

NHS Clinical Commissioners' response to NHS England's Digital-first Primary Care: Policy consultation on patient registration, funding and contracting rules – August 2019

About NHSCC

1. NHS Clinical Commissioners (NHSCC) is the membership body of Clinical Commissioning Groups (CCGs). Established in 2012, we have nearly 90% of CCGs in membership. We offer a strong national voice for our members on policy issues and support them to commission services effectively for their local populations.
2. Clinical commissioners fully support the right of patients to have access to a digital primary care as envisaged in the Long-Term Plan for the NHS. We welcome the opportunity to respond to this consultation as it raises several issues for CCGs. The vast majority of CCGs have delegated authority to commission primary care.

Overview

3. Technological innovations hold great promise for improving patient care and health outcomes, increasing access to health services and promoting patient choice, enabling patients to see the right professional at the right time, and thereby providing workforce resilience – but only if those innovations are properly supported, resourced and implemented.
4. We live in a digital world. We use digital platforms in most other functions of daily life such as banking. There is clearly a demand for digital services which has led to the emergence of products such as those offered by Babylon GP at Hand (BGPaH).
5. These services provide convenient access to GP consultations for their patients. However, these models risk destabilising general practices in a number of ways:
 - they tend to attract healthier patients. As GP funding is based on an average patient, weighted for age and not health needs, it in effect shifts funding away from traditional general practice which is needed to care for patients with more complex health needs
 - they risk creating more demand for GP services
 - they risk siphoning GPs from already-strained practices, reducing GP practice sustainability.
6. We also note the wider challenges listed in the consultation - namely that having a digital-first primary care provider which is not geographically based where patients live can impact on integration efforts. For example, the effective delivery of integrated local health services, the drive to use a population health management approach, addressing health inequalities and delivering screening. Yet these proposals do not attempt to tackle these. These are essential components of primary care in future.
7. Whilst discussing this consultation and the arrangements for digital-first primary care providers, we understand the intention is for them to be part of Primary Care Networks (PCNs). In this way, they should therefore be involved in tackling health inequalities and

using a population health management approach, but there is no clarity yet on ensuring they will be delivering the prevention and demand reduction expected of this way of working.

8. Growth in digital-first primary care providers will only increase, not slow down. We recognise that the current rules need to change to reflect these new services. The proposals outlined in the consultation raise a number of questions and implications for CCGs. We respond in detail below.
9. Our members have raised concerns that the approach outlined in this consultation does not do enough to help deliver and expand digital primary care from existing primary care providers. We understand that digital-first providers are just one piece of the puzzle. We encourage more communication from the centre about the entirety of the digital support offer and plans to achieve it. Not enough context was given for this consultation which resulted in incomplete information being given. Without having more detail on the framework for digital suppliers that NHS England are working on, our members were concerned that these proposals suggested that adapting to BGPaH was the only approach being pursued.
10. Our view is that a digital offer must do more than provide convenience of access and choice, but also promote the future vision for the integration of primary and community services via PCNs. Digital applications should certainly not undermine general practice or continuity of care. Therefore, the best way to deliver digital first primary care is to invest in practices and PCNs to offer digital services to their patients - ensuring patients can see a healthcare professional face-to-face when they need to and enabling them to link in with other local services.
11. It is therefore reassuring that NHS England has noted in the introduction to the consultation that *“One important step is to help existing practices digitise their offer. NHS England has already committed to a programme to support practices and commissioners to do that via a framework for digital suppliers to offer their platforms and products to primary care on standard NHS terms for use from 2021. The creation of Primary Care Networks (PCNs) will see them play an essential role in supporting practices and other partners to deliver a comprehensive digital offer for their patients and integrating these services across a local area.”*
12. We urge NHS England to make this framework clear and tackle questions that have been raised during this consultation.
13. We believe there should be ongoing monitoring and evaluation of these proposals – this is a live area where solutions may need to be revisited. There has also not been very much time to test these detailed proposals with our member CCGs, and their impact still needs to be ascertained depending on each CCG’s circumstances.
14. We are also concerned that there is a changing CCG landscape, and need to consider the implications for these proposals in relation to forthcoming mergers of CCGs.

15. We have also seen suggestions that digital-first primary care should not be viewed as a replacement to 'traditional' general practice, but another component, like the 111 service.¹ This would therefore mean digital-first primary care providers would not be eligible for a registered patient list. We understand that this would be difficult to achieve given there are already contracts and registered patients in place, and that a solution for the existing situation does need to be found. There is still the potential that digital primary care could be treated like an out of hours service – that was up to providers to opt into providing their own or not. If a local practice decided not to deliver their own digital offer, then the CCG would be obliged to contract a provider for these patients.

