EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (GENERAL MEDICAL SERVICES CONTRACTS AND PERSONAL MEDICAL SERVICES AGREEMENTS) (AMENDMENT) (NO.2) REGULATIONS 2020

2020 No. 911

1. Introduction

1.1 This explanatory memorandum has been prepared by the Department of Health and Social Care and is laid before Parliament by Command of Her Majesty.

1.2 This memorandum contains information for the Joint Committee on Statutory Instruments.

2. Purpose of the instrument

2.1 This instrument amends the following Regulations relating to the provision of primary medical services in England:

i. the National Health Service (General Medical Services Contracts) Regulations 2015 (SI 2015/1862) (the "GMS Contracts Regulations") which set out the framework for General Medical Services ("GMS") contracts; and

ii. the National Health Service (Personal Medical Services Agreements) Regulations 2015 (SI 2015/1879) (the "PMS Agreements Regulations"), which set out the framework for Personal Medical Services ("PMS") agreements.

2.2 Every individual or partnership of GPs must hold an NHS GP contract to run an NHS-commissioned general practice. The contract sets out mandatory requirements and services for all general practices, as well as making provisions for several types of other services that practices may also provide, if they so choose. There are three different types of GP contract arrangements in England: General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS). All types of contract are managed by the NHS commissioner (either NHS England and NHS Improvement, (NHSE/I), the operating name of the NHS Commissioning Board, or Clinical Commissioning Groups).

2.3 The amendments in this instrument implement part of the agreement between NHSE/I) and the General Practitioners Committee (GPC) of the British Medical Association (BMA) on changes to primary medical services (GP) contracts made in February 2020.

2.4 This instrument also makes amendments to correct drafting errors made in an earlier instrument, the NHS (Amendments Relating to Primary Care Services During a Pandemic etc.) Regulations 2020 (S.I. 2020/351) ("the 2020 Regulations").

3. Matters of special interest to Parliament

Matters of special interest to the Joint Committee on Statutory Instruments

3.1 The Joint Committee on Statutory Instruments, in its 10th report of session 2019-21 of 8th May 2020, (HC 75-X/HL 58) reported the 2020 Regulations for defective drafting on two counts. The errors that were identified are corrected in this instrument.

Matters relevant to Standing Orders Nos. 83P and 83T of the Standing Orders of the House of Commons relating to Public Business (English Votes for English Laws)

3.2 As the instrument is subject to the negative resolution procedure there are no matters relevant to Standing Order Nos. 83P and 83T of the Standing Orders of the House of Commons relating to public business at this stage.

4. Extent and Territorial Application

4.1 The territorial extent of this instrument is England and Wales.

4.2 The territorial application of this instrument is England.

5. European Convention on Human Rights

5.1 As the instrument is subject to negative resolution procedure and does not amend primary legislation no statement is required.

6. Legislative Context

6.1 Part 4 of the National Health Service Act 2006 (c. 41) requires NHSE/I to secure the provision of primary medical services in England. It makes provision for regulations to be made to govern the terms of contracts under which primary medical services operate.

6.2 Agreement was reached in February 2020 between NHSE/I and the GPC on changes to be made to primary medical services contracts for 2020-21.

6.3 This instrument is being made to amend existing regulations to reflect the terms which will form part of the GP contract. Such amendments are usually made twice a year. It takes forward amendments which were not included in an earlier instrument, the NHS (General Medical Services Contacts and Personal Medical Services Agreements (Amendment) Regulations 2020 (S.I. 2020/226), that came into force on 1st April 2020.

7. Policy background

What is being done and why?

