NHS Leicester, Leicestershire and Rutland ICB Health Equity Payments Evaluation

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Contents

Glossary

Term (Acronym)	Description
Additional Rates and Reimbursement Scheme (ARRS)	A national funding scheme introduced from 2019 which enables Primary Care Networks (PCNs) to support recruitment across reimbursable roles including clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics. Further information available at: https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/ [Accessed 04/09/25]
Carr-Hill formula or global sum allocation formula	The method used in the UK to calculate the core funding for general practices (GPs). It takes into account and weights factors that affect workload and costs: patient age and sex; long-term condition and mortality rates; patient list turnover; geographic variation in staff costs; and rurality
Clinical commissioning group (CCG)	Clinically-led statutory NHS bodies that were previously responsible for planning and commissioning local services. They were . They were created in 2012 and replaced primary care trusts. They were then dissolved in 2022 and replaced with integrated care boards (definition below) in 2022.. Further information is available at: https://www.nhsconfed.org/articles/what-are-clinical-commissioning-groups [Accessed 22/09/2025]
Community-based services (CBS)	Contract issued by LLR integrated care board (ICB) to cover a range of health services not included in the core national general practice contract. Previously included in one funding allocation as part of the LLR Primary Care Funding Model (PCFM) with the Health Equity Payment (HEP), this was changed and issued as a separate contract in 2024, to which LLR GP practices can opt in.
Friends and Family Test (FFT)	A short questionnaire that provides the opportunity for patients to provide anonymous feedback about their experiences of NHS services. Further information is available at: https://www.nhs.uk/using-the-nhs/about-the-nhs/friends-and-family-test-fft/ [Accessed 01/09/25]
General Medical Services (GMS)	The standard, nationally negotiated contract between NHS England and GPs to provide core primary care services. The contract outlines the duties expected from GPs and provides the funding for GPs, who act as independent contractors within the NHS
General Practice Funding Model (GPFM)	Primary care funding model introduced in 2024 by NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS) which includes the Health Equity Payment and was previously known as the Primary Care Funding Model (PCFM)

Term (Acronym)	Description
GP Patient Survey (GPPS)	An independent survey administered by Ipsos research agency on behalf of NHS England to provide patients with the opportunity to feed back about their experiences of their GP practice and other local NHS services.
Health Equity Payment (HEP)	Element of the PCFM and GPFM funding models, introduced by NHS Leicester, Leicestershire and Rutland Integrated Care System (ICS) to address inequalities in funding resulting from national core GP funding allocations
Index of Multiple Deprivation (IMD)	A small area measure of relative deprivation in England. IMD is based on seven domains: income, employment, education, health, crime, housing and living environment. Further information is available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019 [Accessed 01/09/25]
Integrated care board (ICB)	An NHS organisation that is responsible for planning, arranging and ensuring the local availability of quality health services, which took on many functions that Clinical Commissioning Groups (CCGs) were previously responsible for. Further information is available at: https://www.nhs.uk/nhs-services/find-your-local-integrated-care-board/ [Accessed 22/09/2025]
Key performance indicators (KPIs)	Specific, measurable standards that are used to evaluate the performance and quality of services
Leicester, Leicestershire and Rutland Local Medical Committee (LLR LMC)	An independent body for GPs and GP practices in Leicester, Leicestershire and Rutland to access support and advice. Further information is available at: https://www.llrlmc.co.uk/ [Accessed 01/09/2025]
NHS App	A freely available digital application that can be downloaded onto a smartphone or tablet. It allows patients to easily and securely access a range of NHS services, such as booking and managing appointments, ordering repeat prescriptions and viewing a GP patient health record. Further information is available at: https://www.nhs.uk/nhs-app/about-the-nhs-app/ [Accessed 22/09/2025]
Patient recall	This refers to when a healthcare organisation contacts a registered patient and requests they return for re-examination or review, which may include a medication review. Further information is available at: https://www.england.nhs.uk/ourwork/part-rel/nqb/recall-framework/ [Accessed 03/09/2025]

Term (Acronym)	Description
Primary Care Funding Model (PCFM)	Primary care funding model introduced in 2021 by NHS Leicester, Leicestershire and Rutland (LLR) ICB, which included the Health Equity Payment and funding for other primary care services provided in the community
Primary Care Network (PCN)	A group of GP practices that collaborate to serve their local community. PCNs provide integrated, accessible care by working with other healthcare providers (such as community services, mental health teams, social care, and voluntary organisations). Further information is available at: https://www.england.nhs.uk/primary-care/primary-care-networks/ [Accessed 01/09/25]
Quality and Outcomes Framework (QOF)	A primary care incentive scheme that rewards GP practices for providing high-quality patient care. It supports improvements to care and is based on a set of evidence-based indicators. Further information is available at: https://qof.digital.nhs.uk/ [Accessed 01/09/25]

Executive Summary

Background

The Health Equity Payment (HEP) scheme was developed by population health leads from NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB), intended to be a fairer approach to funding than the current national core GP funding model, which is based on the global sum allocation or Carr-Hill formula. First introduced in 2021 as part of the Primary Care Funding Model (PCFM), the HEP in its current iteration provides additional top-up funding to the most underfunded half of GP practices in LLR, as defined by NHS LLR ICB. The calculations of funding allocations are based on patient needs including case mix, patient list turnover and communication needs, as well as levels of deprivation. The ICB provides HEP funding without spending restrictions or formal reporting requirements, to reduce the burden on practices.

Purpose of the evaluation

The Health Foundation Improvement Analytics Unit (IAU) commissioned the Strategy Unit in February 2025 to support their independent evaluation of HEP patient-level outcomes, by conducting qualitative interviews with participating GPs and practice staff. Interviews were intended to provide insights into how GP practices have spent their HEP funding and share process learning with any stakeholders interested in alternative general practice funding routes.

Methods

Following a scoping stage, which included agreeing the information governance for the evaluation, online interviews (of up to 60 minutes) were conducted between April and July 2025. Twelve practice staff (lead or managing GPs and operational managers) from ten HEP-funded practices were interviewed, having responded to an invitation extended to 77 eligible practices. The practices were sampled by demographic factors, patient population size and level of deprivation and provided services in a range of settings. Interview participants described their understanding, views and experiences and uses of the HEP funding, as well as providing suggestions for the improvement of future HEP or similar schemes.

Findings

- **Participants supported the rationale of the HEP model**, welcoming it as a fairer alternative to the Carr-Hill formula, which better aligned with local need, though understanding of individual allocations and scheme conditions varied.

- **HEP funding was widely valued,** with most practices reporting improvements in staffing and access, bringing benefits for patient experience. However, changes to funding allocation amounts in early years posed challenges for planning and recruitment.
- **Practices used the funding in a wide variety of ways,** reflecting the lack of restrictions imposed on the funding, which practices welcomed for supporting them to make appropriate spending decisions for their context and patient needs.
- **Staffing was the most common use of funding**, with investment in diverse roles and skill mix seen as central to tackling health inequalities. Some practices hesitated to recruit without longer-term guarantees of increased or recurrent funding or found it difficult to recruit to fixed-term roles. Pooled budgets have been used to address these challenges and mitigate risk.
- **Funding also supported targeted service improvements and infrastructure upgrades**, though attribution to HEP alone was difficult due to pooled budgets. Reported benefits included reduced call-waiting times, improved screening rates, and enhanced staff wellbeing.
- **Participants suggested clearer funding breakdowns, recurrent payments, and improved communication** would improve the scheme, with some proposals reflecting existing ICB activity, highlighting the need for continued engagement and awareness-raising.