Response to consultation questions

Chapter 1 – Out-of-area registration

The proposal is to amend the out-of-area registration rules so that where a practice exceeds a threshold number of out-of-area patients in any CCG (we propose to fix this somewhere between 1,000-2,000 patients in any CCG, subject to views from consultees), then their main contract will be automatically disaggregated. They would separately be awarded a local APMS contract in that CCG, through which to serve those patients, meeting all normal requirements including access to physical premises where required. Those patients would no longer be out-of-area patients.

Q1a. Do you agree with the principle that when the number of patients registering out-of-area reaches a certain size, it should trigger those patients to be automatically transferred to a new separate local practice list, that can be better connected with local Primary Care Networks and health and care services?

In principle the creation of a new, local list would be welcome in continuing the geographical and population-based link between primary care funding and provision. We support this proposal as it means that commissioners do not have to fragment their existing mental health and community provider contracts because many of their resident population are registered with a GP practice hosted in another CCG.

However, we have concerns about this being automatically triggered: this means the CCG will have no autonomy about this, and poses questions about how they would be commissioning to ensure quality.

There would therefore need to be a formal process to manage the creation of a new contract, rather than an 'automatic right' to a new contract. Commissioners must be able to quality assure the provider, input into the content of the APMS contract, review any estates implications and costs and understand the impact on Primary Care Networks.

Q1b. Are there any factors which you think should be taken into account if this option were to be implemented?

The timing of any new contract would be important, particularly on any commissioned services with quarterly or annual targets.

The length of the APMS contract would need consideration too, as well as clarity as to what the arrangements would be at the end of the contract term and who would be eligible to run the service.

APMS contracts ordinarily allow significant CCG discretion and allow for the purposeful procurement of primary medical services, and under these arrangements we would expect the same assumptions to apply.

Any local CCG contract should have a requirement to formally partner with a local GP contract holder. This would ensure the patients are covered by an appropriate PCN, have access to estates, and are integrated into the local health economy. This formal partnership should be a clear pre-requisite to any contract award.

It is also important to consider how this proposal will need to adjust to the forthcoming CCG mergers – CCGs will have considerably larger populations and cover wider geographies. They will probably be establishing new ways of locality or place-based working within a newly merged CCG, but may mean that these rules about out-of-area patients and local practice lists will need to adjust based on how larger, merged CCGs describe their more local constituent parts.

Q1c. Please provide any views you may have about the proposed threshold of 1,000-2,000 patients for the triggering of this localisation.

We have heard from our members that there are mixed views about an appropriate threshold of patients to trigger a new local contract. Some examples have been given that suggest a financially sustainable list would need to be over 3,500 patients, and others have said that a list of under 6000 patients is usually assessed for ongoing viability. This may suggest that 2000 patients as the threshold is too low and could lead to an unfair market advantage to digital-first providers under the current APMS contract structure, as it assumes they will be holding this contract and will be able to serve a smaller patient list because it is just one part of their overall business.

However we have also heard that it would be preferable to have a lower threshold so that the costs of locally commissioned community and mental health services are covered for the patients who were registered elsewhere. Some CCGs have suggested that if 300-400 patients deregister and move to an out-of-area, digital-first provider, this also has the potential to destabilise funding, so it is important there is something in place to reflect patient movement.

It would be useful to know how many CCGs would currently be affected by this and therefore where a new contract would be created – and how many are close to a potential threshold. As this would create a cliff-edge, it may be useful to know if there are ways to give an early warning about a CCG approaching a threshold.

There also doesn't seem to be any detail about what happens if this new practice list drops below the proposed threshold as patients may de-register – does they CCG then go back to the quarterly funding reallocations proposed in chapter 2? This ongoing 'churn' and the accompanying instability in funding may mean that planning is impossible. It will need to explain what is the CCG's obligation in relation to practice resilience as patients re-register or list sizes are too small to withstand costs.

Q2. Do you agree that, although the service obligations are not identical, given the small scale of any possible change and the burden of its implementation, payments for out-of-area patients should remain the same as those for in area patients?

Yes. However, efforts should be made to improve recording of 'out of area patients' – as noted in the consultation the extent of out of area patients is not well known, and nor are patients' reasons

for registering out of area.

Chapter 2 – CCG Allocations

The proposal is to change the allocations system to enable quarterly recalculation of CCG funding to reflect patient movements of the sort which have been stimulated by registration with digital-first practices in London

We understand that for London, the non-recurrent fix proposed is a transfer of resource by inter authority transfer based on actual cost of treatment for patients whose registration has moved. Due to the transient population in London, it is important that any proposals recognises that a patient may have moved several times – so adjustments need to be made based on the current home address. Although this creates an administrative burden, it does ensure the funding is in the relevant CCG, and basing it on actual cost of treatment ensures it's not just based on a theoretical level per capita, as this would not reflect the generally low level of need for the cohort in question.