7.1 Following the conclusion in February 2020 of negotiations between the GPC and NHSE/I over changes to the GP contract for 2020/21, NHSE/I published Investment and Evolution, an Update to the GP contract agreement 2020/21-2023/24 (see: https://www.england.nhs.uk/publication/investment-and-evolution-update-to-the-gp-contract-agreement-20-21-23-24/)[1]. A number of regulatory amendments were

[1] Negotiations are held as part of a five-year framework for GPs agreed in 2019. (See: https://www.england.nhs.uk/publication/gp-contract-five-year-framework/). This framework is supporting the

agreed; some are being implemented through this instrument, whilst others will be taken forward at the beginning of 2021. The following amendments are here made:

Correcting minor drafting errors in pandemic regulations

7.2 The GMS Regulations and PMS Regulations are amended to correct errors made in the 2020 regulations which were laid before Parliament on 26th March 2020 (see: https://www.legislation.gov.uk/uksi/2020/351/made). These errors were reported by the Joint Committee on Statutory Instruments (JCSI) in its 10th report of session 2019-21 of 8th May 2020, (published as HC 75-X/HL 58). The 2020 Regulations made amendments to paragraph 11B (direct booking by NHS 111) of Schedule 3 of the GMS Regulations and paragraph 16B (direct booking by NHS 111) of Schedule 2 of the PMS Regulations. These regulations correct a drafting error so that obligations of the contractor in relation to direct booking of appointments apply equally where those appointments are booked by NHS 111 or via a connected service. The 2020 Regulations also inserted a new regulation 3A (variation of core hours while a disease is or in anticipation of a disease being imminently pandemic etc.) into both the GMS and PMS Regulations. These Regulations amend the wording surrounding the making of an announcement to ensure consistency with other similar provisions in the 2020 Regulations and are intended to have the same effect.

Alteration to the definition of "primary care network"

7.3 An amendment has been made to paragraph 15A of Part 1 of Schedule 3 and paragraph 10A of Part 1 of Schedule 2 to the GMS Contracts Regulations and the PMS Agreements Regulations, to alter the definition of "primary care network" (PCN) to reflect that these structures can be approved with a minimum population of fewer than 30,000 people.

7.4 Guidance issued by NHSE/I in May 2019 noted that: `A PCN is defined as GP practice(s) and other providers serving an identified Network Area with a minimum population of 30,000 people… (however) in exceptional circumstances, commissioners may 'waive' the 30,000 minimum population requirement where a PCN serves a natural community which has a low population density across a large rural and remote area' (see https://www.england.nhs.uk/wp-content/uploads/2019/03/pcn-faqs-may-2019.pdf).

Updating of guidance on data collection

7.5 An updated contractual requirement is being introduced for GP practices to submit their workforce data on a monthly basis (where previously it was quarterly). Guidance published by the Health and Social Care Information Centre (also known as NHS Digital) is being updated accordingly, in relation to the data that must be recorded by contractors and submitted to NHS Digital for the purposes of the NHS Digital workforce collection. *Investment and Evolution* set out plans to increase the frequency and timeliness of primary care workforce reporting so that data is available on a monthly basis with less of a time lag before publication. This is part of a broader push to increase the accuracy of data available to commissioners and the public, which ultimately will underpin the overall NHS access offer. It is hoped this more frequent reporting will, together with an expanded dataset, correctly identify GPs

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delivery of the NHS Long Term Plan, announced in January 2019 (see: https://www.england.nhs.uk/long-term-plan/).

working in settings outside of traditional practice who are currently not included in workforce data, such as NHS 111, Accident & Emergency, walk-in centres, out-of-hours services and sub-contractors.

Introduction of new requirements in respect of collection of data relating to appointments in general practice.

7.6 A new provision requires practices to participate in the GP appointments data collection. This is in support of measures to alleviate winter pressures by supporting national analysis of any developed general practice access and waiting time standards, as well as capacity and utilisation metrics. Practices will also be required to record and make available for extraction all data relating to appointments, as set out in agreed guidance, to improve data quality in support of a government manifesto commitment to deliver more appointments in general practice.

A requirement for practices to support NHSE/I to fulfil its statutory duties to maintain an accurate and up-to-date list of patients

7.7 This requires practices on receipt of a written request to take reasonable measures to update patient data, including registering or deregistering patients, and providing information reasonably requested by NHSE/I about that list within an appropriate timescale (contacting patients where necessary to confirm their data is correct). This will directly assist NHSE/I in its statutory duties to maintain an accurate and up-to-date list of patients.

