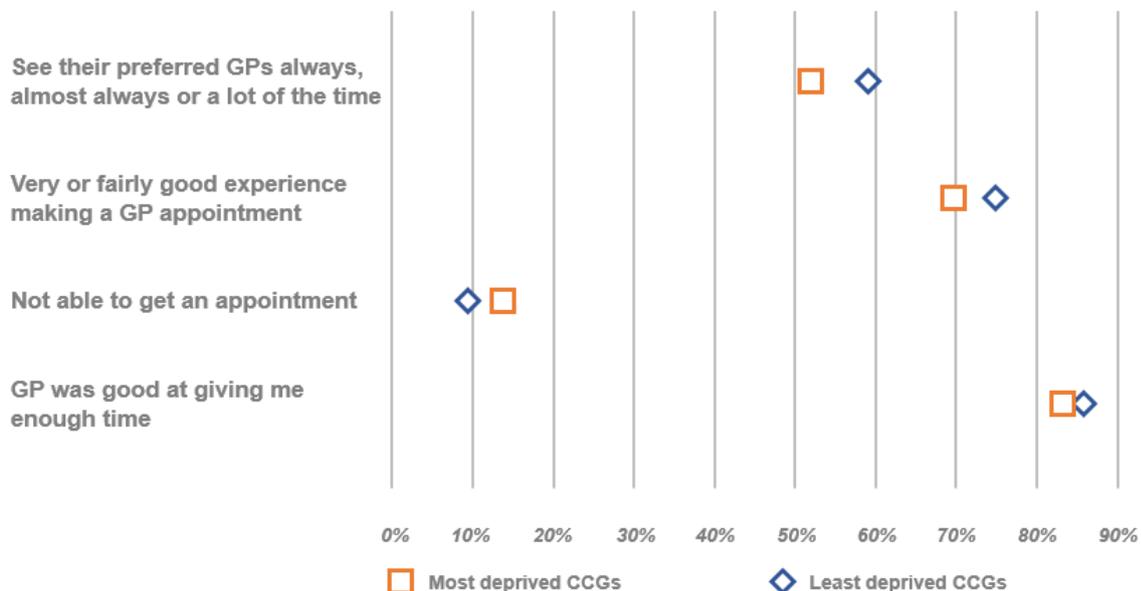
Figure 2: Registered weighted population per GP FTE



Note
 NHS England analysis. Sources: NHS Digital General Practice Workforce December 2018, Index of Multiple Deprivation 2015. 'GP FTE' refers to all full time equivalents from fully qualified general practitioners including registrars; weighted population is as of January 2019.

77. Furthermore, the 2017 GP Patient Survey shows that patients in the most deprived areas find it harder to get a GP appointment. See Figure 3.

Figure 3: GP Survey 2017, selection of indicators related to access



Source: GP Patient Survey 2017 and English Indices of Deprivation 2015. Dayan M (2018) "Are parts of England 'left behind' by the NHS?" Nuffield Trust comment. <https://www.nuffieldtrust.org.uk/news-item/are-parts-of-england-left-behind-by-the-nhs>

78. The NHS Long Term Plan promises stronger action on health inequalities, in line with NHS England's legal duties.³¹ As such, we think there is a stronger case for introducing extra capacity in areas considered to be under-doctored e.g. the most under-doctored 10% or 20% of the country.
79. This would not be the first time the NHS has developed approaches to try to address under-doctoring. The Medical Practices Committee (prior to the 2002 NHS Act) tried to ensure more equitable distribution of GPs, while the short-lived Equitable Access to Primary Medical Care programme offered incentives for practices to be opened in under-doctored areas.³²
80. **But the development of digital general practice now offers the possibility that has never before existed – to expand GP capacity for patients in an area even when the GP sessions are provided at some distance.** By targeting under-doctored areas, it could help to bring additional capacity into these areas and deliver improvements in access. This would support our wider goals to reduce health inequalities. **We would therefore require any such providers to have a credible plan for bringing additional GPs into the area from outside, and to deliver this additionality as an ongoing contractual requirement.**
81. Identifying under-doctored areas is challenging as there is no standard definition or methodology. We could take a simple approach and analyse the average number of weighted patients per GP and aggregate this data to CCG level. We could restrict entry to the lowest 10% or 20% of CCGs.
82. Or we could consider other factors that affect access to services. For example, the Equitable Access to Primary Medical Care programme assessed under-doctoring on the basis of:
- Number of primary care clinicians (WTE GPs and WTE nurses per 100,000 population);
 - Health outcomes: life expectancy, cancer mortality amongst under 75s, cardiovascular mortality amongst under 75s, index of multiple deprivation; % of patients with diabetes in whose HBA1c is 7.5 or less, % of patients with hypertension in whose BP reading is 150/90 or less;
 - Patient satisfaction: % of patients seen within 48 hours; % able to book an appointment more than two days in advance; % satisfied with their practice telephone system; % able to see a specific GP; % satisfied with the practice opening hours.

³¹ Including duties under the Equality Act 2010 and section 13G of the NHS Act 2006.

³² The programme sought to invest £250 million towards establishing new general practices services in the 38 most under-doctored areas.

83. In addition to under-doctoring, other factors are indicative of constrained GP capacity including numbers of closed practice lists. These factors could be used to determine where opportunities should be available. We envisage having a rolling list of areas in which new providers can be established, reflecting the prevailing position as circumstances changed.
84. We would welcome your views on the methodology we could apply to identify areas lacking GP capacity as part of this engagement exercise, particularly the methodology around under-doctoring. A full methodology would be developed following this consultation, depending on its outcome
85. The location of physical premises would also need to be agreed with the relevant local commissioner. **We think there would be a strong case to require at least some of the face-to-face services to be set up in a deprived part of the CCG; while ensuring patients have adequate access to face-to-face services across the whole practice footprint.** This would help bring in extra capacity, improve access to services and support our wider goals to reduce health inequalities by giving patients in the most deprived parts of the country more choice. We propose to identify areas of deprivation on the basis of Index of Multiple Deprivation (IMD) scores at Lower Layer Super Output Area (LSOA) geographical level.³³ The full methodology would be developed following the consultation. We are keen to hear your views on the methodology we should use and whether it should also be applied to contracts established under the proposals in chapter one.
86. In addition to this, **we would expect providers not only to establish services in deprived communities but also to take steps to ensure that their registered population reflects the wider population which they are being asked to serve.** These requirements would be reflected in the APMS contract.

