HFMA briefing
March 2020

How it works – primary care finance and primary care networks

Introduction

This briefing gives an overview of primary care finance and the financial arrangements to support evolving primary care networks (PCNs). The briefing is intended to give a basic understanding for those working in NHS finance teams or those who may be new to the financial management of primary care.

The main part of this briefing focuses on general practice in England but also includes an overview of dental, ophthalmology and community pharmacy services. Sections are included for each of the devolved nations, highlighting differences and similarities between the approaches.

Links to further reading and guidance are provided in each section. The information included in this briefing is correct as at March 2020.

What is primary care?

Primary care is the first point of contact for many people when they have a health problem. The term primary care, while often most closely linked to doctors in general practice, also covers dentists, opticians and pharmacists. Other professionals such as nurses or physiotherapists may also be part of the primary healthcare team.

Most family doctors, dentists, opticians and pharmacists are independent contractors or businesses which deliver their services through contracts with the NHS. They are not usually NHS employees, although there are new delivery models developing in some parts of England.

How is general practice contracted and financed?

General practice is funded to deliver care on a list-based system. This means that the funding received is to cover the primary care needs of their registered population across the spectrum of

healthcare needs; from healthy individuals to people with multiple complex conditions. General practice services are split into three categories; essential, additional, and enhanced.

Essential services must be delivered and are covered by baseline funding. Essential services cover the care of a patient during an episode of illness, the general management of chronic disease and care of the terminally ill.

Additional services are also covered by baseline funding, but practices can choose to opt out of one or more of these. If a practice chooses not to deliver an additional service, their baseline funding is reduced accordingly. Additional services cover areas such as contraceptive services, minor surgery or out of hours services.

Enhanced services attract a payment on top of the baseline funding. Directed enhanced services (DES) cover areas such as childhood immunisations and health checks for people with learning disabilities and must be commissioned. Local enhanced services (LES) are optional and commissioned by individual clinical commissioning groups (CCGs) depending upon local requirements.

General medical services (GMS)

The GMS contract is a national contract with a nationally specified payment rate per patient (referred to as global sum income; this is the baseline income for the GMS contract). Some practices receive an additional payment (minimum practice income guarantee) on top of their GMS contract, although this is being phased out (see later section on funding streams). The contract is held in perpetuity by the practice and is not with individual GPs, although there must be a named GP within the partnership at all times. Payments for contracted services are made to the practice.

Personal medical services (PMS)

The PMS agreement is locally negotiated in place of a GMS arrangement, and uses locally agreed prices. PMS contracts are held in perpetuity but are with the individuals in the practice and not the partnership. Commissioners are able to give six months' notice on the contract if necessary.

Alternative provider medical services (APMS)

An APMS contract allows services to be delivered by alternative providers, with locally agreed contracts and prices. This differs from GMS and PMS contracts as it is time limited.

Directed enhanced services (DES)

All contractor groups are entitled to sign up to deliver directed enhanced services. These are nationally defined services which can include areas such as minor surgery; health checks for people with learning disabilities; and dealing with violent patients.

The primary care network (PCN) contract is also a DES, enabling PCNs to be included within the main GP contract. PCNs are covered in more detail later in this document.

Local enhanced services (LES)/ local quality improvement schemes/ local commissioning schemes

CCGs may commission local schemes from general practice to meet the requirements of their population.

Quality and outcomes framework (QOF)

The QOF framework rewards practices based upon the quality of care delivered to patients. The framework sets out a range of standards across three domains – clinical, public health and quality improvement. Points are awarded for achievement against indicators in each standard and practices

receive a payment per point, based upon their number of registered patients. Participation in QOF is voluntary and some areas use local quality improvement schemes instead.

Statement of financial entitlements

All general practice contractors are governed by the statement of financial entitlements (SFE) which details the payment framework and methods. The current full statement of financial entitlements was published in 2013 and subsequently amended each year. It sets out the payments due for each element of the contract (global sum, quality and outcomes framework, directed enhanced services, and additional specific payments) and the conditions attached to them.

The global sum (baseline) payment per patient is revised quarterly and paid monthly. Total practice income is calculated by multiplying the global sum payment by the weighted list size. The weighting is obtained using the Carr-Hill formula which takes account of six indices:

- additional needs; mortality rates and long-term conditions
- number of nursing and residential homes
- list turnover
- rurality
- age and sex profile of the population
- market forces, for example differing staff costs.

The total payment is then reduced by a nationally agreed percentage for any additional services that the practice has opted out of providing.