Conclusions and recommendations

Evaluation findings support NHS LLR ICB's decision to address limitations in the global sum allocation formula, particularly for practices serving populations with greater health inequalities. While all participants felt funding should continue, some explicitly advocated for this to be delivered through a reformed national core funding mechanism. This echoes the conclusions of other recent reports and the NHS 10-Year Plan, and the evaluation findings support the potential of a national funding model that follows the principles of HEP to lead to meaningful change on a wider scale. Therefore, the following recommendations are made in light of different potential scenarios, including national adoption, the opportunity for similar models to be introduced or adapted in other local systems, or for HEP funding to continue in LLR.

For national-level stakeholders:

- Consider HEP as a pilot for national reform, to address known limitations of existing core funding mechanisms
- Ensure flexibility in funding for any alternative pilot models by removing spending restrictions, mirroring current core funding structures

- For evaluation purposes, align future scheme key performance indicators (KPIs) with existing data collection (such as the Quality Outcomes Framework (QOF) or GP Patient Survey (GPPS) to reduce reporting burden
- Maintain transparency in any future funding changes, with clear practice-level rationale to build trust and accountability
- Promote awareness and share learning from equity-focused funding models across systems.

For NHS LLR ICB and other ICSs:

- Continue to communicate clearly and transparently the funding methodology and rationale
- Provide funding allocations which are stable over longer periods to help practices plan and recruit staff with more confidence.
- Pilot documentation with a sample of practices to gather feedback on clarity of explanations
- Embed engagement into existing forums and tailor support to varied practice capacities
- Offer light-touch data collection and analysis tools to help practices monitor impact and plan with greater confidence
- Use current, locally relevant data and support improvements in coding quality where feasible
- Facilitate peer learning through PCNs and informal case sharing.

For GP Practices

- Strengthen internal data monitoring where possible to evidence HEP or similar funding-related impact
- Share examples of effective use, particularly around staffing and service redesign, through local networks such as PCNs or the LMC
- Engage proactively with ICB communications to stay informed and influence future iterations of the model.

1. Introduction

1.1 Background to the Health Equity Payment scheme

NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) first introduced a local primary care funding model (PCFM) in 2021 (see Figure 1.1 for a timeline of the model's initial development and iterations). This was developed in response to long-standing reported concerns[1] about the national global sum allocation formula (the Carr-Hill formula), which has been used since 2004 to allocate core funding to GP practices under the General Medical Services (GMS) contract.[2]

To address the impacts on their communities, LLR Integrated Care Board (ICB) population health leads developed a PCFM using patient-level data and population health indicators to identify practices most affected by funding shortfalls. Drawing on the Johns Hopkins University Adjusted Clinical Group (ACG) population health analysis system,[3] 127 LLR-based practices were grouped according to the difference between their estimated funding needs, based on the LLR model, and the actual centrally allocated funding they received. Half of the practices had higher estimated funding needs than their centrally allocated funding and were eligible for additional resources from the total HEP fund of £2.8 million.

The funding calculation method estimates the number of appointments each practice is likely to need each year, as a proxy measure for patient need. It is based on:

- **Case mix analysis** using the Johns Hopkins ACG system, drawing on current diagnostic data from both primary and secondary care, and a set of weightings derived from an ACG cell linked analysis of practice consultation data.
- **Adjustments for data completeness**, accounting for variation in the quality and coverage of practice-level data
- **Patient turnover**, which can increase demand for appointments
- **Communication needs**, which may require longer or more frequent consultations (see Section 2.2)

[1] Fisher, R., Dunn, P., Asaria, M., and Thorlby, R. (2020) Level or not?; The Health Foundation. Available online at: https://doi.org/10.37829/HF-2020-RC13 (Accessed 6 October 2025)
[2] British Medical Association (2024) *Global sum allocation formula.* Available online at: https://www.bma.org.uk/advice-and-support/gp-practices/funding-and-contracts/global-sum-allocation-formula (Accessed 1 September 2025)
[3] John Hopkins ACG® System (undated) *About the ACG System* Available online at: https://www.hopkinsacg.org/about-the-acg-system (Accessed 1 September 2025)

- **Index of Multiple Deprivation (IMD) data**, used to factor in the impact of deprivation on patient need and align with national funding principles.

Between July 2021 to April 2023 the payment amounts ranged from £390 to £120,000 with an average payment of £48,000 per practice, per year, equating to an average 5% funding increase as a proportion of their practice core funding.[4] Funding is currently based on a three-year cycle with annual reassessments, with a policy also developed to account for any change in practice circumstances during this period which might affect their payments.[5]

The PCFM was not intended to address absolute levels of resourcing across the ICS (considered the remit of the national funding model), be directive of how practices should spend the money, or require practices to formally report on this.[6] It therefore differed from other primary care funding sources, such as the Quality Outcomes Framework (QOF), which requires practices that opt in to demonstrate performance against specific indicators to receive payment.[7]

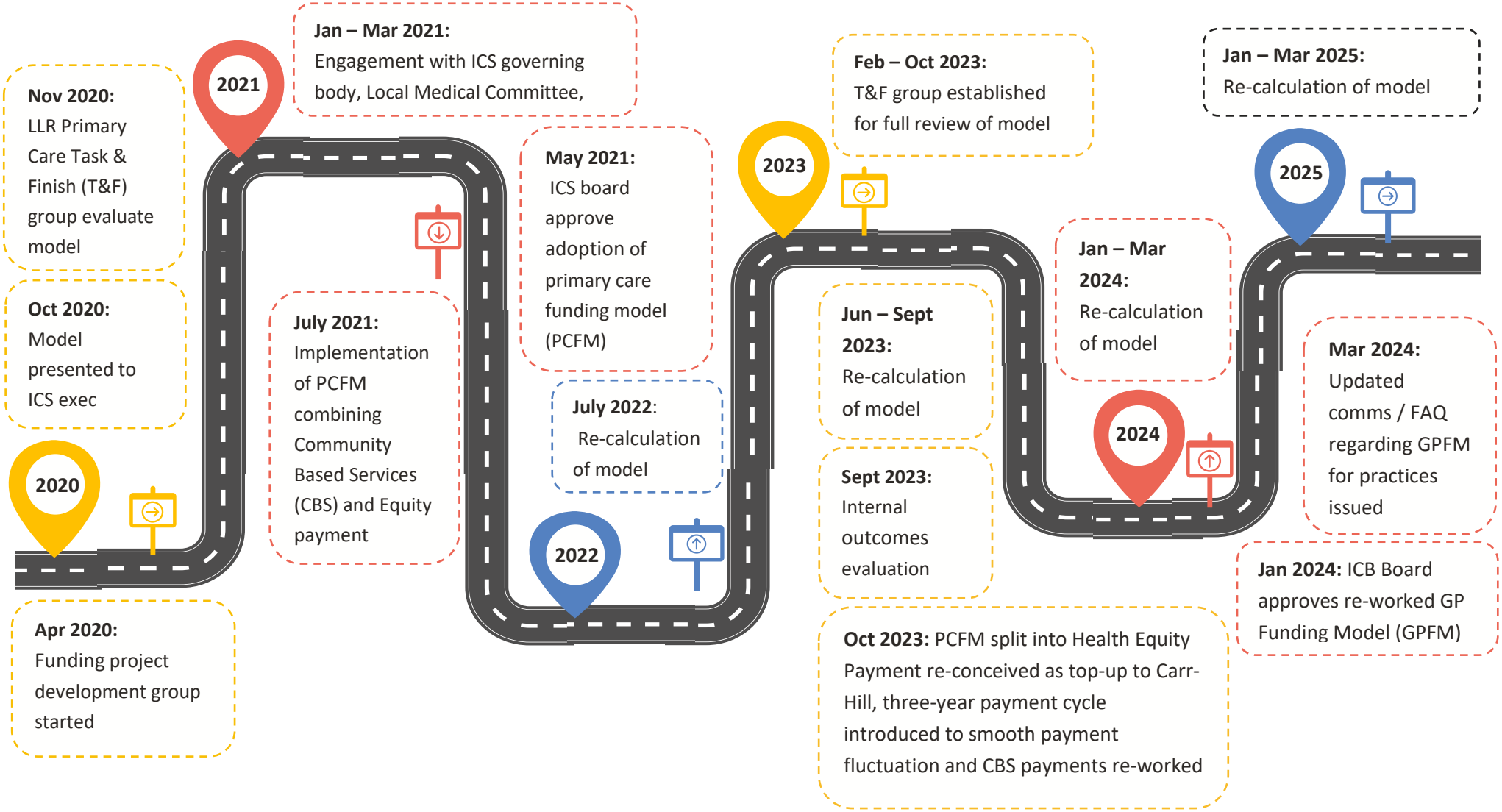
Since 2021, LLR ICB leads have worked closely with NHS Frimley Health and Care ICB colleagues who used the PCFM model as a template for their own Fairer Funding Model. The two ICBs have conducted mutual peer reviews of their scheme funding allocations, in order to validate calculations.[8] In 2023, the LLR model was revised following local feedback and an internal review; it was relaunched as the General Practice Funding Model (GPFM) in 2024. This separated the Health Equity Payment (HEP) from local funding related to Community-Based Services (CBS), which was previously included in the PCFM.