Evaluation and review of entry criteria

87. We could initially enable new providers to set up in areas which lack GP capacity from April 2020 as per Option 2. Simultaneously we would support existing general practice to expand its digital-first offer via a national framework as well as a national funding and support programme. Subject to the successful evaluation of such new opportunities having been made available, there could then be future reasons to expand the list of CCGs in which contracts could be offered. These might include for example consistent failure to make an offer of digital-first primary care to a specified standard.

Possible commissioning routes

88. We have considered three possible ways to award an APMS contract to new providers:
- Via a standalone procurement exercise, with each commissioner responsible for designing and initiating a call to competition, open to any provider;
 - Via a call off exercise, with each commissioner using a framework or other purchasing system to select from a range of pre-approved providers;
 - By creating a new opportunity for providers to set up new practices in defined circumstances.

Standalone procurement exercise

89. This is where commissioners run a process to select a provider(s) to deliver a service. Typically, commissioners procure around 100 individual APMS contracts each year for core GP services e.g. to replace existing contracts. However, there are significant transactional costs associated with this type of procurement, which typically take between six to nine months and it would be very inefficient as a means for securing similar services.

Framework or other purchasing systems

90. Procurement processes can be organised more effectively and efficiently at scale for similar services, particularly where needed across the country. Traditional provider frameworks are more commonly recognised in response to very defined needs (but lock in only qualified providers at the point of establishment). However, just like individual procurements, these necessarily take time to establish and call-off still requires procurement/mini-competitions.
91. NHS England has been working to establish in 2019/20 more streamlined procurement arrangements to support local commissioners to secure APMS and urgently needed (caretaker) GP services. This would use a Dynamic Purchasing System (DPS), an online procurement system comprising pre-approved GP providers (who can join the DPS at any time unlike a traditional framework), which local commissioners would be able to use to invite bids more quickly to deliver APMS or caretaker services when these needs arise.

An opportunity to set up new practices in defined circumstances

92. Under this model, all approved providers meeting a set of criteria would be able to set up and deliver services to patients who choose to register with them as their GP practice. This approach would in our view be more practical and simpler and would be our preferred option as it would reduce

transactional costs associated with running multiple local procurement processes.

93. The approved providers list would likely include NHS trusts, whether acute or community, who may also be partnering with digital-first providers. It could also include groups of salaried or sessional GPs who want to set up their own new independent partnerships on a digital-first model, thus creating a new additional route to maintaining independent contractor status of the profession.

Implementation

Qualification criteria

94. We would expect the national qualification criteria to consist of the following elements:
 - Eligibility to hold a GP contract including ability to deliver “essential services” for primary medical care;³⁴
 - Suitability to hold a GP contract;
 - Ability to deliver a digital-first service (in addition to physical care when necessary).
95. In terms of the entitlement to hold a contract, we envisage using the standard APMS eligibility criteria. We would assess suitability of the provider to deliver full primary medical care to their registered population. For example, capability and experience, financial standing and stability, and governance amongst other things.
96. We would require the provider to have a credible plan to bring additional GP capacity from outside the local area. This would form part of the assessment process discussed below.
97. The provider would also need to demonstrate its capability to deliver a full digital-first service. We expect this would include as a minimum:
 - The ability for patients to book appointments online;
 - An evidence-based symptom checker;
 - Video consultations;
 - Asynchronous (online) consultations e.g. via text, email;

³⁴ The NHS Act does not list persons who may (or may not) enter into an APMS contract. However, the APMS Directions contain provisions relating to circumstances in which certain types of persons or organisation may not enter into an APMS contract (Direction 4). Further information can be found in Annex 3 of the “Primary Medical Care Policy and Guidance Manual”; available from: <https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/>

- Management of repeat prescriptions online;
- Full and integrated access to a GP medical record and personal health record.

98. Providers will also have to demonstrate that they meet new IT standards for data security and interoperability currently being developed.³⁵

99. A full technical specification would be developed if it is agreed to take this approach forward. It is likely this specification would need to be regularly updated to ensure providers are offering the appropriate digital services to their registered population. Providers would need to continue to meet an updated and contemporary technical specification to remain eligible to provide services.

Assessment of providers

100. All providers wishing to take up the opportunity to offer services in this way must go through an assessment process in order to become an accredited provider, ensuring that meet the qualification criteria.

101. To avoid unnecessary duplication and placing too significant a burden on local areas, we propose to undertake as much of the assessment as feasible.

There are three possible assessment approaches:

- NHS England could establish a single national provider list, accredit providers onto the list and then the providers would be contracted with NHS England to deliver a national service model in agreed areas.
- NHS England could require CCGs to establish a provider list. Providers would have to apply to be put on each provider list with CCGs undertaking the assessment of providers to ensure they meet the conditions set nationally. This would be time consuming for CCGs and potential providers who may be forced to apply to a large number of CCGs, as well as duplication and risk of inconsistency.
- The alternative, and our preferred approach, would be for NHS England to run a national approvals process for providers and require CCGs to establish services from the national provider list.³⁶ In doing so, each CCG would automatically give a contract on the agreed terms to providers that have been approved by NHS England and express a desire to provide in their area.