Reimbursements

The statement of financial entitlements also sets out a number of areas where general practice may receive cost reimbursements.

Premises

GP premises payments under both GMS, PMS and APMS contracts, are covered by the GP premises directions. The NHS will reimburse practices for costs relating to rent, rates, clinical waste and, in some cases, assistance towards service charges. Practices that own their premises receive a notional rent payment.

Dispensing doctors

Patients who live in some rural areas are able to receive dispensing services from their GP practice (under specific conditions). GP practices that provide dispensing services for patients receive a fee for each item dispensed and are able to sign up to deliver the dispensary services quality scheme which attracts additional funding. Fees are in line with a nationally agreed scale.

Locum cover

Practices may receive a contribution towards locum costs to cover parental leave, suspension of a GP or sickness of a GP.

Care Quality Commission fees

All GP practices (GMS / PMS / APMS) are entitled to full reimbursement of Care Quality Commission (CQC) fees.

Reducing funding streams

Seniority

Seniority payments are made to recognise the experience of individual GPs, based on their years of service. They have been reducing by a fixed percentage per annum until they are abolished from April 2020 and the funding will become part of the global sum. There have been no new entrants to the seniority scheme since April 2014.

Minimum practice income guarantee (MPIG)

The MPIG payment is a historical payment to some practices which was designed to protect practice income when they entered into a GMS contract. It is based on historic earnings, not patient need. This payment is achieved by topping up the global sum income with a correction factor. However, from April 2020, this payment will be removed, having been gradually reduced since 2013. The funding will become part of the global sum.

Out of hours services

Out of hours services are classified as an additional service, so GP practices are able to opt out of delivering them, with their baseline funding reduced accordingly. Many practices have chosen not to provide an out of hours service. CCGs are responsible for commissioning out of hours services where practices have opted out of doing so.

Useful resources

Department of Health and Social Care, *NHS primary medical services directions,* April 2013 (updated October 2019)

NHS England, *GP contract*, 2020

General practice forward view (GPFV)

The *General practice forward view* was published in 2016 and sought to address the pressures general practice faced, particularly around workforce and increasing workload. The *NHS operational planning and contracting guidance for 2017-19* set out increased investment across a number of areas through a sustainability and transformation package totalling over £500 million. In addition, funding was allocated to improve access to primary care and CCGs were invited to bid for support from an estates and technology transformation fund.

A key part of the GPFV was addressing workforce issues, through increases in funding for additional roles and GP trainees. The additional funding came with a requirement to redesign care to ensure that services were sustainable and able to take advantage of changing technology. A general practice resilience programme allowed NHS England regional teams to support practices in greatest need.

The GPFV set the groundwork for the development of general practice through PCNs, set out in the *NHS long term plan.* A number of funding streams set out in the GPFV are still in place:

Online general practice consultation software systems

Funding has been allocated over three years from 2017/18 to support the implementation of online consultation systems in general practice.

Training for care navigators and medical assistants

Funding has been allocated over five years from 2016/17 to support staff training for roles that will support GP practices.

General practice resilience programme

£40 million non-recurrent funding has been allocated over four years from 2016/17 to improve the resilience of general practice. NHS England regional teams determine how this funding is distributed.

Other funding streams created through the GPFV to transform working practices and improve access, have now become part of the funding for PCNs.

Useful resources

NHS England, *General practice forward view,* April 2016

NHS England, *NHS operational planning and contracting guidance for 2017-19,* December 2017

NHS England, *NHS long term plan*, January 2019

Digital first primary care

Digital first primary care is a programme that plans to move towards a new approach for GP practices, where patients can easily access the advice, support and treatment they need using digital and online tools, thus freeing up professional time for more complex patients. The *NHS long term plan* commits that every patient will have the right to be offered digital-first primary care by 2023-24.

The GP contract sets out a number of requirements to move towards this right, giving all patients the right to online consultations by April 2020 and video consultations by April 2021. Building on GPFV funding, £15 million per year will be provided for the next three years, from 2020/21 to 2022/23, to continue to support online consultations and the delivery of a digital first approach.

Useful resources

NHS England, *Digital first primary care,* 2020

Primary care in integrated care systems

The *NHS long term plan* sets out the intention that the whole of England will be covered by an integrated care system (ICS) by 2021. Within an ICS, decisions are made at three levels: neighbourhood (population 30,000 – 50,000); place (population 250,000 – 500,000); systems (population 1 million – 3 million people). Every ICS will have a partnership board which will be drawn from the organisations within the system, including PCNs, enabling primary care to have a voice in decisions made to develop system level strategy and allocate resources.

