

# A five year framework for GP contract reform to implement the NHS long term plan

## Introduction

NHS England and the British Medical Association's (BMA) GP committee have reached an agreement for general practice contract reform for the next five years with the aim of supporting the delivery of the NHS Long term plan. They have jointly published a new framework for general practice over the next five years to 2023/24: [Investment and evolution: A five year framework for GP contract reform to implement The NHS Long Term Plan](#). This briefing summarises the changes set out in the contract, and explores the potential implications for trusts and their local partnerships with primary care.

The contract introduces a range of changes aimed at addressing workforce pressures, supporting integration and joined up care, and facilitating efficient use of resources in general practice, as well as changes to the Quality Outcomes Framework (QOF) and the introduction of a new state-backed indemnity scheme. The changes are supported by a guarantee of investment of £4.5bn a year for community services and primary care, to implement the 'triple integration' of primary and specialist care, physical and mental health services, and health and social care.

## Summary of changes to the contract

- Primary care networks (PCNs) formed of practices covering populations of 20,000-50,000 patients will cover the whole of England and work closely with integrated care systems (ICSs) as a formal basis for collaborating with other system partners including community services
- Initiatives such as the enhanced health in care homes scheme, rapid-response community reablement services, and anticipatory care services, supported by the introduction of an Investment and Impact Fund (IIF), will be implemented by local systems led by PCNs in collaboration with community providers.
- In response to workforce pressures in primary care, PCNs will form multidisciplinary teams comprising of clinical pharmacists, physician associates, first contact physiotherapists, social prescribing link workers and first contact community paramedics. These roles will support GPs and nurses in general practice and play a key role in providing joined up care, working in ICSs to streamline care pathways.
- There is flexibility for networks to decide who employs the staff associated with the new network contract, including trusts, GP federations or a single lead provider.
- A new state-backed indemnity scheme will introduce a number of measures to relieve the impact of spiralling cost of indemnity cover on out-of-hours staffing and GP recruitment and retention.

- A refresh to the Quality Outcomes Framework (QOF) will retire 'low value' indicators in favour of new indicators which reflect the changing evidence-base and up-to-date clinical practice.
- A raft of changes to the use of technology in general practice, including IT infrastructure reform, the introduction of patients' right to access records and correspondence online as well as access GP appointments via video link, and an increased focus on anticipatory care and analytics supported by technology.

## Considerations for the provider sector

- Proposed additional roles in primary care, including social prescribing link workers, physician associates, physiotherapists, paramedics and clinical pharmacists will all play an important role in joining up care pathways between services. There may be a need for local systems to ensure that the recruitment of staff into general practice, in particular paramedics and physiotherapists, does not have an adverse effect on the ability of trusts to recruit and retain staff in these roles.
- PCN network boundaries will be expected to align sensibly with constituent GP practices, local populations, and community based providers. Network agreements will determine how the PCNs work with other organisations in the system, and ICS oversight will ensure PCNs work in an integrated way with other community services. However community providers will subsequently be asked to configure their teams according to these boundaries, which may bring about changes to care pathways, frontline staff team configurations and system relationships.
- An increased role for PCNs in delivering urgent care will hold implications for trusts involved in delivering urgent care and out-of-hours services, including acute trusts with urgent treatment centres, and ambulance trusts holding NHS 111 contracts. Further clarity on how networks will work alongside existing services will be welcome.
- Initiatives forming part of the increased investment in primary and community services and increasing integration between the two, including rapid community response and enhanced health in care homes will have implications for the way community and mental health trusts resource services, plan care, and work with local partners.

## Key elements of the contract in detail

The contract builds on the publication of the NHS Long term plan, outlining how GP practices will be expected to transform over the next five years to address the challenges facing general practice, and deliver the expansion and improvements to services and outcomes set out in the Plan.

### Creating primary care networks

A core commitment in the contract is the implementation of PCNs of 20,000-50,000 patients, covering the whole of England as a 'core building block' of integrated care systems (ICSs), with the expectation that there will be 100% geographical coverage of the Network Contract Directed Enhanced Service (DES) by July 2019.

PCNs will work more closely with ICSs alongside their CCGs, with simplified commissioning arrangements. PCN boundaries are required to make sense to constituent practices, local populations, and community based providers which will configure their teams accordingly. PCNs will hold accountability for health and wellbeing for a defined place as part of their responsibility within an ICS, and a clinical director for each network will lead on the network's contribution to strategic plans and service quality improvement.

