BMA

Digital-First Primary Care: Policy consultation on patient registration, funding and contracting rules

Date August 2019

Executive Summary

- 'Digital-First Primary Care Policy: consultation on patient registration, funding and contracting rules' was published by NHS England on 27 June 2019
- The paper sets out proposed changes to patient registration, funding and contracting rules and makes suggestions for tackling workforce shortages, particularly in under-doctored and deprived communities. It sets out options and includes a number of questions for response
- NHSE state they want to help practices digitise their offer; Primary Care Networks will 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
- The growth in new digital GP providers allowing patients the choice to register with them directly and contact the practice through an app
- The current GP patient choice scheme allows them to register with practices miles from their home making it hard to deliver integrated local health services and is impacting on the way they are funded; the distribution of general practice funding must be fair.

The proposals

- It is proposed that the current Patient Choice Scheme is amended so that:
  - money follows the patient;
  - existing GP surgeries can expand and improve their own digital services; and
  - digital-first providers can register new patients in areas where people can't currently access digital GP services
- Changes to the out of area registration rules to allow a maximum number of such patients before disaggregation of the main contract
- Changes to the allocations system to enable quarterly recalculation of CCG funding to reflect patient movements
- Changes to the new patient registration premium
- Changes that could allow other digital providers to set up and start registering patients in any part of England
- Changes to allow new digital first practices into the most under-doctored geographies only – for example, CCGs in the bottom 10 or 20%
- Changes to remove the need for most local APMS procurements by looking to PCNs as the default mechanism for maintaining primary care provision.

GPC England view

- The out of area regulations should be withdrawn, they allow digital providers to prioritise largely healthy patients and short-term care over patients with more healthcare needs and continuity of care for a local population in order to profit from this arrangement
- We do not agree with the proposal 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
- Regarding funding, we propose that payments to patients who have historically been registered with a practice and have retained that registration when moving out of area and making use of the regulations remain the same. Should the out of area regulations be retained, a reduced payment should be applied to patients who have registered with a Digital First provider using the regulations
- We 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 that the new patient registration premium should only be paid if a patient remains registered with a practice for a defined period, if they have registered as out of area, other patients should not be subject to this proposal
- There need to be restrictions on allowing new contract holders to set up anywhere in England
- We do not agree that digital first providers have the potential to tackle the inverse care law, by restricting any new entry by them to the most under-doctored areas, existing GMS contract holders should be supported to provide services in these areas instead
- We do not agree with the principle that PCNs should become the default means to maintain primary care provision. PCNs have been established to better integrate existing providers of primary care services. These providers, particularly GMS practices, should remain the route through which primary care services are provided.

Introduction

GPC England is not opposed to new initiatives that could improve services to our patients and that aim to tackle workload pressures in general practice, whether these are developed by GPs/practices, NHS England or other local NHS organisations. We also recognise the opportunities and benefits the increased use of mobile technology could bring and believe it is essential that all practices are supported to develop their services where it is appropriate to do so. This is dependent on NHS England commissioning, funding and providing the necessary hardware, software and broadband capacity. However, this consultation needs to be clear about what sort of model of provision NHS England wants to promote.

The five-year framework for GP contract reform set out how the best way of digitising primary care will be to help existing practices, and the NHS Long Term Plan announced that a new centrally-funded programme would create a framework for digital suppliers to offer their platforms on standard NHS terms. Both imply that what is being developed is a digital first model, which if properly funded, we would welcome and not a digital only model, which would be detrimental to patient care within general practice.

This consultation doesn't disguise the fact that one practice, Babylon/GP at Hand has caused considerable difficulties by its exploitation of the Patient Choice Scheme and out of area regulations, both to neighbouring contract holders and Hammersmith and Fulham CCG. While we have addressed the questions as presented within the consultation, we suggest that the way to resolve the problem created by Babylon/GP at Hand's operation is not only to properly fund and enable every practice to have digital access, but to separate GP at Hand from the registered patient and instead link it to NHS 111. Patients are clearly using GP at Hand in the same way they would NHS 111. It therefore would be more appropriate, rather than making the current system more complicated, to instead use Babylon/GP at Hand as an adjunct to NHS 111 to triage and where appropriate treat patients and decide whether they need to see their registered GP or not, without the requirement for patients to be registered with them.

Section 1: Out of area registration

Question 1a. 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?

As previously stated, we believe that the out of area regulations should be withdrawn as they are not in line with wider NHS England policy relating to population-based health management and are no longer required due to the greater use of telephone, and in the future digital, consultations via existing practices. The regulations, furthered by the proposals in the consultation, give the potential for largely healthy patients and short-term care to be prioritised over predominately multi-morbid patients and continuity of care for a local population in order to profit from this arrangement.

The proposals within this consultation create a more complex system to accommodate new digital first providers in a controlled manner, and to resolve issues that have been realised by the piecemeal way digital first provision has been implemented up to now. It would be very difficult for CCGs to manage an unlimited number of new APMS contracts being forced upon them. Furthermore, the proposals seek to avoid NHS England and Commissioner responsibility for investing appropriately in all practices to achieve a fair and consistent digital first offer to patients. Providing the funding, resources and ability for all practices in England to provide safe and appropriate care via a digital first platform would negate the need to introduce the proposals within this consultation and would cause the out of area regulations to become redundant.

The operation of the scheme, enabled by the regulations, is particularly problematic where practices have used it in a way that was not intended. Over 125,000 patients have registered as out of area, but these are not evenly distributed across England and there has been an element of market distortion as a result.