Primary care has a role to play at each level but is integral to the success of care delivered at a neighbourhood level. Care at a neighbourhood level is based on understanding the needs of the local population and delivering care as close to people's homes as possible. PCNs are central to this, expanding what is offered in GP practices and building multi-disciplinary teams that span organisational boundaries.

Multispecialty community provider (MCP)

Multispecialty community provider contracts were created under the vanguard programme, a forerunner to integrated care systems. A MCP combines the delivery of primary care and community-based health and care services. The building blocks of a MCP are the 'care hubs' of integrated teams. Each typically serves a community of around 30,000 - 50,000 people. A MCP supports practices to work at scale and also to benefit from working with larger community-based teams.

What is a primary care network?

The *NHS long term plan* introduced primary care networks (PCNs) to expand integrated community-based healthcare, building on previous voluntary working arrangements in some parts of England. All GP practices are expected to be part of a PCN, although participation is voluntary. A PCN is a group of general practices working together with a range of local providers – including across primary care, community services, social care and the voluntary sector – offering more personalised, coordinated care to their local populations.

As PCNs develop, they are expected to work jointly with other organisations to deliver neighbourhood care and set out these working arrangements as part of their network agreement.

Additional roles

Each PCN must have a named clinical director who must be a practicing clinician within that PCN.

To expand the primary care workforce, PCNs are also able to recruit to other roles in order to meet the needs of their local populations. It is up to each PCN to decide the distribution of roles required. These roles are:

- social prescribing link worker (funded from 2019/20)
- clinical pharmacist (funded from 2019/20)
- physician associates (funded from 2020/21)
- first contact physiotherapists (funded from 2020/21)
- pharmacy technicians (funded from 2020/21)
- health and wellbeing coaches / care co-ordinators (funded from 2020/21)
- occupational therapists / dietitians / podiatrists (funded from 2020/21)
- first contact community paramedics (funded from 2021/22)
- mental health practitioners (funded from 2021/22)

The *Update to the GP contract agreement 2020/21 – 2023/24* sets out the agenda for change band and maximum reimbursement amount available for each role.

Funding PCNs

A number of different income streams will fund the development and operation of PCNs. Each PCN will have a nominated practice which receives the payments on behalf of the network.

PCNs receive an amount of core funding from CCG allocations per registered patient per year. Further funding is received from the CCG to fund the clinical director role, from the primary medical care allocations. In addition, each practice that participates in a PCN will receive a participation payment from NHS England. This is paid directly to the practice.

The PCN model allows each network to recruit a number of additional roles. PCNs can claim 100% reimbursement of the salary costs for these roles, through the additional roles reimbursement scheme (ARRS). The funding comes from the CCG's primary medical care allocation and is subject to a maximum amount per role.

Extended hours and extended access

Extended hours have become a PCN responsibility and the funding associated with the extended hours directed enhanced service has transferred to the network contract DES.

The *General practice forward view* set out the intention to improve access to primary care, with 100% of the population now able to access appointments outside of core hours. This extended access attracts a payment per patient, which will transfer to PCNs from April 2021.

A nationally consistent offer combining extended hours and extended access requirements will be developed but, in the meantime, PCNs and CCGs are expected to work together to define local arrangements.

Investment and impact fund

The investment and impact fund (IIF) will be available to PCNs from 2020/21. The fund will operate in a similar way to QOF, rewarding achievement of PCN objectives through a points-based system.

Useful resources

NHS England and BMA, *Investment and evolution: A five-year framework for GP contract reform to implement The NHS long term plan*, January 2019
BMA, *The primary care network handbook*, 2019
NHS England and BMA, *Network contract directed enhanced service specification*, April 2019
NHS England and BMA, *Update to the GP contract agreement 2020/21 – 2023/24,* February 2020

CCG commissioning of primary care

Since 2014/15, CCGs have been able to take on greater responsibility for general practice commissioning in their areas. This change was introduced to support the development of integrated out-of-hospital services, based around the needs of local people but only applies to general practice; dental, ophthalmic and pharmacy services remain the responsibility of NHS England. There are three commissioning models available for CCGs to use.

Co-commissioning

Through co-commissioning, CCGs are able to collaborate more closely with NHS England to ensure that decisions taken align with the objectives of the local health economy. CCGs can be involved in discussions around the full range of primary care including primary medical care, dental, eye health and community pharmacies. However, NHS England retains its statutory decision-making responsibilities.

