

**NHS Hammersmith and Fulham CCG and NHS England (London) Medical Directorate
Clinical Review of Dr Jefferies and Partners GP at Hand service
9th October 2017**

1. Introduction

Dr Jefferies & Partners (a practice within NHS Hammersmith and Fulham CCG), and subcontractors including Babylon Health (a digital healthcare company) have developed a new operational model using the national GP Choice Policy to grow the GP list through a digital and remote site offer aimed at improving access. This service, provided by the partnership, is known as GP at Hand.

GP at Hand offers full GMS services to all patients who register, without explicit restrictions except to women who disclose that they are pregnant at registration, in line with NHS recommendations. However, the service is clear that ‘each consultation enables a clinical assessment to confirm the on-going clinical appropriateness of the patient for the service. Should the service not be clinically appropriate, the reason is clearly documented and patients are assisted as far as possible in finding an alternative service, in line with the Choice of GP policy’.

As part of the model of care since late 2016 the partnership has been supplying the following services in collaboration with Babylon:

- Symptom checking
- Consultations by video or phone
- Photo and text based questions sent to clinicians
- Information on conditions and symptoms from NHS Choices
- Video replay of consultations
- Patient health profiling

Patients registering for the service at 139 Lillie Road Medical Centre were initially restricted to postcodes within approximately 45 minutes public transport time from the current practice location in Fulham. The second phase of the service launch involves a rollout of the service across London with physical locations at transport hubs to enable access to patients from a wider geography. This second phase has not yet gone live due to a formal objection issued by NHS England on 20th September. The aim is to steadily increase the number of locations in London and then launch the service outside London later this year. As of 3rd October 2017 the number of full patient registrations for the GP at Hand service was 2,243, of whom 71% are aged between 18 and 34, and only 24 patients are over 55 years of age.

In parallel, Babylon is also working in London on a number of commissioned pilots across NWL and NCL. The Jefferies – Babylon development is not one of the commissioned London pilots and is being taken forward by the practice.

The GP at Hand model represents an innovative approach to General Practice that has the potential to deliver benefits to Londoners, as well as being closely aligned to emerging national priorities such as Online Consultation and NHS Online. NHSE (London) and Hammersmith and Fulham CCG recognise that the innovation behind the GP at Hand model, particularly the use of digital technology, represents an exciting and potentially transformational approach to healthcare. As with any innovation, there are risks with implementation and they therefore commissioned this clinical

review to assess any impact on the quality or safety of care being offered to patients as a result of this novel approach to service delivery. This report, outlining the findings of this review, aims to recognise the very positive benefits that such an innovative approach can bring, whilst making clear recommendations to ensure that patient care is not compromised and that GP at hand provides a safe, effective service as part of the wider health and social care system.

2. Scope of Clinical Review

As part of this process, NHS Hammersmith and Fulham CCG and the Medical Directorate in NHS England London Region worked together to lead a clinical review of the GP at Hand service. The review sought assurance regarding the GP at Hand clinical model in the following areas:

- Clinical Governance
- Policies and procedures
- Consistency of offer
- Links with other out of hospital services
- Registration criteria
- Clinical capacity
- Management of patients with complex care needs
- On-going monitoring and management of patients with long term conditions
- Safeguarding
- Screening
- Access to clinical record systems
- Repeat prescription process
- Patient information regarding the service

As well as making recommendations regarding the clinical model for the new service, the review team have also attempted to identify any implications for national NHS England policy, particularly regarding the application of the Choice of GP Policy as part of the service.

The review took the form of a paper review and a meeting with some of the lead clinicians responsible for providing the GP at Hand service to discuss in more depth the model of care being delivered. Key lines of enquiry were shared with the practice in advance of the meeting and clinical scenarios were used where appropriate to understand more deeply the clinical governance and care process in place to ensure quality and safety of patients.

This report covers the discussion and outputs of the Clinical Review meeting between representatives of NHS England (London) Medical Directorate, Hammersmith and Fulham CCG, the practice, and Babylon on 30th August 2017.

It should be noted that it is the intention of NHS England (London) and the commissioners that this review and report should be part of an on-going process of assurance in which all parties can collectively deepen their understanding of how clinical quality can be maintained and enhanced using digital technology. As with any innovation the precise benefits and risks remain unknown – it is therefore essential that the roll out of this service is accompanied by an evaluation of the impact, in partnership with local and regional commissioners. This report cannot be considered conclusive but rather directive in highlighting areas of concern where further action or evaluation will be necessary.