Going forward, and where the threshold for a new local contract has not been triggered, another solution is needed.

Q3a. Do you agree with the principle that resources should follow the patient in a timely way where there are significant movements in registered patients between CCGs as a result of digital-first models?

We agree there does need to be a method for resources following the patient, but this may have been solved by the proposal in chapter 1.

However, our members have said that any adjustments should not be made 'in year' as this would create instability and the inability to effectively plan. Quarterly changes would also lead to a significant administrative burden. Therefore any adjustment below the creation of a new local list should be made annually at most.

Some CCGs have said that if new local lists are created, as suggested in chapter 1, they are in favour of no adjustments being made to allocations as digital-first primary care is just one reason why CCG allocations and patient registrations are mismatched.

Q3b. For these purposes, how do you think "significant" movements in registered patients should be defined?

Q3c. What threshold, if any, do you think should be applied to the flow of out-of area patients to a CCG before this adjustment is applied?

As suggested, it may be that this should not be pursued given the administrative burden of calculating an accurate adjustment. It also singles out digital-first primary care provision as a unique case whereas CCGs (especially in London) have said that patient movements are common and that the need to link funding back to the 'source geography' of the patient is embedded within the proposal to create new local contracts.

Q3d. Do you think it is necessary to cap or restrict the maximum deduction from any one CCG on an in-year basis?

If there was any deduction it would be necessary to cap the deduction so that CCGs are not subject to untenable uncertainty and fluctuations in their funding. It also may mean that an underfunded CCG is sending funds to an overfunded CCG. This cap should be based on a percentage of their five year plans that all CCGs have submitted to NHSE. This will ensure that minimal disruption to health provision is incurred.

In addition any funding transferred will need to be transferred back to the local CCG at 100% - no cap applied.

Q4. Do you agree that a capitation-based approach is the best way to determine the size of the adjustment required per patient or do you have other proposals?

A capitation-based approach does not feel fair, even with adjustments for age and sex, as those using digital-first primary care are likely to have less complex health needs. Calculating actual spend against the registered list (although there are issues with this given the 'paying' CCG would have little leverage to manage this cost, e.g. prescribing programmes, admission avoidance schemes etc), or a more sophisticated capitation that reflected the average cost of digital first provision might be alternatively considered.

It would be useful to use actual workings to understand the impact of capitation based or actual treatment costs.

Chapter 3 – New Patient Registration Premium

We will not make further changes to the GP payment formula for newly registered patients at this point. We conclude that scrapping the premium would be unfair given the extra work as well as undesirable given the huge redistribution effect it would have in practices with highly transient populations. But we do propose to pay it only if a patient remains registered with a practice for a defined period. We are inviting views on that period, and suggest somewhere between six to twelve months;

Q5a. Do you agree that we should only pay the new patient registration premium if a patient remains registered with a practice for a defined period?

It may be better to distinguish between existing practices and digital-first providers when it comes to paying the new patient registration premium.

Our members have suggested that only paying a new patient registration premium if a patient remains registered for at least 6 months could lead to instability for practices where there are high levels of patient turnover. The premium exists to reflect the additional work often required when a patient first registers with a practice, and due to the transient nature of the population (especially in London), many practices would not be adequately resourced to undertake this work. Patients may leave practices before a 6 month minimum period, having needed significant levels of care, through no fault of the practice or the service provision on offer. This would consequently deter practices from registering new patients and ultimately restrict choice for most patients.

There have been suggestions that due to the different demographic served by digital-first providers, and the different expectations, they should not receive the premium.

Q5b. What do you consider to be the right period of time for a patient to be registered with a practice for the practice to be paid the new patient registration premium? Six months, nine months, twelve months or other?

Although you have presented data about most patients de-registering within 6 months, if digital-first providers are paid a new registration premium then this should be when a patient is retained for a period for at least 9 months.

This will need to look at how it effects practices with large care homes in their lists.

Chapter 4 – Harnessing digital-first primary care to cut health inequalities

The proposal is to use practice entry rules to address the inverse care law in general practice. We suggest allowing new digital first practices to register patients in our most under-doctored geographies– for example, CCGs in the bottom 10 or 20%. And require these new practices to meet three strict criteria: (i) demonstrate that the GPs they will be bringing into the local community are wholly additional; (ii) ensure the physical part of their service also covers the most deprived areas of the CCG; and (iii) actively promote their service to the most deprived communities, so that their lists properly reflect the make-up of the local population. In this way, the NHS could harness the potential of digital-first providers to reduce health inequalities. We propose to do this through national rules rather than local commissioning;

Q6. Do you agree that we should not create a right to allow new contract holders to set up anywhere in England?