Joint commissioning

Joint commissioning enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with NHS England, through a joint committee or 'committees in common'. The joint committees can make decisions on GMS, PMS and APMS contracts and enhanced services, as well as other matters relating to GP practices. Joint commissioning arrangements exclude individual GP management.

Joint committees can discuss other areas of primary care, such as dental, community optometry and community pharmacies but have no decision-making powers. However, CCGs are able to commission local enhanced services from community pharmacy and optometry providers.

Delegated commissioning

Delegated commissioning allows CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning and will require assurance that its statutory functions are being discharged effectively.

A CCG will have a delegation agreement with NHS England which sets out the matters for which the CCG has decision-making responsibility.

Useful resources

NHS England, *About primary care co-commissioning*, 2020

Nationally commissioned primary care services

NHS England are responsible for commissioning dental, ophthalmic and community pharmacy services; CCGs do not commission the mandatory parts of these services. However, CCGs can be involved in discussions about the provision that is needed for their population, through the co-commissioning model described in the previous section. In addition, CCGs are able to commission some local enhanced services to meet the needs of their population.

Dental

NHS England are responsible for commissioning all NHS dental services, including secondary dental care provided by hospitals. Dental contracts are negotiated locally, using national guidelines. Payments are governed by a statement of financial entitlements which covers reimbursement for services provided and employment related charges. The dental contracts pay dentists for a set number of units of dental activity (UDAs) or units of orthodontic activity (UOA), plus any additional services agreed with the commissioner.

Dentists can provide private dental services from their premises, but it must be clear to the patients whether their care is being provided under the NHS or privately.

There are three contract types for NHS dentistry used within primary care dentistry:

General dental services (GDS)

The GDS contractor provides mandatory services – the typical range of services which must be provided by all dentists, they may also provide advanced mandatory services such as orthodontics, domiciliary services and conscious sedation. GDS contracts are usually held in perpetuity.

Personal dental services (PDS)

PDS agreements are time limited with a defined and fixed expiry date. The typical range of services which must be provided within these contracts are advanced mandatory services inclusive of domiciliary services, orthodontic services and sedation services.

Personal dental services plus (PDS+)

Activity under these contracts is UDA activity and specific key performance indicators in respect of access and performance.

Patient charges

There are three standard charges for NHS dental treatment in England and Wales, which most people pay. There are exemptions from fees for patients who meet certain criteria; for example for children aged under 18 or people in receipt of certain benefits.

Useful resources

NHS England, *Dental commissioning*, 2020

Ophthalmic services

NHS England is responsible for commissioning all mandatory and additional ophthalmic services. Enhanced services can be commissioned by either NHS England or by a CCG.

Mandatory (or essential) ophthalmic services must be provided, for example the provision of NHS sight tests.

Additional services must be commissioned but not all contractors are obliged to provide them, for example provision of sight tests in a nursing home.

Enhanced services can be commissioned to meet local needs.

Payments for NHS sight tests for patients who meet set criteria, for example children under 16 and adults over 60, are made in accordance with the Department of Health and Social Care's general ophthalmic services (GOS) regulations. All other patients pay privately.

Useful resources

NHS England, *Optometry commissioning*, 2020

Community pharmacy

There are three levels of pharmacy service. NHS England are responsible for commissioning the essential and advanced services. Enhanced services can be commissioned by a range of different commissioners including CCGs and local authorities.

Essential services and clinical governance

All pharmacies must provide essential services. These include dispensing, disposing of unwanted medicines, supporting self-care and promoting healthy lifestyles.

Advanced services

There are six advanced services within the NHS community pharmacy contractual framework (CPCF). Community pharmacies can choose to provide any of these services as long as they meet the requirements set out in the Secretary of State's directions. Accredited pharmacists and pharmacies can provide additional services such as appliance use reviews and flu vaccination.

Enhanced (or locally commissioned) services

Enhanced services are locally commissioned and may include services such as stop smoking schemes or emergency contraception.

NHS Prescription Services (part of the NHS Business Services Authority) receives details of all prescriptions dispensed in England. They calculate the amount payable, allowing for the drug and container cost, as well as a service fee. The cost of drugs dispensed is charged to the CCGs' prescribing budgets based upon the GP practice that issued the prescription. Prescriptions from dentists are charged to NHS England.