It should be noted that the scope of the clinical review covered the application of the GP at Hand service model, but did not include any assessment or evaluation of the clinical algorithms supporting

Babylon's online triage application which has been, and continues to be, subject to national and regional evaluation as described previously. It is also assumed by the clinical review team that Babylon's compliance with statutory and mandatory clinical safety standards including SCCI0129 and SCCI0160 has been assured under existing digital governance processes.

The clinical review meeting was attended by:

- David Finch (DF) – Responsible Officer, Medical Director for North West London (NHS England London Region)
- Jonty Heaversedge (JH) – Medical Director for Primary Care and Digital Transformation (NHS England London Region)
- Julie Sands (JS) – Head of Primary Care, North West London (NHS England London Region)
- Ashok Gorazia (AG) – Independent GP, St David's Practice, Hounslow
- Sophie Ruiz (SR) – Head of Primary Care, NHS Hammersmith and Fulham CCG
- Sian Howell (SH) – GP Clinical Lead for Primary Care Access (Healthy London Partnership)
- Paul Bate (PB) – Director of NHS services, Babylon
- Edmund Jahn (EJ) – Clinical Operations Director, Babylon
- Matthew Noble (MN) – Partner, Lillie Road Surgery and Associate Medical Director, Babylon
- Mobasher Butt (MB) – Partner, Lillie Road Surgery and Medical Director, Babylon
- Hannah Coyne (HC) (minutes) (NHS England London Region)

The following documents were also provided to NHS England (London) and the commissioners by GP at Hand as part of the clinical review process:

- A comprehensive description of the GP at hand service, including
 - How GP at hand helps patients and the NHS
 - Model of care
 - Fulfilment of GMS obligations
 - Contractual arrangements
 - Implementation plan
 - Communications to people interested in the service
 - Evidence for safety, clinical effectiveness and patient experience of the Babylon service
- Clinical Governance Framework (last reviewed August 2017)
- GP at Hand repeat prescription policy (created August 2017, version 1.1)
- GP at Hand Babylon Safeguarding Flowchart (2017)
- GP at Hand Safeguarding Policy (14th June 2017)
- GP at Hand written responses to clinical scenarios proposed by Dr David Finch and Dr Jonty Heaversedge in advance of the clinical review

3. Model of Care

The providers of GP at Hand have developed the following model of care for all registered patients:

Registration

- Patients register, in accordance with the NHS registration policy and Choice of GP policy.

- Patients complete a standard registration form (based on the GMS1 form) via the website, the Babylon app or in-person.
- Identity verification (e.g. passports, driving licence, birth certificates) is requested from all patients.
- While the service is being rolled out, the offer is limited to postcodes surrounding locations of clinics.
- Patients choosing the GP at hand service register with 139 Lillie Road Medical Centre (other NHS GP practices are also able to offer this service).

Health Assessment

- Patients are offered a health check within 6 months of registering with the partnership, in accordance with GMS regulations.
- Babylon app can send out notifications to promote health and well-being, and a digital personal health assistant is being developed for each user of the service.

Triage

- Patients can be triaged via the Babylon app (adults only), by sending text questions and photos to clinicians or by talking to a GP during smartphone appointments. The triage outcomes include self-management and pharmacy, as well as primary care appointments (and where necessary, A&E).
- Patients can choose to book an appointment without using the triage services.

GP Appointments

- Patients can have a digital appointment (video and/or phone call), a physical appointment or home visit.
- Physical appointments are available throughout the core GMS hours of 8am to 6.30pm, Monday to Friday.
- Digital appointments are available from 8am to 8pm, 7 days per week.
- Patients book an appointment by calling the GP at hand services support team or via the Babylon app (currently digital appointments only). Patients can also use SystmOnline for booking physical appointments.
- All GPs have access to the full NHS medical record when carrying out digital appointments.
- Medical notes and actions from all appointments captured in SystmOne. Patients can replay video and audio of all their digital consultations.

Investigations and Referrals

- Clinicians will arrange investigations and referrals, where appropriate, for patients through SystmOne and other referral mechanisms used by the NHS.
- Patients can choose where to access such services, as per the choice arrangements set out in the NHS constitution.
- The service will follow up on investigations and referrals, and all information will be input into SystmOne, and actioned appropriately, by the GP at hand clinicians and service support team.