To promote and support understanding, the ICB developed further GP practice-facing resources to explain the different iterations of the model throughout its implementation, including a HEP Frequently Asked Questions (FAQ) document, HEP Explainer and patient record coding guidance, issued alongside the GPFM relaunch in 2024. The ICB also ran webinars and offered to conduct

[4] Opie-Martin, S., Tracey, F., Whitfield, E. et al. (2025) Evaluating the impact of capitation funding top-up payments in primary care, preprint available at: Research Square https://doi.org/10.21203/rs.3.rs-7509545/v1 (Accessed 7 October 2025)
[5] NHS LLR ICB (2024) *Health Equity Payment Explainer*. Local document provided to Strategy Unit.
[6] NHS LLR ICB (2024) *Health Equity Payment Explainer*.
[7] The Kings Fund (2025) *Cents and sensibility: Micro financial incentives in the GP contract.* Available online at: https://www.kingsfund.org.uk/insight-and-analysis/blogs/cents-sensibility-micro-financial-incentives-gp-contract (Accessed 1 September 2025)
[8] NHS Confederation webinar (2025) *A fairer way to fund General Practice: Learning from LLR and Frimley ICS.* Recording available at: https://www.nhsconfed.org/events/watch-fairer-way-fund-general-practice-learning-llr-and-frimley-icss (Accessed 1 September 2025)

individual meetings with practices to explain the calculation method. At the time of this evaluation, the GPFM was being considered for renewal by the NHS LLR ICS Board.

Figure 1.1 LLR funding model development timeline



1.2 Purpose of the evaluation

As part of an independent evaluation of the HEP, commissioned by the Health Foundation Improvement Analytics Unit (IAU) in 2024, the IAU engaged the Strategy Unit to conduct qualitative research with participating GP practices. This was intended to accompany the IAU's quantitative analysis.[9]

The purpose of the Strategy Unit qualitative strand was to:

- Understand how practices have spent their allocation, to inform and complement the outcome analysis
- Gather insights from GP practices on what they perceived to work well and less well during the implementation of the HEP
- Illustrate potential benefits of providing funding to GP practices based on an alternative funding formula.

The scope of the qualitative strand was limited to the HEP element of the current GPFM funding model but covered all funding years since the model was introduced as part of the PCFM in 2021.

1.3 Methodology

The qualitative evaluation research was conducted in three stages between February and September 2025: scoping, fieldwork, and analysis and reporting.

1.3.1 Scoping (February to April 2025)

Outputs from the initial scoping stage included agreeing:

- A sampling framework to guide recruitment of practice staff, based on geographic location, patient population size, and levels of deprivation (see Section 2.1). The aim was to engage practices operating in a range of contexts.
- Topic guides and participant information materials to support consistency and clarity across interviews.

[9] Sarah Opie-Martin, Freya Tracey, Emma Whitfield et al. (2025) Evaluating the impact of capitation funding top-up payments in primary care, preprint available at: Research Square https://doi.org/10.21203/rs.3.rs-7509545/v1 (Accessed 7 October 2025)

- A Data Protection Impact Assessment (DPIA) (with NHS LLR ICB's information governance team), alongside the ICB's formal notification of the evaluation to all GP practices and the provision by the ICB of contact details (for lead partners and practice managers) to the Strategy Unit to support recruitment.

1.3.2 Fieldwork (April to July 2025)

Key activities during the fieldwork stage were:

- Invitations issued to practices, for up to two staff per practice, to take part in individual or joint online interviews of up to 60 minutes, on a confidential basis (this report includes quotes, which are attributed to generic practice participant numbers only). Participants included GPs and operational leads responsible for budget management
- Issuing invitations on a staggered basis, with priority given to practices funded in 2021/22 and 2022/23 to align with the IAU's quantitative analysis
- Selecting an initial sample targeting practices that received the highest proportion of funding, while maintaining variation across the sampling criteria. Further rounds of invitations were issued to achieve a target of 15 interviews, which eventually included practices funded in both 2023/24 and 2024/25
- Completing interviews with 12 participants from ten of 77 practices that received HEP funding and were invited to participate[10]
- Conducting and recording interviews with participant consent, with full verbatim transcription by an external firm (with unique identifiers assigned to recordings and transcripts).

1.3.3 Analysis and Reporting (July to September 2025)

Following completion of the interviews, the final stage involved:

- Thematic data analysis using NVivo software, drawing on both deductive and inductive coding approaches
- Strategy Unit project team meetings to discuss emerging themes and refine the interpretation of findings, which shaped the structure and content of this report
- Internal and external quality assurance of the report by the Health Foundation, with factual accuracy review completed by the ICB.

[10] The 77 practices were those that received HEP funding in any financial year from 2021/22 to 2024/25.

1.4 Limitations

Although all efforts were undertaken to ensure that the evaluation was conducted with rigour, the following limitations apply:

- The small number of interviews, although involving staff from practices working in varied contexts, reflect the views of only a proportion of GPs with experience of the HEP
- Qualitative research is not intended to be representative, but it is important to acknowledge the potential bias in participants' motivations to take part, whether driven by particularly positive or negative experiences, and findings should be read with this in mind
- Similarly, although one participating practice was no longer in receipt of HEP funding, the evaluation did not include the views of practices that have never received HEP funding, which might have affected perspectives on the funding model
- Several factors may have limited participation, including workload pressures in primary care, individual organisational changes, and invitations potentially being sent to incorrect contacts within practices
- One potential participant declined to take part, stating that they were unaware their practice had received HEP funding. This may have been due to being new in post, not having seen communications from the ICB, or not being the designated contact with oversight of the funding
- Although steps were taken to clarify that the evaluation research covered both the PCFM and GPFM, changes in terminology since 2021 may have caused confusion and deterred some potential participants.