Clarification of the rules around removal of a patient who has moved out of the practice list

7.8 This clarification concerns the circumstances in which a contractor can request the removal of a patient from its list by NHSE/I, where a patient has moved out of its practice area. When a contractor notifies NHSE/I that a patient has done so, that patient will continue to be registered with the practice for a set period or until they register with another practice – whichever is the sooner, after which NHSE/I removes the patient from the practice list. Until then, the contractor is responsible for their care. The patient will remain registered with that practice for 30 days (unless they register with another practice), but the contractor will not be responsible for home visits during that period. This strikes a balance between ensuring continuous access to primary medical care while not requiring contractors to provide home visits at a distance from their practice. Patients requiring home visits during these 30 days will need to either register with another practice or access the services commissioned locally for out-of-area registered patients.

Amendments in relation to the list of patients who are violent

7.9 These amendments will prevent a contractor deregistering a patient previously removed from another contractor's list because of violence, where that patient has participated in a Violent Patient Scheme and has been satisfactorily discharged from that Scheme and is therefore eligible to register with a contractor to receive primary medical services. Violent Patient Schemes, often referred to as Special Allocation Schemes (SAS), are intended to balance patients' rights to continuing primary medical care with proper protection for GPs, practice staff and other patients. After a period of time, the responsible SAS contractor may decide that it is appropriate for the patient to be eligible to return to mainstream primary medical care, because they are no longer considered likely to behave violently or threaten violence. However, as

currently drafted, the regulations allow a practice to deregister a patient who has previously been removed from another practice list even if they were subsequently allocated to a SAS and considered eligible to return to mainstream primary medical care. This is not what was intended and risks some patients never being able to re-register with a practice even though they should be eligible. It may allow practices to effectively refuse to register patients because they do not want to, which goes against patient choice. This amendment corrects this.

Amendment to regulations concerning assignment of a patient and list dispersal

7.10 This amendment is to the circumstances in which NHSE/I can assign a new patient to a practice (where that person has been refused inclusion in a contractor's list or accepted - or not accepted - as a temporary patient), so as to include a practice in whose Clinical Commissioning Group (CCG) area the person resides. Previously a patient could only be assigned to a practice in whose outer practice area they were resident in, but with practice mergers increasingly restricting choice, and better availability of remote consultation it makes sense to extend that area to a CCG.

7.11 This change addresses circumstances in which a patient has been refused admission onto a practice list or removed from a practice list (or multiple practice lists), for one of several legitimate reasons that are set out in the Regulations. Most commonly this situation arises where there has been a breakdown in relationship between the patient and the GP Practice(s). Currently, NHSE/I[2] has a limited choice where it can assign such patients - they can only be assigned to a practice where they are already resident in that outer practice area. With practices and CCGs increasingly merging, in rural areas particularly it is possible that a patient may only be resident in one or two practice areas, which severely restricts choice.

7.12 The intention behind this amendment is that commissioners will be able to assign those patients to any practice in the CCG in which the patient is resident. This will mean a much greater choice of practices. This revision essentially seeks to restore previous arrangements that were in place when Primary Care Trusts (PCTs) existed. The current provisions were only in put place from April 2013 because, NHSE/I at the time was effectively a single commissioner for the whole country and it was unreasonable that it had powers to allocate a patient to any practice in its commissioning boundary (England). With the advent of CCG delegation, this is no longer an issue, hence the restoration to provision similar to that which previously existed for PCTs. This has benefits for both patients and commissioners alike.

7.13 This amendment also allows NHSE/I to assign a patient to a new practice in circumstances where their current practice has closed or has provided notice that it will close. NHSE/I may assign the patient to any practice in which CCG area they are resident, although if they are resident outside that practice area the practice may accept them as an out-of-area patient. Usually the Board will assign patients to a new practice of their choice; however, where the Board has been unable to contact the patient, they may choose the practice, so as to ensure continuity of access to primary medical services.

7.14 This amendment changes the assignment provisions concerning out-of-area provision, allowing rules for out-of-area registration to apply as if a person had been accepted by

[2] In the vast majority of cases this will be a fully delegated CCG but there are a few areas where the NHSE/I local team is still the commissioner.

the practice as an out-of-area patient. (This is in the circumstances where that person - who resides outside of a contractor's practice area but within the CCG area of which it is a member - has been assigned to a practice by NHSE/I, and where the contractor elects to accept that patient as an out-of-area patient). If a patient is assigned to a practice somewhere in a CCG, and the patient lives outside of the practice area, the practice may choose to register them as an out-of-area patient.