Prescriptions

- All prescriptions, including repeat prescriptions, are generated through SystmOne. These are delivered to the pharmacy of the patient's choice via the Electronic Prescribing System and/or by patients who choose to have a paper copy.
- Patients can request a repeat prescription by contacting the practice or the GP at hand support team.

Monitoring

- Patients can monitor their health digitally using the Babylon app. The data is available to the GP during digital consultations.
- A dedicated complex care team, with GP, nurse and care navigator roles, will co-ordinate the face-to-face and remote care provided by multiple health and social care teams, for anyone needing this (e.g. mental health, frail elderly, palliative care).

De-registration

- Patients can choose to switch to another GP practice at any time.
- Patients residing out-of-area may be advised to de-register, in accordance with the Choice of GP policy, if it is no longer clinically appropriate to be registered out-of-area.
- Patients are de-registered through SystmOne, following standard NHS processes.

4. Clinical Review findings

The GP at Hand service provides several important benefits to patients and the practice, as well as being closely aligned to emerging NHS policy regarding digital approaches to Primary Care, these include:

- Improved access and ease of ability to register with GP
- Prompt smart phone consultation and online offer, but with direction to a face-to-face appointment where appropriate
- Registration is not limited to traditional practice boundaries, offering access to services particularly conveniently located for commuters
- The online service may be preferred by some individuals and patient groups with limited mobility for whom accessing their GP is difficult
- Ease of new registration and change of registration
- The digital offer may promote self-help, through symptom checking and easy access to NHS Choices information within the app
- Enhanced patient choice in how to access support
- The service can systematically support quality improvement through review of video consultations to support individual learning and development
- More flexible working for GPs and other clinical staff
- Potential for improved capacity management and workflow by directing demand to the most appropriate service or support to meet their needs
- Data captured to create insights and inform service delivery, individual and organisational development, and quality improvement
- Potential to systematise care delivery to support greater consistency of quality

- All clinicians have access to a patient's full medical records – ensuring a more seamless service

The GP at Hand service is likely to be of particular benefit to:

- Patients with episodic well-defined needs who are likely to be dealt with in a single smart phone consultation and are unlikely to need follow up with a face to face consultation (our understanding is that as of October 3rd 2017, 220 in-person consultations have been carried out through GP at Hand, less than 20% of the 1,110 digital consultations)
- Digitally confident patients with access to a smart phone
- Commuters
- Younger people (20-50 years old) – recognising that the ongoing shift in utilisation of technology across all age ranges will further extend this in future
- Patients with limited mobility – particularly in conjunction with the home visiting service

The service may be less appropriate for:

- Patients without a smart phone, or not confident in using a smart phone
- Patients not confident to consult in English, although translation services may result in better written e-consultation support for people who do not have English as a first language and who would otherwise have to rely on friends or family to translate for them, or require traditional GP services to access interpreting services
- Patients with hearing or sight problems, or other physical disabilities that would limit utilisation of digital technology
- Patients who are likely to need to be physically seen more often – for example with frequent asthma or COPD exacerbations, or require regular practice nurse visits (for example for wound dressing or B12 injections)
- Patients with reduced mobility when a physical consultation is required (although this may be mitigated by the GP at hand visiting service)
- Patients who are not prepared to travel up to 45 minutes for a physical consultation should this be required, or who are unable to afford travel costs to the nearest centre if they need to be seen
- Patients who value continuity of care and would like to see or speak to the same health care professional regarding their health concerns (although this can be arranged via the GP at hand support team)
- Potentially patients whose needs require effective integration with other local services, multidisciplinary team working, or very personalised care planning, for example:
 - Pregnant women
 - Adult safeguarding patients
 - Complex mental health patients
 - Patients with complex physical, psychological and social needs
 - Dementia patients
 - Frail elderly patients
 - Those requiring end of life care
 - Parents of children who are in the 'Child at risk' protection register
 - Patients with learning difficulties
 - Those with drug dependence
- It was noted that, of the cases with complex needs discussed with the GP at Hand Team, the majority would result in the GP at Hand team having a conversation with the patient about

registering with a practice nearer their home. This is reassuring and suggests that the service is aware of its limitations, however the question then becomes how these can be more explicitly communicated to patients prior to registration to inform them in their choice.