1.5 Structure of this report

This report brings together the qualitative evaluation findings from across the interviews conducted with GPs and practice staff. The remainder of the report is structured to provide:

- **Section 2:** Profiles of participating GP practices, including contextual factors which affect the care they provide to patients
- **Section 3:** Overview of the key findings including understanding, experience and outcomes from the funding model payments
- **Section 4:** Conclusions and recommendations for stakeholders (at national, regional and ICS levels) considering introducing alternative funding models for primary care.

2. GP practice profiles

This section describes the characteristics of the ten practices that took part in the research. It highlights the contexts in which they are providing services, including particular challenges they face in providing equitable or sufficient access to patients.

2.1 Characteristics of the LLR area

The geographic area covered by NHS LLR ICB, including the city of Leicester and the counties of Leicestershire and Rutland, has an estimated population of 1.3 million people. Around 85% of the population is White, 12% South Asian, 1.2% Black British and 1.5% Mixed ethnicity.[11]

The city of Leicester has a high population density, with over 300,000 residents. It also has high levels of deprivation, with over 30% of residents categorised as living in the 20% most deprived areas in England. Leicestershire has around 700,000 residents. In contrast, Rutland has 41,000 residents across a large area. Both Leicestershire and Rutland have lower levels of deprivation, relative to Leicester (less than 5% of residents live in the 20% most deprived areas nationally). Leicester has the greatest proportion of residents from ethnic minority groups (67% compared to 17% in Leicestershire and 9% in Rutland). Leicester also has a higher proportion of people aged under 25 compared with England, while Leicestershire and Rutland have smaller under 25 populations but a larger proportion of residents aged over 65 compared with England.[12]

There are significant differences in healthcare access and outcomes across LLR. Residents in the most deprived areas experience up to nine years shorter life expectancy and fewer health-adjusted life years compared to those in the most affluent communities. This effect is greater for people from ethnic minority groups as well as those from vulnerable groups, such as adults with disabilities.[13]

2.2 Characteristics of participating practices

Interviews were undertaken with staff from ten GP practices, sampled to reflect different contexts across a range of characteristics (see Table 2.1 for the full summary). A key dimension was whether

[11] Leicester, Leicestershire and Rutland: Health and Wellbeing Partnership (2023) Improving Health and Wellbeing in Leicester, Leicestershire and Rutland: Our Integrated Care Strategy 2023-2028. Available online at: https://leicesterleicestershireandrutlandhwp.uk/wp-content/uploads/2024/09/Integrated-Care-Strategy_FINAL.pdf (Accessed 22 September 2025)

[12] As above

[13] Leicester, Leicestershire and Rutland Integrated Care System (2022) Better Care for all: A framework to reduce health inequalities in Leicester, Leicestershire and Rutland. Available online at: https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2023/03/HIF-BETTER-CARE-FOR-ALL-Final-03.02.22.pdf (Accessed 22 September 2025)

they were based in areas of high (n=3), medium (n=2) or low (n=5) levels of deprivation. Patient population was also considered, with variation across practices with small (n=1), medium (n=3), large (n=3) or very large (n=3) population sizes (see table definitions). The sample also included practices located in a city (n=3), suburb (n=4) or wider county area (n=3). Almost all (n=9) were located in an urban area.

Although not all practices disclosed the total amounts they received per funding allocation, among those who did, it ranged from around £4,000 to over £100,000 (with amounts changing between payments).[14] These allocations constituted differing proportions of each practice's total income.

Table 2.1 Summary of practice characteristics

Practice	Level of deprivation*	Patient population size**	Location type***	Rural-urban Classification****
Practice 1	High	Very large	City	Urban
Practice 2	Low	Large	County	Urban
Practice 3	Low	Very large	Suburb	Urban
Practice 4	Medium	Very large	City	Urban
Practice 5	High	Small	City	Urban
Practice 6	Low	Large	Suburb	Urban
Practice 7	Low	Large	County	Urban
Practice 8	Medium	Medium	County	Rural
Practice 9	Low	Medium	Suburb	Urban
Practice 10	High	Medium	Suburb	Urban

**Low: Indices of Multiple Deprivation deciles 7-10; medium: decile 4-6; high: decile 1-3*

***Small: between 3,500 and 7,000 patients; medium: >7,000, but up to 10,000 patients; large: greater than 10,000 patients, but up to 15,000; very large: greater than 15,000 patients.*

****As defined by interview participants*

*****Based on Office of National Statistics data on proportion of rural population.*

[14] Not included in the table as total amounts of funding were not considered as part of sampling.

2.3 Working in different demographic contexts

The participants described the context in which they provide care and its impact on their practice. Key issues were:

- **Access issues for diverse populations (n=3)[15].** Participants from inner-city practices described serving large, ethnically diverse populations and/or non-English speaking patients (including deaf patients), which can require additional considerations for appointments. These include access to practice staff who speak other languages or interpreters, as well as longer appointment times. They also noted that access to and ability to use technology may be more limited for these patient groups
- **Difficulties with recruiting and retaining staff (n=2).** Participants from inner-city practices with high levels of deprivation reported challenges around recruitment and retention due to factors such as staff salary, language skill requirements, and facilities issues including lack of parking
- **Estate/infrastructure issues (n=2).** Participants from smaller, inner-city practices reported that they are based in older buildings, which may not meet accessibility requirements (for example, due to smaller spaces for consultations, fewer consultation rooms and stairs without lifts)
- **Deprivation/ethnicity links to multiple co-morbidities (n=6).** Participants from inner-city practices described having a larger proportion of patients from areas with high deprivation levels and greater ethnic diversity. These factors are linked to increased risk of specific health conditions (such as ischaemic heart disease, hypertension, diabetics and/or asthma) and can interact with other risk factors and vulnerabilities (including drug and alcohol misuse, mental health conditions, housing issues, assisted living and learning disabilities). As a result, patients from these groups may require longer and/or more frequent appointments as well as greater safeguarding considerations
- **Practices straddling neighbourhood borders (n=3).** Participants from a few practices reported that they also serve neighbouring areas. The demographics and healthcare needs of populations in the neighbouring areas were described as vastly different. For example: an elderly population in one area with a younger population in the nearby area; a life expectancy

[15] The number of practices that reported the factor(s) as being relevant to their practices.

difference of 12 years between adjacent areas; an area with high deprivation and another with high affluence. This leads to challenges for the practices in meeting different patient needs

- **Growing patient population sizes (n=3).** Participants from a few practices reported increases in patient list size that exceed the funding that the practice receives. Growth in the number of patients results in a need for practices to hire and train more staff
- **Higher expectations of healthcare (n=2).** Participants from practices that were in more affluent areas described patients as having higher expectations of healthcare, such as receiving a same-day appointment. Patients in more affluent areas were also reported to have a lower threshold for seeking healthcare, which leads to more frequent contact with healthcare services and a greater demand on services. Similarly, practices from areas with a high proportion of patients born outside of the UK reported that patients may have greater expectations of the healthcare they receive in the UK, such as a yearly appointment with a gynaecologist, which affects their satisfaction with the care available
- **Older patients with complex needs (n=4).** Participants from practices located near care homes, particularly those supporting people with dementia or housebound with mobility problems, described these patients' complex needs, including multiple morbidities, which require more frequent appointments and longer appointment durations.

3. Key findings

This section presents the key findings relating to participant understanding, experience, and use of HEP funding, as well as suggestions they had for improving the HEP or similar future scheme.