³⁵ They would also have to, for example, operate in line with the fully digital standards: “BETA - NHS digital, data and technology standards framework”; available from: <https://digital.nhs.uk/about-nhs-digital/our-work/nhs-digital-data-and-technology-standards/framework>

³⁶ Ultimately this could be a direction under Section 98A of the NHS Act 2006.

Local implementation

102. There would be a need to ensure appropriate local input into the establishment of the new services. Similar requirements would be needed in relation to the contracts established under the proposals in chapter one. Local commissioners would need to supplement the core terms of provision with details of local arrangements necessary to secure integration of the new service into the local offer. This could include:

- Requirements in relation to out-of-hours and extended access provision;
- Any enhanced or local incentive scheme requirements;
- Compliance with local referral processes and procedures that are currently in place;
- Requirements around digital integration.

Participation in Primary Care Networks (PCNs)

103. The same principles/rules as currently in place would apply to all new APMS contracts, however established:

- Contract holders would be offered the PCN Network Contract Directed Enhanced Service (DES);³⁷
- There would be a requirement for the new provider to co-operate with established PCN(s) and vice versa – this could require amendments to contract arrangements;
- If new providers meet the minimum criteria of the network contract DES they could become a PCN without partnering with other practices, subject to commissioner approval of the footprint;
- If the provider chose not to sign up to the DES, the relevant CCG would need to make alternative arrangements for provision of network services and associated funding to the provider's patient list by commissioning delivery from another PCN.

The role of PCNs

104. **NHS England could increasingly look to PCNs as the default to maintain or expand primary care provision. PCNs could support practices in their network when, for example, partners are retiring or seeking to hand back their contract.** Patient and public engagement would be part of those decisions. We are looking to simplify procurement processes as far as possible, and will consider what can be done under the existing legislative

³⁷ "Network Contract Directed Enhanced Service (DES) Specification 2019/20"; available from: <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-des-specification-2019-20/>

framework and what might require change. A public engagement exercise was recently undertaken about the future of procurement rules.³⁸

Consultation questions

- Q6.** Do you agree that we should not create a right to allow new contract holders to set up anywhere in England?
- Q7a.** Do you agree we should seek to use the potential of digital-first providers to tackle the inverse care law, by targeting new entry to the most under-doctored areas?
- Q7b.** What methodology could we apply to identify these areas, specifically those that are under-doctored?
- Q7c.** Do you think that opportunities should be made available to a wider range of local areas in future following any successful evaluation?
- Q7d.** Do you agree with the proposal to require new contract holders to establish physical premises in deprived areas of a CCG?
- Q7e.** If we require new contract holders to establish physical premises in deprived areas of a CCG, what methodology could we apply to identify such areas?
- Q7f.** Do you agree with the proposal to require new contract holders to demonstrate that they will bring additional GP capacity to the local area?
- Q7g.** Do you agree that we should require new contract holders to seek to ensure that their registered list reflects the community they are serving?
- Q7h.** Do you agree with the proposed approach to avoiding local bureaucracy by awarding contracts on the basis of satisfying agreed national criteria?
- Q8.** Alongside these potential changes, do you agree that PCNs could become the default means to maintain primary care provision, thus removing the need for most local APMS procurements?

³⁸ “Implementing the NHS Long Term Plan. Proposals for possible changes to legislation”; available from: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/02/nhs-legislation-engagement-document.pdf>

5. How to get involved

105. During the consultation, we will seek to gather views from a range of people, including GPs and other primary care clinicians, the public, charities, representative bodies, the technology industry, CCGs and others.
106. We will undertake appropriate assessments of the impact of the proposals as the consultation progresses and proposals are finalised.
107. The engagement exercise closes on **Friday 23 August 2019**.
108. You can respond using NHS England's online Citizen Space survey: <https://www.engage.england.nhs.uk/consultation/digital-first-primary-care-consultation/>
109. If you prefer, we would be happy to receive views in writing to:

Digital-First Consultation
Primary Care Strategy and NHS Contracts Group
NHS England
Floor 2D
Skipton House
80 London Road
London
SE1 6LH
110. We are grateful to individuals and organisations who take the time to respond to this consultation.

Annex A: Summary of consultation questions

Please note this is an adapted version of a questionnaire designed for an internet web page. To view the questionnaire in its intended format and submit responses please visit: <https://www.engage.england.nhs.uk/consultation/digital-first-primary-care-consultation/>

You can respond with your name and/or organisation, you can remain anonymous or ask that your details are kept confidential and excluded from the published summary of responses. If you would like any part of the content of your response (instead of or as well as your identity) to be kept confidential, please let us know and make it obvious by marking in your response which parts we should keep confidential.

If you provide us with any personal information (i.e. name or email address) we will process, hold and store this in accordance with the General Data Protection Regulation and the Data Protection Act 2018. Your details will be kept for the minimum time necessary.

Introduction

In what capacity are you responding?

- Patient/Family member, friend or carer of patient/Member of the public/Patient representative organisation/Voluntary organisation or charity/Clinician/Clinical Commissioning Group/NHS Provider organisation/Industry/Other NHS Organisation/Other Healthcare Organisation/Professional Representative Body/Regulator/Other (please specify)

Have you read the document: Digital-First Primary Care: Policy consultation on patient registration, funding and contracting rule?

- Yes
- No

Chapter 1 – Out-of-area registration

Q1a. Do you agree with the principle that when the number of patients registering out-of-area reaches a certain size, it should trigger those patients to be automatically transferred to a new separate local practice list, that can be better connected with local Primary Care Networks and health and care services?

- Q1b.** Are there any factors which you think should be taken into account if this option were to be implemented?
- Q1c.** Please provide any views you may have about the proposed threshold of 1,000-2,000 patients for the triggering of this localisation.
- Q2.** Do you agree that, although the service obligations are not identical, given the small scale of any possible change and the burden of its implementation, payments for out-of-area patients should remain the same as those for in-area patients?