The contract stipulates that the 'strength of its relationships' with the wider health and social care system will determine the success of each network, and all PCNs will have a network agreement through which the network sets out its collective rights and obligations. This agreement will also act as the formal basis for working with other community based services locally. ICSs are expected to play a 'critical role' in ensuring PCNs work in an integrated way with other community staff such as nurses, geriatricians, dementia workers and allied health professionals.

The network contract DES will provide extended hours access to 100% of patients, implementing a single coherent access offer to physical and digital services to deliver convenient in-hours appointments, reduced duplication, and integration between NHS 111, urgent treatment centres and general practice, reduce unnecessary A&E and ambulance service use, and divert patients to community pharmacies where appropriate. ICSs will be expected to move quickly with the development of an expanded role for PCNs in running urgent care in the community, with the potential to be supported by payments reflecting their impact on A&E attendances.

## Integrating primary and community services

Increased investment in primary and community care will be supported by a funding boost of £4.5bn. The contract identifies a number of new or expanded services which will deliver the commitments made in the NHS long term plan, including further integration and closer working between primary care and community services. These include:

- **The Enhanced health in care homes initiative** which builds on the vanguard model and includes effective care in care homes, support for recovery from ill health by speech and language therapists and others, which will require input from wider community services. The programme will be expanded across the country, led by primary care networks in collaboration with community providers.
- **Anticipatory care services** will identify people at greatest risk to be offered targeted support for physical and mental health needs involving structured programme of proactive care and support from wider multidisciplinary teams. Community providers and GP practices will have to work together to achieve this with input from social care and hospitals.
- A community-led **urgent response and reablement service** will be provided in partnership with community providers. The long term plan sets out a requirement for this service to be delivered within two days of referral by primary care.
- PCNs will have a responsibility for working with **Cancer alliances** and other local partners to commit to increasing the proportion of cancers diagnosed at stage 1 and 2 from half to 3 quarters.
- A national network **Investment and Impact Fund (IIF)** will start in 2020 rising from £75m in 2020/21 to a minimum of £300m in 2023/24, and is intended to help plan and achieve better performance

overseen by ICSs. The principle of 'shared savings' will apply, including elements of avoidable A&E attendances, avoidable emergency admissions, timely discharge through development of integrated primary and community teams, outpatient redesign, and reducing prescribing costs. The utilisation part of the IIF will not create unfunded risk for CCGs or hospital contracts.

## Resolving workforce pressures

The contract identifies the key challenge of staff shortages facing general practice. This is due to the rising complexity of patient needs, the growth in population, and a rise in the number of GPs working fewer hours or retiring early, as well as a fall in the proportion of nurses working in primary or community services. The contract aims to help address this workforce challenge by both increasing the GP workforce and diversifying the wider general practice workforce. The contract commits to delivering against the long term plan's ambition to increase the number of GPs by 5,000 'as soon as possible' by extending the following programmes for the duration of the five year period to 2023/24:

- **International recruitment** to supplement the UK-trained GP workforce with qualified doctors from EEA and non-EEA countries
- **GP retention programmes** to ensure support is available for GPs to remain in practice rather than reduce their commitment or leave the profession
- **The practice resilience programme** to ensure continuing support for practices in acute need of help
- The **specialist mental health service** for GPs
- The **Time for Care national development programme** supporting practices across the country to make sustainable improvements to the way they work and decrease workload pressures

An increase in funding for the core GP practice contract by £978m a year by 2023/24 will support the increase of nurses and doctors working in general practice, including the increase of FTE nurses working in general practice through guaranteed placements in primary care supported by Health Education England (HEE), and the introduction of primary care training hubs.

A key element of the contract is the introduction of £891m of funding for additional roles reimbursement to support the expansion of multidisciplinary teams working in general practice. Practices will be reimbursed 70% of ongoing salary costs for clinical pharmacists, physician associates, first contact physiotherapists and first contact community paramedics, and will be reimbursed 100% of the ongoing salary cost of social prescribing link workers. Reimbursable roles have been selected on the basis of an estimation by NHS England that there will be sufficient supply, and that the roles will decrease workload and support higher quality care. These additional roles will be asked to support primary care in a number of ways, including:

- **Advanced practice physiotherapists** to create stronger links with wider musculoskeletal (MSK) services, and provide community physiotherapy treatment, liaising with secondary care MSK services, and creating more streamlined pathways

- **Advanced paramedic practitioners** to assess and triage patients, and provide definitive treatment and perform certain tests where appropriate, supporting the delivery of anticipatory care plans and community-based monitoring services.
- Every PCN will be able to employ a team of six **whole time equivalent clinical pharmacists**, supervised by a senior clinical pharmacist and taking a leadership role in supporting the further integration of general practice with wider healthcare teams.