The service model also presents some potential clinical risks, challenges and unforeseen impacts for patients and the wider system:

- The GP at Hand model is novel, it has not been formally evaluated, and may therefore result in unintended consequences
- Further detail is needed on how the service ensures that identity checks are in place for remote consultations
- Patients who need rapid face to face assessment may need to travel up to 45 minutes to see a health professional. This may:
 - Reduce convenience for those patients who need to be seen
 - Increase the likelihood that they use closer, but less appropriate providers, particularly A&E or other urgent and emergency care services (recognising the benefits the digital aspect of the service may have on demand for urgent care)
 - Increase the likelihood patients are redirected to other commissioned NHS services such as NHS 111 for advice on local services – resulting in a duplication of cost that would not happen with the traditional local GP provider model
 - Be inconvenient for patients who need regular contact, for example for dressing changes
- Patients are likely to self-select in a way that results in a younger, healthier, more mobile population registering for the new service – whilst being beyond the scope of this review it is important to evaluate the impact that this could have on the stability of the wider primary care provider landscape
- There is a risk that the service may improve access to general practice differentially, in a way that contributes to inequality in service provision and potentially inequality in patient outcomes. Any possible impact on inequalities would need to be carefully assessed, and evaluated in an ongoing way
- Patients may demonstrate reduced concordance and be less likely to attend for routine care, such as an annual diabetes review or screening such as smear tests if these require travel to hubs that are inconveniently located for them – however it is recognised that there will equally be some for whom this service will be more convenient
- Whilst GP at Hand intends to offer a comprehensive service to all the patients who register, the model of care involves a range of separate components which are in themselves partial, making the integration of care both within the organisation and with other care providers potentially more challenging
- Complex case discussion or MDT working can be done virtually, but without effective personal or organisational relationships with local teams there is a risk that care will be less coordinated, and impact patient outcomes for those with greatest need
- As a result of the NHS '5 Year Forward View' most health and social care systems in England are integrating community based services geographically around 'place' – this is resulting in increasing variation in local services arrangements. It is important to give further thought to how a service intended to cover a wide range of different geographies will effectively integrate with these place-based models of care
- It is also noted that the pace of change may make it difficult to identify and mitigate any unintended consequences that have not been considered, particularly given the difficulty of maintaining effective oversight of quality issues across a geographically widely-spread service.

5. Recommendations:

The innovative nature of the GP at Hand service means that the impact of this new model of care and the implications for the delivery of care to individuals outside the local system remain largely unknown, and it may be some time before potential risks and benefits are realised. This means that it is not possible at this stage to fully assure the clinical model. The inclusive nature of the service with very few limitations on who should register, the very wide geographical coverage, and the pace of the roll out of the service mean that there is a very real risk that there could be some unintended effects on both patient care and the wider system. We would suggest that a rigorous evaluation framework be agreed with local commissioners and the NHSE Regional Directorate, to accompany a more gradual roll out of the model that enables any concerns to be rapidly identified and learning applied to mitigate the risk of any detrimental impact.

We believe that much of the clinical risk associated with the current GP at Hand model of care could be mitigated by reducing the geographic coverage of the service and/or by restricting registration to better reflect the demographic characteristics of the population for whom this service is likely to be most beneficial. This, alongside a robust process of evaluation would give us greater assurance regarding the safety of patients using the service, without limiting the long-term ambitions of the service to extend as new evidence emerges. This would also give the providers of the service time to further develop their operational capability, governance and workforce to support the model as it expands. Whilst the governance described to us was adequate for the current service, we have concerns that it may not be sufficient to effectively maintain patient safety at greater scale in the future. It is important that GP at Hand continue to work with commissioners to develop governance arrangements that are fit for a service being delivered at much greater geographical scale.

Governance, safeguarding and risk management

GP at Hand's existing governance and safeguarding arrangements are adequate should the patient list size remain relatively modest and the geographic boundaries of the service continue to be limited to Hammersmith and Fulham CCG. However, as the list size grows and coverage expands, the practice will need to interface with multiple sites, organisations and agencies across a wide geographic area. We have not received sufficient assurance that GP at Hand's governance and safeguarding arrangements are adequate should the service expand into areas that are not geographically coterminous with the practice. Similarly, we would wish to have additional assurance that GP at Hand's governance and safeguarding arrangements will adequately support the service's expansion across several sub-contracted locations.

It is very important that the Partner's responsible for providing this novel service are clear on their collective responsibility for any aspect of the care patients registered with the practice receive. Some of the policies provided seem to allocate responsibility differentially between Dr Jeffries and the Babylon partners. Whilst this is fine for administrative purposes it is important to be clear that clinical accountability for the service lies with all named partners.