If a pharmacy signs up to use an electronic prescription service (EPS) to receive prescriptions directly from the prescriber, an additional monthly payment is made, recognising the improvements in efficiency and safety that this brings.

NHS, *Community Pharmacy Contractual Framework 2019-2024,* July 2019

Primary care in the devolved nations

Northern Ireland

Primary care expenditure in Northern Ireland is in the region of £1bn per annum, split across general medical services, community pharmacy, community dental and ophthalmic services. The contracts with the independent providers of all of these services are held by the Health and Social Care Board; the regional commissioning body for the whole of Northern Ireland

Health and Wellbeing 2026: Delivering Together provides a ten-year road map for the transformation of health and social care services in Northern Ireland. A central element within this strategy is the development of a multi-disciplinary team (MDT) model, with a £15m investment to place physiotherapists, mental health specialists and social workers at GP practices. This is supported by increased investment in district nursing and health visiting and builds on existing investment in the practice-based pharmacists initiative.

There are 17 GP federations within Northern Ireland, established as community interest companies limited by guarantee. Their aims are to support and protect GP practices and help deliver the transformation agenda. The average size of a GP federation is approximately 100,000 patients with

17 practices. Northern Ireland is the only part of the United Kingdom which uses a common operating model and members' agreement across all GP federations.

Useful resources

Department of Health, *Health and Wellbeing 2026: Delivering Together,* October 2016

Scotland

NHS Scotland invested £161.5 million in 2019/20 to support implementation of a new GP contract and wider primary care reform, which focuses on multi-disciplinary working. This reform is part of the wider health and social care delivery plan published in December 2016.

The health and social care delivery plan covers areas such as improving population health and developing the primary care infrastructure. It also includes investing in workforce to increase the number of GPs in Scotland as well as additional district nurses, advanced nurse practitioners, paramedics and link workers. Vaccination services will be removed from GP workload. It is also intended that all GP practices will have access to a pharmacist. The 2018 GMS contract refocused the GP role in the community, recognising the GP's expertise as the senior clinical leader in the community and their greater involvement in complex care and system wide activities.

In Scotland, GP practices' main resource allocation is a global sum based on the Scottish workload formula which replaced the previous Scottish allocation formula. Practices continue to have an income and expenses guarantee to protect historic earnings, with a minimum earnings floor for individual GPs. The local seniority payment also remains in place. Scotland has replaced QOF and this is now included in the global sum payment, with funding for participation in local quality clusters. Scotland also fund enhanced services for participating practices.

GP practices are contracted by their local NHS board but a memorandum of understanding between the integration authorities, Scottish General Practitioners' Committee, NHS boards and Scottish Government will set out agreed principles of service redesign together with national and local oversight arrangements.

Pharmacy services in Scotland are delivered under a different payment framework to England and focus on specific services within an overall guaranteed global sum. Focus is on areas to promote engagement in specific national strategies such as the minor ailments scheme and serial dispensing. A dispensing pool replaces the individual dispensing fees seen elsewhere.

Ophthalmic services are funded by item of service fees with new categories to promote a wider range of services. Dental services are funded by a mix of capitation payments, item of service fees and entitlement payments.

Useful resources

Scottish Government, *Health and social care delivery plan,* December 2016

Scottish Government, *GMS Contract: 2018*, November 2017

Wales

Finance and contracting arrangements for primary care in Wales, follow similar lines to England. However only GMS contracts are used to contract with general practice.

Funding is allocated to health boards by the Welsh Government for general practice, dental services, pharmaceutical services, as well as funding a range of optometric services and some aspects of primary care prescribing and dispensing. GMS funding is ring fenced, meaning that health boards

should spend their entire allocation on these services. However, the same does not apply to dental services as not all of the general dental services allocation is ring fenced.

The NHS in Wales is trying to change the way that the public accesses primary care services and introduced the National Primary Care Fund in 2015/16 to encourage innovation. This has resulted in a number of clusters being created, which are groups of neighbouring GP practices and partner organisations; such as the local authority, ambulance services and third sector. Each cluster serves a population of between 30,000 and 50,000 people and aims to give improved access for patients through multi-disciplinary working and integrated working practices. This should contribute to the future sustainability of the primary care sector.

In 2017, the Welsh Government announced a £68 million investment to build 11 new hubs and GP centres, and improve eight existing health centres, to be delivered by 2021.

Useful resources

Auditor General for Wales, *A picture of primary care in Wales*, April 2018

NHS Wales, *Strategic programme for primary care*, November 2018

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About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For nearly 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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