The contract includes provision for 20,000 staff or more, but leaves individual decisions about the makeup and distribution of this workforce to PCNs working with system partners, and networks will be able to decide who employs staff working in these additional roles, including NHS trusts, where all parties agree this is appropriate. CCGs will be expected to continue any local schemes which fund posts in the five reimbursable roles, for example where a CCG is currently funding a local community provider for a physiotherapist or community paramedic working in a local practice.

## A solution to indemnity costs

Following unexpectedly high indemnity costs in 2016/17 and 2017/18, the contract confirms that NHS England will provide one-off funding in 2018/19 to meet its assessment of inflation in actual indemnity costs in 2018/19, as well as agreeing a state-backed scheme introducing a number of measures to relieve the impact of spiralling cost of indemnity cover on out-of-hours staffing and GP recruitment and retention, including:

- A new clinical negligence scheme for general practice, starting in April 2019
- All NHS GP service providers including out-of-hours providers will be eligible, and will not have to pay for subscription for membership
- Coverage will extend to all GPs and other staff including GPs, GP locums, nurses, allied health professionals and all other professional groups delivering primary medical services, including out-of-hours work

## Improving the quality outcomes framework (QOF)

The framework announces the decision to refresh QOF in recognition of a broader definition of high quality care and changes in clinical evidence. The changes aim to address some of the weaknesses identified by the current framework, including limitations where a more personalised and targeted approach would be more appropriate, and where the changing evidence base supports a change to the indicators used in QOF.

The QOF implementation guidance will retire 28 indicators which were identified as 'low value' and introduce 15 more clinically appropriate indicators will take their place, focusing on areas related to diabetes, blood pressure management, cervical screening, COPD and weight management among those with severe mental illnesses.

## Increasing the coverage of digital technologies

In alignment with the continued emphasis on modernising IT infrastructure and increasing the use of technology in primary care, the contract confirms that NHS England will continue to resource IT infrastructure for general practice, in order to provide safe and useful data for patients, allow interoperability between systems, and allow for the better comparison of activity and outcomes. ICSs will play a role in ensuring predictive analytical tools are available to support anticipatory care, and all patients will have a right to access online or video consultations by April 2021, as well as online appointment booking, online access to records and correspondence, and an end to the use of fax machines.

## NHS Providers view

Trusts see primary care as one of their most important local partners, and we welcome the move to integrate services with increased investment in primary and community care. The new five year GP contract is a positive indication that the commitment in the NHS long term plan to invest in community and primary care services is being implemented.

The development of Primary Care Networks (PCNs) is one model which rightly aims to enable community services and primary care to develop more integrated models of delivery for patients. The roll out of PCNs as described in the contract will however have significant implications for the provider sector, particularly providers of community services and out-of-hours urgent care services, as they look to deliver new expanded services and develop multi-disciplinary teams. It will therefore be important that PCNs are allowed the flexibility to support new service models that best suit local needs and context, in close collaboration with trusts and other local partners. We know for example that in some areas greater collaboration between trusts and primary care is well underway, either through structural integration between practices and trusts, or other partnership approaches including those developed within the vanguard programme.

Diversifying and investing in the primary care workforce is welcome and has the potential to reduce the need for hospital admissions, A&E attendances and outpatient appointments. This both improves patient experience and enables person-centred management of people's health. That aspiration now needs to be supported by a workforce implementation plan which addresses the wider system challenges facing the health and care workforce, and to ensure that very welcome investment in additional primary care roles does not destabilise recruitment and retention in other parts of the sector.

We look forward to working with the national bodies and our partner organisations in primary care as the plans for PCNs progress. It seems likely that the capacity to develop PCNs at pace will vary across the country and local systems will all welcome support. We will be sharing examples of good practice to capture how different care models, including PCNs, are developing which operate with strong primary care and community services at their core.