Sub-contracting of clinical services

7.15 GMS Contracts Regulations and PMS Agreements Regulations prohibit a sub-contractor further sub-contracting clinical services. This amendment provides an exemption to that prohibition, so a contractor may, with the prior written approval of NHSE/I, arrange for its sub-contractor to further sub-contract clinical services under the Primary Care Network Contract Directed Enhanced Service. This allows PCNs to collectively delegate pooled functions via a lead practice model or using a provider such as a GP Federation.

Amendment concerning termination of contracts

7.16 This is an addition to the grounds for which NHSE/I may give notice in writing to the contractor to terminate the contract to include where the contractor's registration with the Care Quality Commission (CQC) has been cancelled. This addresses an anomaly in order to allow a contract to be terminated if the contractor's CQC registration is cancelled which is the case where a contractor is removed from the General Medical Council Register or the Medical Performers List. This new ground of termination is unlikely to increase the prospect of termination of a contract but will simplify and make the process to terminate a contract less onerous for commissioners to carry out and arrange a new GP for the contractors' former registered patients. Changes to related APMS Directions will be made separately for October 2020.

8. European Union (Withdrawal) Act/Withdrawal of the United Kingdom from the European Union

8.1 This instrument does not relate to withdrawal from the European Union / trigger the statement requirements under the European Union (Withdrawal) Act.

9. Consolidation

9.1 The GMS Contracts Regulations and the PMS Agreements Regulations from 2015 were consolidating instruments. Both sets of Regulations have since been amended: however, the Department does not consider there to be a current need to further consolidate these regulations.

10. Consultation outcome

10.1 There is no statutory requirement to consult on proposals to amend the GP contract regulations. However, contractual changes are negotiated with the GP Committee of the BMA. The Department referred a draft of these proposed amendments to the BMA, who are the recognised representatives of GPs for these purposes, and to NHSE/I for their consideration and comment. They, and the BMA have commented on the draft amendment regulations. We have responded to the comments received and made appropriate changes to the Regulations. Several of these amendments will not directly impact patients, for example changes to the collection of workforce and appointments data, the definition of a PCN or the termination of a contract when the

practice loses its CQC registration. The regulatory changes in relation to patient registrations are primarily being altered as a result of issues raised by patients, either through complaints processes or feedback via local commissioners. The changes therefore are intended to have a positive impact for patients in terms of their experience, care and treatment.

11. Guidance

11.1 NHSE/I will provide commissioners and practices with a letter setting out appropriate information about these changes ahead of their implementation on 1st October. There is a range of supporting material already on the 2020/21 GP contract page – see https://www.england.nhs.uk/gp/investment/gp-contract/.

12. Impact

12.1 There is no, or no significant, impact on business, charities or voluntary bodies.

12.2 There is no, or no significant, impact on the public sector.

12.3 A full Impact Assessment has not been prepared for this instrument as no, or no significant impact, on the private, voluntary or public sector is foreseen. However, an internal Equality Impact Assessment has been produced, which we have not published.

13. Regulating small business

13.1 Although many GP practices are small businesses, they are nevertheless exempt from the Small Firm Impact Test. This is because they are considered as part of the public sector due to their provision of primary medical services for the NHS.

14. Monitoring & review

14.1 The approach to monitoring of this legislation is the responsibility of NHSE/I. However, the Secretary of State has responsibility for the terms of contracts contained in regulations and for the consolidation of those regulations.

14.2 The Regulations do not include a statutory review clause.

15. Contact

15.1 Grant Hibberd, GP legislation policy and parliamentary business officer at the Department of Health and Social Care, can be contacted with any queries regarding these Amending Regulations and this Explanatory Memorandum. Please email: generalpracticemailbox@dhsc.gov.uk.

15.2 Sarah Gravenstede, Deputy Director for Primary Care at the Department of Health and Social can confirm that this Explanatory Memorandum meets the required standard.

15.3 Jo Churchill, Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care at the Department of Health and Social Care, can confirm that this Explanatory Memorandum meets the required standard.