We have not received assurance that the practice has undertaken a formal risk assessment of the new model of care, or whether they plan to maintain a risk register and risk log. It is recommended, as part of the risk assessment process, that the practice develop a formal Clinical Safety Case.

It is essential to have appropriate and adequate indemnity in place and we would request further assurance that the service has secured the necessary indemnity provision for the new model of care being implemented. In particular, further assurance is required regarding the service's indemnity provision for online/virtual assessment of babies and children.

The CQC, in their letter dated 24th August 2017 regarding the regulation of providers of online primary care, highlight how healthcare provision in the online environment challenges the existing regulatory landscape by transforming how care is delivered and blurring the geographic borders that are more clearly defined in physical practice. In particular, the CQC draw attention to several key themes where concerns were identified in recent inspections of online providers or primary care services – confirmation of patient identity, the assessment of mental capacity, the process of consent, effective communication with a registered GP, and safeguarding. Whilst we note that Dr Jeffries and Partners are rated ‘Good’ by the CQC, it is important that the practice engage with the CQC to ensure that the GP at Hand service model complies with any emerging requirements as these are developed by the CQC.

In the autumn, the CQC will be establishing a provider forum to draw on the views of providers and industry bodies in the sector. We would recommend that the Partners participate in this forum.

Service model

We have concerns regarding several aspects of the GP at Hand service model. In particular, we are not sufficiently assured that:

- 45 minutes is a reasonable travel time for patients who need to see their GP for a face to face consultation. We are also concerned that this may have unforeseen impacts on the wider health system, with patients attending urgent care services close to their home address rather than travelling a longer distance to be seen by the GP at Hand service.
- Under the ‘Choice of GP practice’ policy, the practice is not obliged to provide patients who live outside the practice area with home visits or services out of hours. It was not clear how long the practice intended the home visiting service to be in place for patients outside the current catchment area. If the home visiting service is intended to be subject to review in future, then transparency is required with the patient that it is an additional service, and that it is subject to review and may be withdrawn in the future.
- Adequate patient engagement was conducted during the development of the service offer. We would like to see further evidence of the engagement that did take place to ensure that the sample of people involved in the focus groups regarding the service were representative of the population as whole, and not just the relatively younger and digitally enabled patient demographic that are likely to comprise a significant proportion of the target audience for GP at Hand.
- Patients will have adequate and timely access to the full range of GMS services, as well as acute and community services when required. It is not currently clear whether all the proposed sub-contracted locations will provide a comprehensive GMS offer – including acute episodic care, ongoing support for a range of long term conditions, public health and preventative interventions, and opportunistic and planned screening to support wellbeing.
- Continuity of care will be provided for patients requiring periodic ongoing consultations, in particular those with multiple long term conditions, mental health problems, and more complex needs who will benefit from a consistent therapeutic relationship with a health care professional.

- Our understanding is that every clinical interaction in the GP at Hand service will be supported by access to full patient records. We welcome the fact that home visiting is in place – while recognising that this is not necessarily a long-term commitment of the service for patients registered via the Choice of GP Policy – but would recommend seeking additional assurance that access to full patient records will be available during all home visits and at subcontracted sites.
- The service can adequately manage patients who develop complex needs requiring effective coordination with local services near to their home having registered with the service. Whilst we recognise the support given to patients to register elsewhere if their needs cannot be effectively met by the service it is very important that people registering with the service are made more aware of any limitations of the service from the outset.
- We note that, whilst it is legal for GP at Hand to prescribe controlled drugs via their digital service (prescriptions will then need to be posted, via recorded delivery, to the nominated pharmacy), it is recommended that GP at Hand's controlled drug policy is informed by the recently published Drug Misuse and Dependence UK guidelines on Clinical Management. Additionally, the General Medical Council provide guidance on remote consultations and prescribing.
- An adequate process is in place for safe prescription request handling for patients who have visited their local hospital and been provided with an outpatient prescription to be handed over to their GP. These prescriptions often require a rapid turnaround for patients.
- Further information is required regarding the operational model for prescription management and referrals between the practice and multidisciplinary community teams (e.g. district nursing service) closer to the patient's home address

Given these concerns regarding the service model we recommend that the pace of rollout is reviewed to ensure that the GP at Hand service is able to deliver comprehensive care, with continuity of clinician for the most complex patients, consistent clinical leadership, and effective integration with local services at all proposed physical locations.