Yes. New service provision should be based on need, and identified by the local commissioners.

Q7a. Do you agree we should seek to use the potential of digital-first providers to tackle the inverse care law, by targeting new entry to the most under-doctored areas?

We have been seeking input from CCGs representing under-doctored areas. There is some hesitation that this will achieve its aim, and this should not be the only effort made to tackle the inverse care law. Currently, digital-first provision is mainly used by young and reasonably fit adults. Therefore this proposal could further disadvantage people with more complex needs in these under-doctored areas

Q7b. What methodology could we apply to identify these areas, specifically those that are under-doctored?

There should not be a national methodology, it should be based on local need identified by the CCG.

Q7c. Do you think that opportunities should be made available to a wider range of local areas in future following any successful evaluation?

Digital-first provision is currently limited in the services it offers (e.g. no home visits.)—Although restrictions on the types of patients who can register have been lifted, the NHS England factsheet still says “It’s not the case that those with mental health issues, who are frail or are pregnant cannot be registered but for some, this type of digital or remote care model may not be clinically appropriate. Therefore these patients would be advised of that by the practice.”ⁱⁱ

Therefore it should only be available in wider areas if these limitations are addressed.

Q7d. Do you agree with the proposal to require new contract holders to establish physical premises in deprived areas of a CCG?

Q7e. If we require new contract holders to establish physical premises in deprived areas of a CCG, what methodology could we apply to identify such areas?

Establishing a physical premises in a deprived area may not necessarily mean the practice ends up serving more deprived people - in some parts of the country lower super output areas designated as more deprived are in very close proximity to a more affluent area, and could still end up being inequitably used. It may be more useful to engage with the CCG to ensure better understanding of void space, proximity to neighbouring practices, needs of local population. It should be up to the CCG to demonstrate need in terms of health outcomes, distance and underserved areas.

Q7f. Do you agree with the proposal to require new contract holders to demonstrate that they will bring additional GP capacity to the local area?

Yes, but 'capacity' should not just be about physical space but input to PCNs and wider primary care priorities.

Q7g. Do you agree that we should require new contract holders to seek to ensure that their registered list reflects the community they are serving?

Yes – this is an expectation of all primary care providers.

Q7h. Do you agree with the proposed approach to avoiding local bureaucracy by awarding contracts on the basis of satisfying agreed national criteria?

Although we understand the desire to reduce bureaucracy, we would like to know:

- How long would the NHS England approvals process take?
- How often would it be updated?
- What if the CCG has already contracted local services that don't make it onto the national list?
- Would a national process comply with the NHS to operate in a fair and open way, and with sufficient public engagement?
- How will the CCG be able to ensure it has sufficient levels of input, to ensure the new contract reflects the needs and circumstances for specific areas?

It therefore seems preferable to use existing the APMS approach.

Q8. We also suggest that as part of these potential new national rules, we could remove the need for most local APMS procurements by looking to PCNs as the default mechanism for maintaining primary care provision. Alongside these potential changes, do you agree that PCNs could become the default means to maintain primary care provision, thus removing the need for most local APMS procurements?

PCNs offer many opportunities but they should not be seen as a panacea, as they are being expected to deliver on many things and are in varying states of maturity. CCGs have expressed that there are some challenges with regard to APMS procurement such as disruption and instability for practices, patients and staff; restriction to a small number of established providers, with significant variation

in quality and outcomes, and the short term nature of the contracts creates disincentives for provider investment and results in a higher cost to the health economy in general.

However, APMS procurements do allow opportunity to purposefully commission primary medical services that reflect the needs of the local population. They provide commissioners with the opportunity to be deliberate in estates and service planning in a way that GMS and PMS contracts do not always allow. The terms of APMS contracts also allow for clearer and more purposeful contract and performance management. So, whilst we strongly welcome an opportunity to move away from APMS procurements there would need to remain provision for local CCGs to determine the content of new contracts alongside the PCNs, to ensure that provision continued to evolve to best meet the needs of local patients.

For further information, please contact Sara Bainbridge, Head of Policy and Delivery via s.bainbridge@nhscc.org

ⁱ <http://www.pulsetoday.co.uk/news/hot-topics/gp-contract-2019/20/out-of-area-regulations-should-be-scraped-says-bma/20039255.article>

ⁱⁱ <https://www.england.nhs.uk/london/our-work/gp-at-hand-fact-sheet/>