Chapter 2 – CCG Allocations

- Q3a.** Do you agree with the principle that resources should follow the patient in a timely way where there are significant movements in registered patients between CCGs as a result of digital-first models?
- Q3b.** For these purposes, how do you think “significant” movements in registered patients should be defined?
- Q3c.** What threshold, if any, do you think should be applied to the flow of out-of-area patients to a CCG before this adjustment is applied?
- Q3d.** Do you think it is necessary to cap or restrict the maximum deduction from any one CCG on an in-year basis?
- Q4.** Do you agree that a capitation-based approach is the best way to determine the size of the adjustment required per patient or do you have other proposals?

Chapter 3 – New Patient Registration Premium

- Q5a.** Do you agree that we should only pay the new patient registration premium if a patient remains registered with a practice for a defined period?
- Q5b.** What do you consider to be the right period of time for a patient to be registered with a practice for the practice to be paid the new patient registration premium? Six months, nine months, twelve months or other?

Chapter 4 – Harnessing digital-first primary care to cut health inequalities

- Q6.** Do you agree that we should not create a right to allow new contract holders to set up anywhere in England?
- Q7a.** Do you agree we should seek to use the potential of digital-first providers to tackle the inverse care law, by targeting new entry to the most under-doctored areas?
- Q7b.** What methodology could we apply to identify these areas, specifically those that are under-doctored?
- Q7c.** Do you think that opportunities should be made available to a wider range of local areas in future following any successful evaluation?
- Q7d.** Do you agree with the proposal to require new contract holders to establish physical premises in deprived areas of a CCG?
- Q7e.** If we require new contract holders to establish physical premises in deprived areas of a CCG, what methodology could we apply to identify such areas?
- Q7f.** Do you agree with the proposal to require new contract holders to demonstrate that they will bring additional GP capacity to the local area?
- Q7g.** Do you agree that we should require new contract holders to seek to ensure that their registered list reflects the community they are serving?
- Q7h.** Do you agree with the proposed approach to avoiding local bureaucracy by awarding contracts on the basis of satisfying agreed national criteria?
- Q8.** Alongside these potential changes, do you agree that PCNs could become the default means to maintain primary care provision, thus removing the need for most local APMS procurements?

Glossary

APMS	Alternative Provider Medical Services
BGPaH	Babylon GP at Hand
CCG	Clinical Commissioning Group
DES	Directed Enhanced Service
DPS	Dynamic Purchasing System
FTE	Full-time equivalent
GMS	General Medical Services
GP	General Practitioner
ICS	Integrated care system
IMD	Index of Multiple Deprivation
LSOA	Lower Layer Super Output Area
PMS	Personal Medical Services
PCN	Primary Care Network
STP	Sustainability and transformation partnership
WTE	Whole Time Equivalent

Reference list

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The National Health Service (Personal Medical Services Agreements) Regulations 2015 Part 7, Right to a General Medical Service Contract. Available at:

<https://www.legislation.gov.uk/uksi/2015/1879/contents/made>

General Practice Premises Policy Review

NHS England and NHS Improvement



General Practice Premises Policy Review

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact england.gppremisesreview@nhs.net.

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Executive Summary

1. Recognising ongoing issues around general practice premises, NHS England launched and has led the General Practice Premises Policy Review, as agreed with the Department of Health and Social Care (DHSC) and the General Practitioners Committee of the British Medical Association (GPC England) following settlement of the 2018/2019 General Medical Services (GMS) contract.
2. In January 2019, the context for the Review developed further with the publication of both The NHS Long Term Plan¹ (LTP) and the Five-Year Framework for GP contract reform². They establish the ambitions for the next ten years to improve the quality of patient care and health outcomes, and to deliver more co-ordinated and joined up primary and community care. The Five-Year Framework described the introduction of Primary Care Networks (PCNs) as the foundation of Integrated Care Systems (ICSs), delivered in part through the introduction of the new Network Contract Directed Enhanced Service (DES)³. These are the most significant developments in primary care in recent years, delivering:
 - i. Major investment into general practice. Funding for the core practice contract has been agreed and fixed for each of the next five years and by 2023/24 will increase by £978 million per year. By 2023/24, the new Network Contract DES will be worth up to £1.799 billion per year.
 - ii. Stability and expansion of the primary care workforce, including up to 20,000 additional posts in five specific different primary care roles. These five reimbursable roles are clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics.
 - iii. A series of digital reforms, which will transform how primary care services are offered to patients, supported by an access review which will develop the offer that PCNs will make for both physical and digital services.
3. These developments clearly have implications for general practice and wider primary care estates, but in many places the development of functional primary care networks is just beginning, with the full implications likely to become clear as they develop in maturity. The findings of the Review set out a series of policy responses to the issues explored. Some will need further work before implementation begins, and where there are new financial commitments these will be dependent on the capital available. Where necessary, details will be subject to negotiation with GPC England. These policy conclusions are only one part of what is required to address the issues the Review describes. We

¹ 'The NHS Long Term Plan'; available from:

<https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

² 'Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan'; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

³ 'The Network Contract Directed Enhanced Service (DES) Specification 2019/20'; available from: <https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/>

know that our primary care premises in many places are not fit for purpose, particularly in the future for implementation of the LTP; this is supported by GPC England's Premises Survey⁴ which reports that 50% of respondents felt that their premises are not suitable for present needs. What must now follow is an implementation framework describing how NHS capital for estates will be deployed to support the LTP, developed alongside the forthcoming government spending review which will determine what resources are available. NHS England and GPC England will work together to describe the case for capital investment in primary care, jointly recognising the importance of this to the delivery of the LTP and the future development of general practice.