Summary of key findings

- Participants **understood and supported the HEP funding rationale**, viewing it as a fairer alternative to the national Carr-Hill formula, better aligned with local need and practice context
- **Understanding of individual funding allocations varied**. While some participants appreciated the ICB's varied efforts to explain the model, others remained unclear about specific calculations or scheme conditions, with differing expectations around the level of detail required
- HEP funding was **widely welcomed**, with most participants recognising its value in supporting improvements with practices and expressing **strong support for its continuation**
- Experiences varied depending on the year-to-year variability of funding received, with some practices reporting challenges linked to **fluctuating allocations in the first years of the model** and the impact on planning and staffing
- **Staffing was the most commonly cited use of HEP funding**, as it was seen as central to improving access and addressing heath inequalities. Practices invested in a range of roles and emphasised the value of a broader skill mix to meet patient needs, but emphasised the need for stable funding to maximise impact.
- Some practices recruited confidently, while others hesitated without longer-term guarantees. Many noted that **losing HEP funding would have serious implications for their staffing**
- Practices also used HEP funding to support **targeted service improvements** (including immunisation outreach and culturally tailored screening campaigns), and **improve infrastructure** such as telephony and enhanced triage systems appropriate for those with low digital literacy
- While attribution was often **complicated by the use of pooled budgets**, participants expressed confidence that HEP had contributed meaningfully to changes including:
  - Patient-level access and satisfaction outcomes including **reduced call-waiting times, improved screening rates, and improved FFT scores** (based on internal monitoring)
  - Practice-level benefits included **improved staff retention, wellbeing, and service sustainability,** with some linking HEP to changes in team structure and increased QOF scores
- Some participants felt **supported by the ICB and recognised system-level pressures**, while others described some potentially ongoing **tension between GP practices and with the ICB**, resulting from overall funding differences (linked only partially to HEP)
- Practices suggested **clearer funding breakdowns, recurrent payments, effective communication and use of most recent data** as improvements or best practice for the

funding model. Some suggestions **reflected activities already undertaken by the ICB,** highlighting varied levels of awareness and the potential value of refresher engagement.

3.1 Understanding of the funding model

Interview participants from all practices demonstrated a good understanding of the rationale behind the model. When discussing this, most described it as a way to address historical underfunding or financial imbalances between local practices. Their language varied, but commonly reflected ideas of fairness, such as correcting injustice or inequalities, levelling the playing field, or ensuring equal per-patient payments. One participant added a further dimension by noting they understood its purpose to be not only to equalise funding but also to reflect differing needs more accurately.

"I think this is trying to [address] that one practice's health needs may be different from another practice's health needs, you know, in [LLR] itself. And that relative scale is what it's trying to calculate and then allocates a fund, you know, to recommend the fund to the ICB for that particular practice… And so, the funding bit is, what I understand is, based on several factors and looking at the relative health needs of that practice." Practice 4

Across practices, many participants highlighted the benefits of the HEP model compared to the Carr-Hill formula. They described the Carr-Hill formula as failing to account for key factors linked to both practice context and patient need (such as those described in Section 2.2). Participants provided examples of practices (including their own) that served more deprived populations previously receiving less funding than more affluent practices across LLR, which they viewed as inequitable or hard to justify. The Carr-Hill formula's complexity was also criticised, with some suggesting it obscured the basis for funding decisions.

"I've been looking into this and I've seen that there's a lot of other places around the country really interested in [the HEP], as opposed to the Carr-Hill formula. The Carr-Hill formula is not fit for purpose. It almost feels the way that's been designed, because it's so complex, it almost feels that it is designed to cheat you out of money. You know, it's almost like you've been bamboozled with all this highfalutin terminology that most people don't understand." Practice 8

There was less shared understanding about how individual practice funding allocations were calculated under the HEP and the specific conditions of the funding scheme. Participants from some practices described the HEP calculations as equally complex to Carr-Hill; others considered it much easier to understand or could list all the different factors included. Several spoke positively about the documentation and various ICB engagement activities that supported practice staff

understanding (as described in Section 1.1) and acknowledged that individuals will have different preferences for the level of detail they require, or ability or experience to understand funding calculations. Nevertheless, some still questioned whether all aspects of the model had been fully explained (discussed further in Section 3.2) or said they would have welcomed greater detail.

> *"I still don't one hundred per cent understand where every number comes from. So, there's a part of me, because I'm a control freak, that would really like to know where-, you know, I don't just want the spreadsheet, I want to be able to see the calculations behind each section in the spreadsheet. And, I'm not sure that we get that level of granularity."* Practice 6

Participants raised some queries about the scheme:

- Participants from one practice questioned why practices they perceived as already well-funded were also receiving HEP allocations.
- There was some uncertainty about how long the scheme would be in place. Participants from one practice explained that when HEP was introduced (as part of the PCFM) they had initially understood the funding to be permanent, but were now unclear on its future; another practice discussed how they understood the model to be an interim solution to be implemented until the Carr-Hill formula or GMS contract could be reformed to take the right factors into account.
- Participants from most practices discussed how they had understood (and welcomed) that HEP allocations were to be treated as a top-up to core funding, that they were free to spend it how they deemed necessary and were not subject to reporting requirements. Some were therefore bemused by subsequent requests from the ICB or the evaluation team to describe how the money had been spent.

3.2 Experiences of the funding model

Participants across the different practices described varied experiences of and perspectives on the HEP funding they had received, shaped largely by the year-to-year variability of the funding amounts they had received since the model was first introduced. The funding was broadly welcomed, particularly given the widely discussed need for greater investment in primary care, and participants from almost all practices wanted the HEP funding to continue (one practice no longer received HEP allocations). Most practices were very positive about what the funding had enabled them to improve within their practices (discussed further in Sections 3.3 and 3.4) and explained that they understood it was difficult for the ICB to satisfy everyone through the approach. Although participants from some practices discussed how funding for primary care remained insufficient on a per-patient basis, they attributed this issue to the wider system rather than to the HEP or the ICB.

However, participants from some practices reported more negative experiences and were critical of aspects of how the model had been implemented (including those who still valued the funding itself) since inception. As described in Section 2.2, participating practices were in receipt of varying amounts of funding, and these amounts also constituted differing proportions of each practice's total income, with some receiving funding that formed a significant part of their budget, while for others it was comparatively marginal. The changes in calculations made between different iterations of the model (particularly in the first funding period) affected practices involved in the evaluation in different ways: some saw significant reductions after their first payment (ranging from half the amount or all of it); some had had gradual reductions since the first payment; while for others the amount has stayed fairly consistent. It was the change in funding that appeared to influence views on the scheme, more than total amounts or proportion of funding, with the most critical comments from those whose practices experienced more significant changes.

In a similar vein to the queries discussed in Section 3.1, the change in funding was a surprise to many practice staff who had not expected this level of variation between funding years. Participants from one practice had expected the amount to be stable over five years and were surprised when (as they reported) they were told it would be altering with activity in later years of the model, or that the amount had to be renegotiated. This was highlighted as a particular problem for recruitment or strategic planning for practices as funding amounts were harder to predict (see Section 3.3). One participant described that with the Local Medical Committee (LMC)'s involvement, the funding amount had been stabilised in later years of the model and that this had made things easier for practices.

> *"So, some practices saw a massive spike and then drop, which of course if you're running a practice isn't terribly helpful. And, so, that was some learning that they've done, and then since then [the LMC have] agreed with them that it should be flattened over a three-year period to try and stop any, sort of, massive peaks and troughs of the funding."* Practice 10

For participants from practices that experienced significant reductions in their HEP funding after the first year, there were mixed views on the communication from the ICB explaining the reasons. One participant was accepting of the change overall and thought that the ICB had provided them with a level of detail they were comfortable with (considering themselves unlikely to ever understand the model's methodology). Others were less satisfied, stating that ICB leads had either not fully or effectively explained why changes to the calculations were necessary, or that they personally had still not been able to understand the reasons. Particular examples of this were:

- A participant from a practice that did not see a significant reduction understood the changes to be linked to spikes in disease prevalence during the pandemic, which skewed the data. However, they also said that this could have been communicated more clearly by the ICB.