Patient Registration

We are not sufficiently assured that patients are provided with adequate clarity on the GP at Hand service offer prior to registering with the service. In particular, patients should be made aware that:

- They may, in future, not be entitled to home visits when registering under the Choice of GP Policy. Patients should also be provided with guidance on the scenarios in which a home visit would, or would not, be provided.
- By registering with the GP at Hand service they will automatically be de-registered from their previous GP practice.
- The service may not be appropriate for certain patient groups (accepting that GP at Hand do not currently accept registrations from pregnant women). As yet, there is insufficient evidence to determine a precise list of patient exclusion criteria but, in the interim, our view is this may include those patients identified previously in section 4 - outlining our 'Clinical Review Findings'.

- The locations of the clinics, and the clinicians and services provided by the individual centres.

Given the lack of evidence to help characterise those people the GP at Hand service is most appropriate for, we recommended that all communication with patients prior to registration makes explicit reference to the potential limitations of the service and provides illustrative examples of the sort of scenarios in which people may prefer to register with a local GP. We believe that the Choice of GP Policy was intended to provide flexibility for those patients whom local catchment area restrictions prove inconvenient – in general those who are most mobile, or would prefer to register near to their place of work. We are not clear that the policy was intended to be applied as broadly as the GP at Hand Model describes. Whilst it is likely that patients will self-select to register for the service if they are younger and more mobile, it is equally possible that a number of people may sign up due to dissatisfaction with their current local GP service. It is important that they are aware from the outset the potential limitations of the service so that they can make an informed choice.

We also recommended seeking additional assurance regarding the process by which guardians/carers can register with GP at Hand on behalf of another person.

We would also expect a written policy with more explicit criteria that are used to discern at what point registered patients might be encouraged to register with a local practice, and further clarification regarding the transfer of these patients to local practices when GP at Hand is unable to meet their care needs effectively.

Patient Identification

GP at Hand's Identification Policy includes adequate measures to ensure the ID provided is authenticated via Onfido (this is above minimum standards)¹. However, regarding the prescription of controlled drugs, it is recommended that a photograph of the patient is also uploaded onto SystemOne, which could then be displayed together with the patient demographics, allowing the photo-verification of the person attending the appointment.

Clinical capacity

We are not assured that GP at Hand has access to sufficient clinical capacity to support the proposed expansion of the service. It would be helpful to have sight of the workforce planning that has been done to ensure that there will be adequate clinical capacity to meet the increased demand on the service based on the current rate of new registration. It is important that additional capacity is in place to match the expected expansion of the patient list and geographic coverage of the service.

Evaluation

We recommend a thorough on-going evaluation of the impact of the GP at Hand service. We would suggest that NHS Hammersmith and Fulham commission an independent evaluation of the GP at Hand service, including the impact of the service on the wider health system and assessment of the whether the service has contributed to inequality in service provision and patient outcomes.

We are aware that NHS England and the Healthy London Partnership are working with the AHSN to conduct a formal evaluation of the NHS 111 Online and Babylon pilot in North Central London. While this evaluation may have important implications for the GP at Hand service, we are mindful of the

¹ The policy of ID verification is for the patient to upload their documents via the Babylon app, and then provide a "selfie" photograph (this replaces the patient attending a reception desk at the surgery and the original photo ID and patient being verified)

limitations of extrapolating the outcomes of research in unscheduled care into a Primary Care setting with a very different service model.

Implications for NHS policy

The GP at Hand service model represents an innovative approach to general practice that poses a number of challenges to existing NHS policy and legislation.

The approach to patient registration – where a potentially large volume of patients are encouraged to register at a physical site that could be a significant distance from both their home and work address, arguably represents a distortion of the original intentions of the Choice of GP policy.

NHS England may wish to consider the impact of GP at Hand's patient registration approach on the wider strategic ambitions for place based systems of accountable care, the impact on new models of integrated care, the potential effect on a well evidence model of comprehensive community based primary care that creates significant value within local health and social care economies, and the financial stability of other providers of general practice in London and beyond.

6. Conclusion

In conclusion, the panel considered that the model was innovative and had the potential to benefit patients and the wider healthcare system. It is not surprising that with such an innovative approach, there are a number of issues that need further consideration. We look forward to working with Dr Jefferies and Partners during the next phase of implementation.