4. The key policy conclusions following the Review are to:

- assign existing practice leases to NHS bodies or other appropriate entities where they are of strategic importance, and where their length and liabilities prevent the healthy renewal of partnerships and the estate. The detail of which leases are of strategic importance will be subject to further detailed discussions with GPC England and within NHS England and Improvement during 2019. The Capital Departmental Expenditure Limit (CDEL) cover which would be required to enable this will be dependent on the outcome of the government's spending review, and a relative prioritisation process;
- support the availability of an ownership model which continues to make sense for GP practices, but over time we expect more practices to want to separate the decision to enter premises ownership from the operation of primary medical services. We will develop best practice guidance on this for all property-owning GPs. Future NHS capital investment would come with a requirement to demonstrate robust governance around property ownership;
- provide clearer guidance on the expectations of owners and occupiers around maintenance and standards, as part of professionalising property ownership and management;
- pilot alternative premises reimbursement arrangements at a network level, to give networks greater autonomy to manage and minimise their costs relating to estates across their premises;
- pilot a simpler model of premises provision in which the NHS directly bears the cost of premises in multi-use new build premises, removing the need for bureaucratic premises reimbursement systems, promoting integration of service delivery and optimal use of space;
- develop a package of support relating to primary care engagement in Sustainability and Transformation Partnerships' (STPs) and ICSs' capital strategies and the capital allocations process;
- encourage networks to start working out their future estates needs now, taking into account joint working and the estate of their community partners;

⁴ BMA GP Premises Survey Results 2018; available from: <https://www.bma.org.uk/advice/employment/gp-practices/premises/bma-gp-premises-survey-results-2018>

- focus our primary efforts on understanding what it would take to ensure we have premises that are fit for purpose, as part of the spending review;
- following the spending review, develop and publish a premises implementation framework.

General Practice Premises Policy Review

Overview

Background

5. NHS England has led this Review, working in collaboration with a number of key stakeholders including DHSC, GPC England, the Royal College of General Practitioners (RCGP), the Strategic Estates Advisors (SEA) service, NHS Property Services (NHSPS), Community Health Partnerships (CHP), the Care Quality Commission, the District Valuers Services and NHS Clinical Commissioners. The Review also had links to the General Practice Partnership Review and NHS Property Board.

Scope

6. The Review first sought to identify a number of barriers to effective service delivery which can occur in relation to general practice estate, which include:
 - The individual cases where partner liabilities associated with estate ownership or occupation make healthy renewal of the partnership very difficult or lead to individuals being ‘trapped’ (also known as ‘last partner standing’).
 - A perception that estate ownership is unattractive and may be a factor in declining interest in general practice partnership.
 - Concerns around signing leases with liabilities of considerable duration.
 - Making the best use of estate.
 - Difficulties in achieving mixed use, particularly of new builds, due to the balance of liability across the different parties involved.
 - Revenue implications of estate preventing developments.
7. The ongoing work of the Review takes place in the context of the Naylor Review “*NHS property and estates: why the estate matters for patients*”⁵ which highlighted the lack of available and consistent data on primary care estate, despite its pivotal role in delivering the future objectives of the NHS, as well as the General Practice Partnership Review Final Report⁶, which called for action to mitigate the personal risk associated with being a lease holder or property owner and support and guidance for GP partnerships around property ownership.

Approach

8. The Review held an open Call for Solutions collecting solutions to the specific issues identified, as well as views on wider questions about the system of

⁵ ‘NHS property and estates: why the estate matters for patients’; available from: <https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>

⁶ ‘GP Partnership Review Final Report’; available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf

estates provision. Further details are at Annex A.

9. 106 proposals were received from a range of contributors, including GPs, patients, CCG representatives, Local Medical Committees (LMCs), pharmacists, practice managers, third party development companies, legal firms, NHS Foundation Trusts, regional and national NHS England employees, Local Improvement Finance Trust (LIFT) companies and NHS PS. No new barriers were identified beyond those outlined in the call.
10. Proposals were assessed using an agreed set of criteria including: feasibility, cost and value for money, impact, and risk before a subset was developed further from the basic concept. The Review group agreed a guiding principle that where NHS money is being committed, it should only be committed in the best interest of patients.
11. The Review also drew upon GPC England's Premises Survey⁷ which was open to all GP practices in England during November 2018.
12. Many submissions to the Call for Solutions covered the same core issues, and proposals were grouped under themes:
 - i. Strategic estates planning (including decision making on NHS capital investment).
 - ii. Central estate ownership and buy out, including loans.
 - iii. Central function to hold or act as guarantor for leases.
 - iv. Separation of estates ownership and partnership model/service contract.
 - v. Simplification of Premises Costs Directions (PCDs).
13. A number of the submissions received highlighted the poor relationship between NHS PS and GP tenants. The Review was not the primary forum in which to address the issues raised, but the context is reflected in its conclusions.

⁷ BMA GP Premises Survey Results 2018; available from:
<https://www.bma.org.uk/advice/employment/gp-practices/premises/bma-gp-premises-survey-results-2018>

Areas considered by the Review

De-risking leases in strategically important estate

Outcome: The assignment of leases to NHS bodies or other appropriate entities, where their length and liabilities prevent the healthy renewal of partnerships and the estate is of strategic importance. We need to reassure GP leaseholders occupying estate which is clearly part of future service provision and where the perceived risk associated with leases is impacting on estate transformation and general practice partner recruitment.