One participant, whose practice had lost HEP funding, said the ICB later attributed the change to issues with the coding of patient records. They questioned this explanation and noted that they believed they had not received sufficient guidance on why coding was so important.

> *"So, the next year when they tried to explain it to us what I found a challenge was that… the way they explain[ed] it, this is all on coding. The more codes you do, the more information they're going to have to be able to determine what work goes through the practice and, therefore, what should be paid for it, but at no point… did people ever explain about what were the codes that they were searching for that would help them to get that information... We did nothing different between [the first two years]. It was purely a [mistake] in their calculations and things. So, that was very frustrating."* Practice 7

3.3 Implications for workforce planning

Most practices discussed how staffing was one of the main uses of the funding. They referred to increased staffing as a key lever to respond to healthcare inequalities and issues with access to primary care, including the number or type of appointments available and call wait-times. Many participants referred to the importance of increasing the skill mix generally to better meet patient needs. Specific roles that participants cited as beneficial to invest in, either through recruitment or upskilling existing staff, included: trainee or salaried GPs: specialist practice nurses (such as long-term condition or learning disability and autism nurses); operations managers and frontline staff (either full-time or additional hours); drug and alcohol workers; or staff with particular community language skills.

Whether practices used the funding for staffing appeared to be at least partially influenced by different attitudes to risk among key decision-makers (such as business managers or managing GP partners); they were described as ranging from being risk averse (needing more funding guarantees before recruitment) to those more willing to take calculated risks despite some uncertainties. The annual funding variations discussed in Section 3.2 also posed challenges for workforce planning for some practices. One city-based practice, serving diverse populations with complex language needs, described difficulties in recruiting staff without assurance of continued investment; the lack of long-term stability limited their ability to offer sustainable roles. Other practices, including another smaller city-based practice, pooled their HEP funding with their overall GMS allocation and other sources such as Additional Roles Reimbursement Scheme (ARRS) funding, and recruited additional staff on permanent contracts regardless. Participants from several practices acknowledged that if the HEP funding ended, it would consequently have significant implications for their staffing levels.

"In terms of how that money has helped us, we've been able to employ, you know, another GP, more reception staff and more admin staff. To lose that money, we'd have to then look at considering redundancy and getting rid of those extra staff. So, that's the impact. I mean, it's fantastic that we were given that money and we've used it to employ and improve the practice. But, to lose it, it will be devastating really." Practice 9

3.4 Service delivery and patient access

In addition to staffing, participants from across the practices discussed specific services or equipment that had been supported by HEP funding – to improve patient access, activities, outcomes or experience of care (see Figure 3.1). However, many found it difficult to identify specific items or initiatives funded solely through HEP, particularly in practices that received smaller allocations. Instead, as with staffing, they discussed resources, initiatives or purchases that HEP had contributed towards as part of their pooled budgets.

Participants described different approaches to spending decisions, shaped by local priorities and funding constraints. One participant explained that decisions often began with identifying which service offers could be improved, followed by determining the resources required to deliver them within budget. A participant from another practice described a more strategic approach, starting with annual meetings to agree on focus areas, such as specific conditions or population groups. Their team were guided by local inequalities when deciding how HEP funding could be used. Examples of particular services that these and other practices cited were:

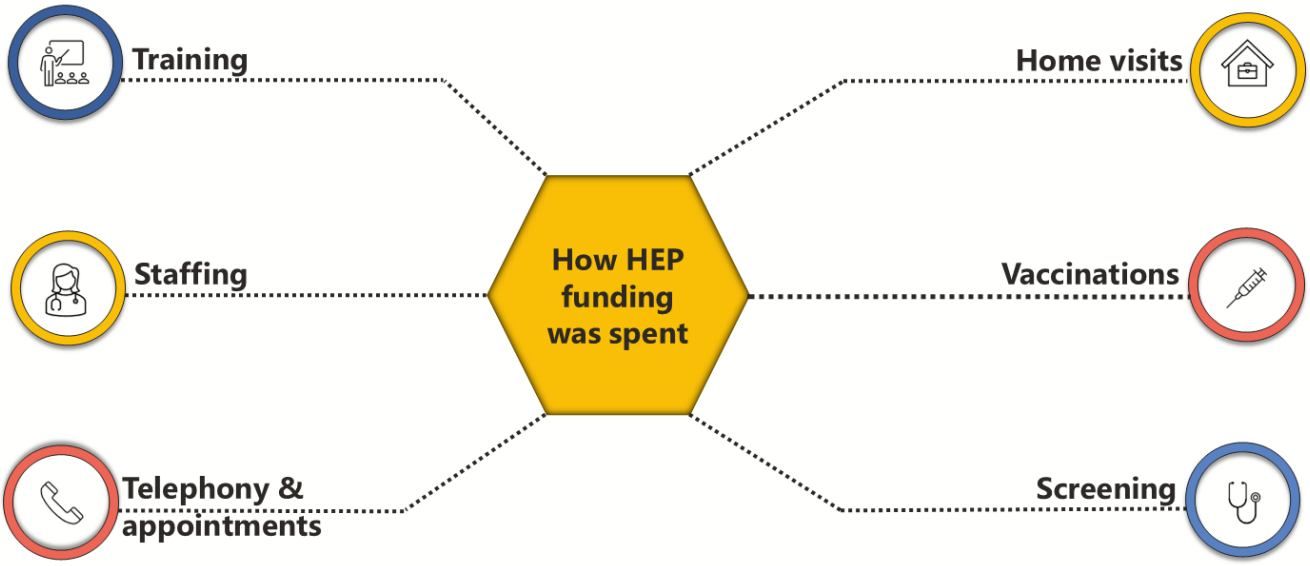
- Immunisation outreach for patients who had missed childhood vaccinations, supported by repeated communications, and additional clinics for a range of conditions
- Offering more systematic health checks for patients with learning disabilities
- Providing more preventative care to housebound patients (rather than reactive care when they become unwell)
- Longer and more frequent long-term condition reviews
- Running a targeted campaign to improve bowel cancer screening uptake among South Asian and British Asian patients, using regular reminders and culturally tailored video resources.

"You look at some of the data, like bowel screening, and one of the highest incidence of bowel cancer is in Leicester city. We'll have less uptake for bowel cancer screening, you know? It's just an example to highlight how we have, you know, all these inequalities and how you address it… even as we speak today, I've just sent almost six text messages to people who did not participate in bowel cancer screening, you know? And I personally sent them a message as to why it is important, how they can ring, it's such a simple test, all you have to do is to give a poo sample and it can detect, you know, cancer at a very early stage. So, we keep doing that. So, yes, this risk factor, because of South Asian population and the predominance, it does have an impact."
Practice 4

A practice that were not confident to use HEP funding to recruit additional staff due to its non-recurrent nature, used it instead to invest in a telephony triage system. This allowed patients with lower digital literacy to continue using landlines to request appointments. Other practices also emphasised the importance of maintaining telephone-based triage and booking systems, with one noting that their rural population was wary even of text message communications. Some practices also shared ideas for future investment or initiatives they hoped to pursue, although these were not necessarily constrained by HEP funding conditions alone. This included:

- Expanding the availability of longer or additional appointment times (already offered to patients with learning disabilities) to support older patients or those with literacy challenges who might struggle to use the NHS App
- Providing more women's health clinics (protected time to discuss a range of women's health topics)
- Getting involved in different primary care-focused schemes such as those relating to environmental sustainability or promoting physical activity
- Investing in (non-specified) Artificial Intelligence (AI) tools
- Improvements to premises, such as: expansion of space available for consultations; installation of lifts; and improving accessibility of clinical rooms more generally.

Figure 3.1 What did practices spend HEP funding on?



3.5 Impacts from HEP funding

3.5.1 Patient outcomes

Just as participants found it difficult to isolate specific activities funded through the HEP alone, due to the use of pooled budgets, they also described challenges in identifying outcomes that could be directly attributed to it. While many reflected on perceived benefits for patients, these were sometimes described as shaped by wider practice changes and overlapping funding sources. Nevertheless, several participants expressed confidence that the HEP had played an important role in achieving positive change within their practices. This included outcomes identified through internal data monitoring as well as those participants described based on their own observations and experiences.

Key outcomes supported by internal data monitoring by GP practices were:[16]

[16] To note, validation of this internal data analysis was outside of the scope of this evaluation.

- **Reduced call-waiting times.** Participants from a few practices reported internal data showing reduced waiting times on appointment phone lines, indicating improved access to appointment booking. They attributed this to a combination of factors, including upgraded phone systems, increased capacity to handle calls, and the introduction of alternative contact routes such as online platforms
- **Changes to patient satisfaction.** Participants from a few practices reported that they had observed an improvement in patient satisfaction scores on the Friends and Family Test (FFT) or the GP Patient Survey (GPPS). By contrast, participants from another practice reported that they anticipated a negative impact on scores following the recent introduction of an online triage system for appointments, which they anticipated that some patients would dislike. This practice was based in an affluent area, with a high demand for appointments
- **Improved activity rates and prevalence of conditions**. Participants from one practice reported that the HEP funding, pooled with other primary care funding, had been used to increase capacity for screening and diagnosis for long-term conditions, offering additional clinics. Subsequently, their practice data had shown improved performance on meeting targets for cervical screening and immunisation rates, as well as improved rates of diagnosis for conditions such as diabetes, chronic kidney disease and hypertension.

Other reported benefits of the funding for patients were:

- **Increased capacity to support prevention and/or management of long-term conditions.** Participants from a few practices reported that the funding gave them more capacity to provide more secondary prevention and management of long-term conditions. This included providing care plans and offering more home-based review visits to homebound patients
- **Specialist care available closer to home.** Participants from one of the practices reported that the additional capacity created by the funding allowed them to offer training to their clinicians who have a special interest. This enabled patients to be seen by a specialist GP from their own practice rather than needing to be referred on to secondary care.

"So, all these things have a positive impact, and if we've got more time then we can invest in having more services, be it enhanced services that get paid for, or potentially through a wish list through our clinicians that may have a special interest… one of our… GPs has got a special interest in [Hormone Replacement Therapy]. So… now rather than referring patients up to secondary care, she's got a special interest in that, so she deals [directly] with the vast majority of queries that we'd previously had." Practice 9

3.5.2 Practice outcomes

As with patient outcomes, participants reported practice-related outcomes which indicated they had some (potential) supporting quantitative evidence, and others based more on their perceptions of the impact (primarily as part of a wider pooled budget). This included a participant who discussed a potential link between the HEP funding and their increased QOF scores, due to a dedicated role focused on patient recalls.

"Yes, I think over the last couple of years our QOF scores have been better… I think our other thing is we've probably changed our recall processes and have somebody dedicated [to] looking after our recalls. So whether that's had an impact on our QOF scores being better, rather than it being linked to any of the other stuff… the Health Equity Payment probably allowed us to have that role… because we looked at it and it wasn't a role we had before… [so after] that we restructured and said 'Well, let's have this [dedicated] role'. That [HEP] payment probably allowed us and helped us to make that change in the team" Practice 3

Other reported benefits for practices included:

- **Ongoing viability of practice**. Participants from a few practices emphasised that ongoing HEP funding, even if pooled with other funding, was critical to sustaining their services, either keeping the whole practice operational, or preventing staff losses or serious financial strain (see Section 3.4)

- **Improved staff wellbeing.** Participants from one practice reported better staff wellbeing as a result of the increase in funding, due to increased capacity and reduced workload pressures
- **Improved staff retention**. Linked to this, one participant described that this improved staff wellbeing and the improved working environment had improved staff retention or encouraged staff to stay at the practice. In turn this reduced staff turnover had improved their practice capacity and enabled them to provide better continuity of care to patients, enabling them the choice to see the same GP if they wished.

"It has enabled us to ensure that we have got a good workforce now, that are happy to come into work, happy to stick with us. So, the resilience I think is far better, hanging on to staff is obviously far better. " Practice 9

3.5.3 Impact on relationships between stakeholders

There were mixed views about whether the funding programme had an impact on the relationship between GP practices and the ICB. While some participants discussed the challenges in communication between the ICB and GPs outlined in Section 3.2, others reported that they felt supported by the ICB and were aware of the challenges that they might be facing in administering the programme across the system.

"So, for us, we probably didn't feel that our relationships were impacted with the ICB or the CCG at the time, purely because at the end of the day, they hold the purse strings… if they're able to put additional funding out into primary care, then that's great, and we absolutely have to take it. So, you know, we probably understand that they're trying to balance their books as well, whereas I don't think everybody's got that insight. So, I think probably we might look at it slightly differently because of that experience I've got from a past life." Practice 3

Some participants described tensions arising between GP practices from comparisons of funding allocations to different practices relative to practice populations. Participants reported this both directly, referring to their own views, and indirectly, through accounts of reported negativity from other practices that also felt disadvantaged or excluded from the funding.

In addition to the LMC, interview participants identified primary care network (PCN) leads as stakeholders playing a key supporting role, providing a useful mechanism for GP practices to discuss the model and share information and learning about it with others.

3.6 Suggested improvements

Practices made suggestions for improving the HEP scheme in the future. Some of these suggestions were activities that had already been undertaken by the ICB (as outlined in Section 1.1)

indicating differing levels of awareness and potentially emphasising the need for refresher engagement activities.

- **Transparency of funding**. Some practices expressed a preference for funding amounts and the calculations within that to be more clearly broken down and easier for practice staff to interrogate (for example, values and calculations linked to communication needs, or frequency of certain case types)
- **Consistent payments**. Although the three-year cycle was welcomed, annual recalculations continued to pose challenges; and some practices called for longer-term or recurrent funding to facilitate future planning, including recruitment, training and changes to staff skill mix
- **Payment included in the core contract/sum.** To enable recurrent funding, some participants called for the HEP to be incorporated into the general medical services (GMS) monthly payment at a local level, although they were uncertain about the likelihood of such suggestions being acted upon
- **Reviewing the scheme.** One participant suggested that the HEP scheme and the funding formula could benefit from evaluation by independent academics/experts for external 'validation' via peer-reviewed publication. The participant thought that this would help to identify improvements, such as updating the funding formula or identify alternative schemes with equally good, or better outcomes
- **An awareness campaign.** A campaign to raise the profile of the scheme to address misconceptions and feed into the national agenda by explaining further where money has gone, why and the impact it has had
- **Responsiveness of the central finance team (ICB)**. Participants from some practices described difficulties in communicating with the ICB finance team and suggested that more timely email responses would support practices seeking information or advice.