14. In line with the findings of the GP Partnership Review⁸, entering into long leases can be off-putting for GPs, and terms which were viable at the beginning of a lease may become less so over time. We know that lengthy lease periods can create significant difficulties where GPs are closer to retirement than the lease's duration, which can impact on moves into new premises, and can also be off-putting for prospective replacement partners.
15. To ensure that NHS funds are used in the best interests of patients, an offer by the NHS to stand behind leases would only be made for estate which has been identified as having ongoing importance for delivery of services, linked to the STP's or ICS's estates strategy. It would be offered as a last resort only, and at the request of NHS England an NHS body or other appropriate entity would take on the lease assignment where key criteria are met, including identifying the strategic importance of the premises.
16. There are clearly costs and risks associated with an NHS body or other appropriate entity taking on a lease from a practice which need to be considered in future budget-setting exercises. These could include legal fees, surveyor costs and Stamp Duty Land Tax for leases with over seven years remaining. In addition, accounting rules require that a provision would need to be made in the CDEL to account for the entire cost of the remaining lease term. Although lease assignment can occur now, without CDEL cover this can be difficult to achieve and therefore in order to implement this recommendation, a proportion of capital allocated to NHS estate would need to be directed to support the CDEL limit. This is therefore dependent on the outcome of the capital allocations process as part of the upcoming spending review. NHS England and GPC England will work together to describe the case for capital investment in primary care, jointly recognising the importance of this to the delivery of the LTP and the future development of general practice.
17. In situations where leases are assigned, a sub-lease (with a shorter term) would need to be agreed between the practices and relevant body. Participating practices would also be asked for undertakings in return. This may include the provision of data on the estate, ensuring the estate is appropriately maintained, and full engagement in the STP or ICS estates planning process.

⁸ 'GP Partnership Review Final Report'; available from:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf

Leaseholders may also wish to take decisions such as co-locating with other services or moving to improved premises. In these scenarios it is envisaged that decisions would be taken collaboratively, with practice tenants engaged in the conversation.

18. NHS PS could be the right entity to hold these leases on the system's behalf but NHS (Foundation) Trusts and Local Authorities might also wish to do so, perhaps making use of space themselves as part of local plans to deliver integrated services.
19. In that vein, NHS bodies or other appropriate entities could also take on the new lease commitment for new builds to better enable mixed use of new premises, with sub-leases or other suitable tenancy documentation in place for tenants. The Review heard that co-location of services in new builds is not always possible due to long leases and questions over who will ultimately hold liability for the asset.
20. The Review noted the ongoing challenge presented by the relationship between NHS PS and GP practice tenants raised via the Call for Solutions, GPC England's Premises Survey⁹, and stakeholders on the Review's Core Steering and Advisory Groups. To effectively operationalise this recommendation via NHS PS, a greater level of trust will need to exist between NHS PS and the GP community, supported by the current work to resolve the identified challenges.
21. Further discussions to agree and implement this recommendation are ongoing.

Central estate ownership and state backed loans

Outcome: Not taken forward

22. The Call for Solutions yielded a series of proposals around state ownership or buy-out of estates and a model of state-backed loans to GPs. These proposals included calls for England to adopt a similar approach to premises as has been introduced in Scotland, where the government has agreed 'a long-term shift to gradually move general practice towards a service model that does not entail GPs owning their practice premises'.¹⁰
23. Review stakeholders were clear that they did not expect or wish to make such a move in England, preferring to retain flexibility for GP partners to choose their model of estates provision.

⁹ BMA GP Premises Survey Results 2018; available from:

<https://www.bma.org.uk/advice/employment/gp-practices/premises/bma-gp-premises-survey-results-2018>

¹⁰ 'National Code of Practice for GP Premises'; available from:

<https://www.gov.scot/publications/national-code-practice-gp-premises/>

24. It was estimated that the indicative cost of buying out the GP owned estate in England would be a minimum of £5-6bn¹¹. Not only is this prohibitively expensive, it would be at the expense of other capital requirements. The Review concluded that there was no convincing argument that this direction of travel would deliver a 'fix-all solution', as it would be impossible to justify taking this step for any premises other than those which are fit for purpose and of ongoing strategic importance.
25. The new premises model in Scotland is part of an agreed package of wider contract reform¹² which has not been replicated in England, and this element of the package could not successfully be 'cherry picked' for implementation without the support of general practice. The recently announced general practice contractual framework¹³ sets the clear direction of travel for primary care in England over the next five years.
26. Insufficient evidence of a market failure was provided to suggest a state-backed system of loans would be a necessary and proportionate response to secure the ongoing delivery of primary medical services; neither would it be likely to be attractive to GPs, given the likely security and control requirements that would be necessary to safeguard taxpayer investment.
27. A complex, state-backed loan system would cement the current model of new partners taking on significant debt rather than support new, more flexible partnership models which are in line both with the call from the profession and the system. The Review therefore concluded that no recommendation should be made relating to state buy-out or state-backed loans. These proposals are not being taken forward as part of its ongoing work.

Property ownership as part of the partnership model

Outcome: Where an ownership model continues to make sense for GP practices, it should continue to be available, but over time we expect and will encourage more often that practices separate the decision to enter premises ownership from the decision to enter into a general practice partnership and the operation of primary medical services. We will develop best practice guidance for all property-owning GPs. Future NHS capital investment would come with a requirement to demonstrate robust governance around property ownership.

28. A key message from the Call for Solutions process, and a finding of the General Practice Partnership Review is that risk, and the perception of risk, is one of the significant factors which can discourage GPs from becoming partners. While for some, property ownership has been highly effective and

¹¹ NHS England internal analysis based on the Current Market Rent (CMR) of 1004 properties across England deemed suitable for long term use.

¹² 'GMS contract: 2018' (Scotland); available from:

<https://www.gov.scot/publications/gms-contract-scotland/>

¹³ 'Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan'; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

should remain an option for practices to choose, tying estate ownership to the partnership's delivery of services via GMS/PMS/APMS contracts can create difficulties in the renewal of partnerships which can contribute to situations of negative equity and last partner standing.

29. A number of general practice partnerships have adopted a model where the choice to own premises is separated from that to become a partner in the service contract, something this Review considered could support the future development of the partnership model in general practice. We expect to see such arrangements grow in number over time and would support such a shift.
30. Where the NHS is investing capital in general practice premises owned by GPs, it should seek evidence that the practice has robust governance arrangements in place, ensuring that general practice partners who choose to own their estate understand the extent of their personal liability, that liability is limited appropriately, and that NHS investment would be protected from associated future risk. Separation of the premises-owning and partnership entities could be one way of demonstrating good governance.
31. The NHS will wish to seek assurance:
 - i. That the relationship between the estate owners and the partnership is formally documented (whether this is the same or multiple entities).
 - ii. That documentation is valid and up to date, reflecting current and former partners as appropriate.
 - iii. That practices seek professional advice in the matter to understand their liabilities and commitments to be made under the terms and conditions of investment.
 - iv. That the documented arrangements adequately record and protect NHS England's investment.
 - v. That all partners support the investment and understand the liabilities to which they will be committing.
32. To support partnerships in providing these assurances, best practice guidance will be produced; existing partnerships will be able to determine the extent of their current risk exposure.

Professionalisation of property ownership and management

Outcome: Clearer guidance on the expectations of owners and occupiers around maintenance and standards, as part of professionalising property ownership and management.

33. We know that we want to promote a consistent and professional approach to property ownership, and this should also include how premises are managed. Through the Review it was identified that a lack of clarity or understanding around the responsibilities of all parties involved in estate ownership and occupancy can lead to these responsibilities not being fulfilled. These obligations apply to parties irrespective of whether the property is owned and

occupied by the same group, or whether there is a landlord/tenant arrangement in place.

34. Under the current rent reimbursement model, NHS England provides GPs with an amount of funding for maintenance. A maintenance backlog will reduce the financial value of a property, its value for future use and any proposal for investment.
35. The Review therefore recommends the production of guidance which clearly sets out the various roles in estate ownership and their associated responsibilities. Guidance should include what is reimbursed under the PCDs, and is therefore an owner/occupier or tenant responsibility, and what is not. This could include a breakdown of the different funding opportunities (e.g. rent reimbursement, business as usual capital and transformation funding) and their intended use.
36. The Review also recommends the production of a Customer Charter, for adoption by owner/occupiers, landlords and tenants of primary care estate. The Charter would set out core principles relating to how each practice premises will be managed, with each party's obligations clearly agreed.

New models and the Premises Costs Directions

Outcome: Pilots for network level premises reimbursement arrangements, which will give networks greater autonomy to manage and minimise their costs relating to estates across their premises.

Pilots of a simpler model of premises provision in which the NHS directly bears the cost of premises in multi-use new build premises, removing the need for bureaucratic premises reimbursement systems, promoting integration of service delivery and optimal use of space.

37. A number of comments on the PCDs were received through the Call for Solutions process identifying that they are complicated and misunderstood; lack flexibility; create barriers in allowing mixed use of space; and do not fully reimburse for all costs incurred by practices. The complexity of the PCDs has hampered agreement on reform. Some of the key issues which the Review discussed in relation to the PCDs include:

- i. *Incentive to manage costs*

Reimbursement is offered for rent, business rates, water and clinical waste. The process for rent reimbursement is closely managed with external advice sought from the Valuation Office Agency. Business rates are reimbursed at face value in relation to approved GMS space, as is water and clinical waste. The table below sets out the annual recurrent spend on premises through the PCDs, which has been increasing year-on-year:

	£ thousands				
	2013/14	2014/15	2015/16	2016/17	2017/18
Premises	793,540	844,714	889,059	893,953	882,980

Although the NHS is responsible for reimbursing the costs, it is not able to directly influence cost incurred and there is no actual incentive within the system for GPs to drive costs down or seek cheaper alternatives where such costs are within their control.

ii. *Flexibility of use by other services*

The Review heard that the hosting of community or secondary care services within practice premises is restricted, with the PCDs setting out the terms under which services may be hosted and the associated impact of doing so, such as the abatement of notional rent or of recurring costs. There is a need to develop an acceptable and workable solution which fits the future model of service delivery.

iii. *Complicated reimbursement process*

The process of reimbursement claims requires time resource at a practice, CCG and national level as it continues to rely on manual checking and payment mechanisms.

38. The Review considered opportunities to amend the Directions and manage payments differently. The main proposal considered was to introduce a single payment to practices, which could be calculated based on historic spend with potential for revision should practices move premises.

39. Potential benefits of a single payment approach include:

- A simplified process, which would lead to practice staff and NHS staff spending less time processing claims.
- Release of system resource could allow support to be redirected towards other matters regarding the estate.
- Delivers an incentive for practices to manage their costs.
- Potential for increased flexibility through removal of the stipulation around use by NHS third parties.
- Could be supported by a 'model health centre', mirroring the 'model hospital' in the acute sector, which would enable a practice to understand a reasonable benchmark of costs.

40. Potential risks of a single payment approach include:

- Increased bureaucracy and impact on resource for GP practices in seeking alternative providers to manage costs within one payment.
- Potential for complex calculation required to inform single payment, including energy costs which may vary across the country.
- Would require flexibility and adjustment when practices want to move premises as rent may increase.

- Removal of stipulation around third party use may have a detrimental impact on use for GP services.
 - If a practice exceeds its single payment, financial risk is held with the practice.
41. Such a change was not supported for immediate implementation, and further work would be required to address the concerns raised during discussions. But the conclusion that the PCDs are simply not fit for purpose was clear, particularly for PCNs, which will need to plan how they will use their available estate across their Network and will have greater opportunity to manage their estates costs at scale. The Review therefore recommends that network-level arrangements are piloted to understand and evaluate the opportunities for more efficient estates management. This allows the benefits of a single payment model to be tested in circumstances that are future-facing.
42. Given the complexities outlined above, the PCDs are also unable to support effectively general practice housed in integrated care hubs or estate with multiple providers; they therefore hamper transformation and development. NHS England would prefer that the PCDs did not apply to practices housed in new NHS estate, such as integrated care hubs, and that they were replaced by a simple model of reimbursement where the NHS directly meets the costs associated with the hub and practices would be responsible for paying those which are currently non-reimbursable under the PCDs, removing the complicated process of charging and reimbursement which currently exists. A simple 'licence to occupy' agreement would be held between the practice and other primary care provider housed within the estate. The NHS would own the asset and practices would not be required to invest any funding in order to be housed in these premises. Such a model will also be developed, in the first instance for limited piloting and evaluation.