Some broader suggestions, offered not as critiques of HEP, but as ideas participants felt would strengthen similar future funding models, included:

- **Communications about the scheme.** Participants suggested that key activities for socialising a model would include webinars, in-person meetings, or drop-in sessions for answering practice queries or providing reassurance. One participant suggested that the opportunity for practices to book personal slots could help discuss practice-specific questions
- **Using up-to-date data**. One participant discussed, in detail, the benefits of keeping funding models updated with as current data as possible

- **Limited or timely introduction of Key Performance Indicators (KPIs)**. Although a few practices acknowledged the importance of evaluating or monitoring how the funding was used, they emphasised the need for any expectations, such as KPIs, to be clearly communicated from the outset of the scheme and kept to a manageable number. Other practice staff considered that the funding should be treated as part of core funding, without additional reporting requirements or conditions attached.

4. Conclusions and recommendations

4.1 Conclusions

The qualitative evaluation research generated rich findings on how the HEP funding model has been experienced and applied across participating practices. They offer insight into both the perceived value of the scheme and the practical realities of its implementation, as well as the ways in which funding has been used to support service delivery and care. The sections below highlight key conclusions and reflect on the overall implications of the findings.

4.1.1 HEP funding model implementation

The evaluation found strong in-principle support for the HEP funding model among most participating practices, including those who reported some more challenging experiences with their individual practice allocations in the initial years of its introduction due to recalculations of allocations based on refreshed data.

Many participants highly valued the additional funding, with some describing it as central to their ability to deliver ongoing (and improved) patient care. There was widespread support for the scheme (or similar) to be continued, and concerns were raised about the potential withdrawal of funding, which many felt would risk undermining progress made.

Nonetheless, it is important to acknowledge that some interview participants had a less positive experience with the implementation of the model than others, particularly in its early years. Yet, some of the suggestions for improvements and queries from participants related to changes already made or actions already taken by the ICB (according to documents reviewed as part of the research scoping stage). For example, detailed explanations of the funding calculations were made available, but may not have reached all intended recipients or been fully understood. This suggests that there may have been gaps in how information was accessed, interpreted or cascaded within practices. Communication strategies should continue to be reviewed and refreshed in any future implementation planning and ongoing engagement efforts to ensure clarity and equitable understanding across all practices.

4.1.2 Uses of HEP funding

Practices described a range of approaches they had taken, supported by HEP funding, to improving access, respond to health inequalities and improve patient experience (supported by HEP funding). This included investment in telephony systems which support those with lower digital literacy, more flexible appointment models for population groups who require more frequent or longer appointments, and preventative rather than reactive home visits. However, staffing (the recruitment of additional or a broader mix of roles, or increased hours for part-time staff) emerged as the most consistently cited area where practices felt HEP funding has the potential to have the greatest

impact, particularly if placed on a more stable and predictable footing. Recurring funding amounts as part of allocations would make this more feasible.

Although interview participants were often unsure whether outcomes could be directly attributed to HEP funding, particularly where it was absorbed into general practice budgets, their reflections on changes identified through internal data monitoring offer promising indications of its potential impacts. The reported improvements in FFT scores, GPPS responses, and reduced call waiting times, which participants at least partly linked to the HEP, suggest the possibility of meaningful change as a result of this kind of funding.

4.1.3 Looking ahead

The evaluation findings reinforce the rationale behind NHS LLR ICB's decision to address limitations in the global sum allocation formula, particularly for those GP practices working with patients experiencing healthcare inequalities or poorer determinants of health. There was broad consensus amongst participants that funding should continue, with several explicitly expressing a desire for that to be via a reformed, nationally coordinated mechanism. The need for reform to national funding has since been recognised in the recent NHS 10-Year Plan[17] and highlighted in other reports[18] which also argue for targeted (increased) investment in GP practices in areas of higher deprivation and complexity. Such an approach would move beyond the limitations of a local pilot, offering a pathway to more consistent, equitable and enduring improvements in primary care. This evaluation highlights the value of taking the HEP approach within LLR and underscores its relevance and potential for scalability at a national level.

4.2 Recommendations

Based on the evaluation findings and conclusions (including, but not limited to, explicit suggestions from participants), Box 1 outlines recommendations addressed and aimed at different relevant stakeholders. They relate to different potential recommended future scenarios, including the adoption of an alternative funding model at a national level, at an ICB level (in other ICBs), and/or the continued implementation of HEP within LLR.

[17] Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future [Accessed 03/09/25].

[18] See as example: Fisher R, Loftus L, Holdroyd I and Ford J (2024) *Fairer funding for general practice in England: what's the problem, why is it so hard to fix, and what should the government do?* Briefing, Nuffield Trust and Health Equity Evidence Centre.

Box 1: Evaluation recommendations:

For national stakeholders:

- As part of meeting 10-Year Plan commitments, consider the HEP model as a pilot for wider reform, addressing limitations of the Carr-Hill formula and embedding equity into national funding mechanisms, to ensure sustainability and reduce reliance on short-term top-ups
- If alternative models are considered for national piloting, consider providing funding without restrictions, modelling the way current core funding is provided
- If KPIs are deemed necessary (for evaluation purposes), align them with existing data collections, such as QOF or GPPS, to avoid duplication and make impact tracking more manageable for practices and ICBs
- Ensure transparency in the communication of any future changes to funding models, including by providing detailed practice-level rationale, to build trust and accountability
- Support efforts to raise the profile of, and share learning from, local equity-focused funding models and share impact stories across systems.

For ICB stakeholders interested in implementing HEP or an alternative model:

- Engage early and consistently with practices to build understanding and trust. Use varied formats such as webinars, drop-ins and tailored one-to-one sessions to explain the model, its rationale, and how allocations are calculated
- Ensure transparency in the funding methodology, with clear documentation that breaks down calculations and links them to population need, activity, and deprivation
- Tailor communications to different levels of financial literacy across practices and consider piloting documentation with a small sample of practices to check for levels of comprehension
- Embed engagement into existing forums such as PCN meetings or locality briefings to share or refresh understanding of the model and gather feedback
- Support light-touch impact monitoring by providing a basic template or checklist for practices to track HEP-related changes (such as staffing, appointment types, patient feedback), without requiring new systems or reporting burdens
- Provide funding allocations which are stable over longer periods to help practices plan and recruit staff with more confidence
- Use current and locally relevant data and be clear about how data quality (such as coding completeness) affects funding. Offer support to improve data quality where needed and feasible within ICB resources
- Anticipate variation in practice awareness and capacity and consider refresher engagement activities to reinforce key messages and address misconceptions – especially if similar schemes have been trialled before

- Facilitate peer learning through existing networks. Encourage practices to share examples of how to use funding effectively via PCN leads or informal case studies, rather than formalised learning events.

For NHS LLR ICB:

- Continue to provide HEP funding at a local level to address inequalities, subject to any potential national funding reform
- Maintain activities which align with the ICB-specific recommendations above which have already been implemented
- Review or refresh communication activities to respond to any ongoing gaps in understanding about the model and funding allocations
- Continue to collaborate or share learning with other ICBs interested in implementing similar funding models.

For GP Practices within LLR:

- Engage proactively with national or ICB communications to ensure awareness of funding conditions, updates, and opportunities for input into future iterations of the HEP model or reforms to national funding model
- For HEP-funded practices, where resources and workload permit, consider strengthening internal data monitoring to better evidence the impact of HEP-funded changes, especially around access and patient satisfaction
- Share learning across practices, through local mechanisms such as PCNs or the LMC on examples of funding for staffing, service redesign, and infrastructure improvements which have provided benefits for individual practices.

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