Developing greater support for community and primary medical care in local estates planning and in developing strong and future-facing ICS capital funding bids

Outcome: A package of support relating to primary care engagement in STPs' and ICSs' capital strategies and the capital allocations process.

43. We do not have a complete picture of the current general practice or wider primary care estate, and this is a significant barrier to proper future estate planning. The Naylor Review reports that there is no national picture for GP estate but that anecdotally it mirrors the picture for overall NHS estate, 42% of which is over 35 years old and 62% of which is over 25 years old¹⁴. As a result, it is difficult to accurately assess how much of the existing estate is fit for current delivery or for future purposes. STPs and ICSs are required to work collaboratively within their areas to produce strategic estates plans and will

¹⁴ 'NHS property and estates: why the estate matters for patients'; available from: <https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>

require a clear picture of their local estate to do this meaningfully.

44. In addition to other data held, the Review was able to access data collected by the DVS. Analysis of information held confirmed the lack of a full and coherent set of data at a national level. Through this work, the Review identified the need for a data collection project to develop a central dataset to support the general practice estate planning process.
45. The NHS Property Board has set up a Data Collection Project for Primary Care to undertake data collection, led by NHS England, during 2019/2020. It is recommended that this data collection include details on leases, utilisation and available space and condition. The data will be used to help drive strategic planning, inform investment, and deliver efficiencies utilising planning tools such as the Model Hospital, the Estates Return Information Collection (ERIC) and the Strategic Health Asset Planning and Evaluation (SHAPE). This will enable the system to plan and target areas more efficiently and strategically to help support Primary Care delivery under the LTP.
46. Through work undertaken with existing capital allocations processes, such as the Estates and Technology Transformation Fund (ETTF) and the Sustainability and Transformation Partnership Waves 1-4 funding programme, the Review heard that there is a perceived disparity between general practice estate and the rest of the system, in terms of ease of access to both capital funding and the relevant expertise to support bids. As above, the GPC Premises Survey¹⁵ reports that 50% of respondents felt that their premises are not suitable for present needs, and that there are identified improvements which practices would like to make. However, nearly 60% of those who responded also confirmed that their practice had not applied for a grant from NHS England since 2015. It is understood from the GP Partnership Review¹⁶ that reasons for applications not being made or being abandoned include a lack of expertise and concerns regarding bureaucracy.
47. Throughout the Review, concerns have been heard about the role and engagement of general practice within STPs and local estates planning, and the impact this can have on the perception of the capital allocations process and transformation. Additionally, the Review acknowledges that there was a loss of expertise in general practice estate with the abolition of Primary Care Trusts (PCTs).
48. The Review recognised that primary care needs access to support and expertise to ensure it is in a position to take advantage of opportunities to apply for capital funding. The Review concluded that, to support this ambition, the roles and responsibilities of all partners relating to estate within a local system

¹⁵ BMA GP Premises Survey Results 2018; available from:

<https://www.bma.org.uk/advice/employment/gp-practices/premises/bma-gp-premises-survey-results-2018>

¹⁶ 'GP Partnership Review Final Report'; available from:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf

need to be agreed and clearly described, including the Strategic Estates Advisors (SEAs), to help ensure that STPs and ICSs are able to ensure robust engagement of all relevant parties and that they are using best practice. The package of guidance proposed by the Review could also help CCGs and local providers to collectively create the right level of expertise and collaboration.

49. Additionally, consolidating the available guidance and training on premises, including on the development of capital bids, will help to address this need. Central funding for a training budget has been secured to deliver a set of modules in 2019/20.
50. Finally, NHS England will continue work to ensure its capital allocations processes are set up in a way which enables and encourages high quality applications from primary care. The LTP confirmed that consideration is being given to reforms that will ensure funding is prioritised and allocated in a way which is effective and supports the transformation of services, as well as better enabling planning and control. Further information about these reforms will be set out alongside the spending review.

Next steps

51. The outcomes of this Review will be taken forward to implementation stage.
52. As described in the introduction, they will help ensure that future investment is made in a more coherent and strategic way into a professionally managed estate. But capital is required both to bring up the standard of current estate and to transform primary care estates across England, to deliver what is required for the clinical and service vision of the LTP in purpose-built premises.
53. The work that follows this Review will create an implementation framework, informed by the government's future spending review timetable and outcome, to start the delivery of that transformation.

Annex A

To support the open Call for Solutions a document was published which outlined the background and context to the Review and included a number of questions to help those responding to the call to structure their proposals:

What is the outline of your proposal: what is the change from the current system, how long would it take for this change to be implemented?

Which of the issues currently impacting on general practice estate will be addressed by your proposal and how?

How will this change support innovation and flexibility for the future, including accounting for the increased use of technology and digital opportunities, which may impact on the type and amount of estate required?

What are the intended benefits and added value of this proposal?

What are the cost and efficiency implications of this proposal, and over what timescale? If additional funding is required, how will this provide value for money for the tax payer? (Please note that no new funding should be assumed to be available.)

Who will be most affected by the change? Including all stakeholders who could be positively or negatively affected by the proposed change and with consideration given to the potential impact on health inequalities.

Are there any risks or unintended consequences which you can foresee? How could these risks be mitigated?

Is there evidence available to support your proposal? Please summarise and include links/references as appropriate.

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