For these reasons, we do not agree with the proposal of creating a new contract for out of area patients once they reach a certain level.

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

While we do not agree with the proposals, if they are implemented, it is essential that those patients transferred to a new local list are treated as in area patients with an agreed practice area and that the right to discriminate on grounds of medical condition that exists under the current out of area regulations is removed. It would then also mean there would be an obligation to home visit where necessary. To be explicit, what we are arguing for is for the full spectrum of national and local contractual requirements to apply.

It is not clear whether this option, if adopted, would mean practices would be eligible for the additional newly registered patient payment, this must be clarified before we would be able to support it.

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 think this is at the upper level in terms of a figure to be considered and that it should be as low as 500 within the PCN boundary, however we would welcome some financial modelling here and in regard to question 7e. We are also not clear whether the contract would be lost as soon as the patient numbers fell back below the particular threshold set and with the rapid registration and deregistration of this group of patients, this could create a very unstable situation. We are also concerned that the impact on CCGs having, in effect, potentially to commission new practices of a relatively small size, risks having significant workload and cost implications for them, detracting from more important activity.

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?

When this issue was considered in 2018 as part of the negotiations, the emphasis was on reducing the payments for out of area patients and we were concerned this would impact practices who had initially registered out of area patients and who delivered a wide range of services to them. For many practices, out of area patients present more often to their GP than in area patients (hence wanting to remain with the practice when they move out of the practice boundary); we therefore argued that reducing the payment for such patients would be inappropriate.

The current proposal is to keep payments the same, because it would avoid the administrative burden of practices reviewing their patient lists to ensure accurate recording of out of area patients. However, we think this fails to take into account the issue of cherry picking of patients who have relatively simple healthcare needs and who are the target of digital first providers.

We therefore propose that payments to patients who have historically been registered with a practice and have retained that registration when moving out of area and making use of the regulations remain the same. However a different and reduced payment should be applied to patients who have registered with a Digital First provider using the regulations.

Section 2: CCG allocations

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?

It is hard to argue with this principle bearing in mind the impact that a single digital first provider has had on one CCG in London. However, as stated above, this would not be an issue if the resources were provided for all practices in England to provide digital first services to their patients.

If this principle is implemented it should be done so fully to ensure that resource follows the patient and activity carried out for that patient is down to the practice that delivers the service. We know that in the current system, where a patient is only registered for a short space of time, services provided are often not recompensed.

It is worth noting that we have previously advocated that resources should follow the patient in a more timely way for all registered patients, rather than payments on a quarterly basis. This is often a problem for practices that care for a large number of patients in nursing homes with palliative care needs. If changes are made to accommodate the problems CCGs have been facing as a result of digital first models, then NHS England should also work to support practices to receive the payments required for patients with significant needs over a short period of time.

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

It might be possible movements could be tracked by quarters, but it is hard to plan activity in this way.

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?

This will need to be determined by appropriate statistical research and evidence and is linked to the threshold proposed in chapter one.

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

If this is about CCG financial allocations changing in year and the risk that it could destabilise them if too significant, then we would support the proposal, however further clarification would be helpful.

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

Whatever approach is adopted must address the significant concerns we have previously raised about the way in which digital first providers have ensured a predominance of patients with low healthcare needs on their lists.

Section 3: New patient registration premium

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?

This proposal appears to have been suggested to deal with an issue arising from the piecemeal way digital first provision has been implemented. NHS England and commissioners must provide every practice in England with the resources required to implement digital first technology. This would negate this proposal and the majority of the proposals in this consultation.

We believe this should only be the case for out of area registered patients. There should be no change for patients registered under the normal regulations, as this would represent a disadvantage to practices working in areas with a high turnover. For example, many patients in care homes will only be registered for a short period of time, while still requiring a large initial workload. It could also be an issue if a practice closes and neighbouring practices get an influx of new registrations within a short time.

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?

As set out above we believe this should be for out of area patients only; as a minimum we would suggest 3 months.

Section 4: Harnessing digital-first primary care to cut health inequalities

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

NHS England and CCGs should target areas with gaps in service provision and high health inequalities, to introduce new contracts to include digital first provision of services. Allowing new contract holders to set up without restrictions has caused significant problems already and should be avoided in the future.

However, allowing discretion to NHS England to select the locations doesn't engender trust among GP practices and there is a suspicion that commissioners may game the system.

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

It seems unlikely that incentivising digital providers will tackle the inverse care law; on the contrary it will make it worse as they will not be providing holistic care to the most in need, leading to a destabilisation of general practice.

Our preference would be for existing GMS contract holders to be supported to provide services in these areas. The alternative poses significant risks of destabilisation of traditional practices and these risks are likely to be highest where capacity gaps exist.

If these projects cause practices to close, and are subsequently not profitable, the new providers will withdraw from the area, leaving a worse situation than at present. It is right that the merits of tele/digital medicine in under-doctored regions are explored, as any access is better than no access. However, it would compound health inequalities to expect patients in such areas to have access only to digital first providers, rather than a properly resourced GP practice, not least as many may not have online services available to them. Digital exclusion as a wider societal issue needs to be tackled first. Such areas are also likely to have proportionately more safeguarding issues within the population and digital first providers are not as appropriate for dealing with this.

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

There are a number of measures that could be employed, including levels of access/A&E UCC attendances/health outcomes, all of which could give a good idea of what level of healthcare is available.

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

We would support this proposal, but it will be hard to achieve. Areas of high deprivation may need focused strategies to improve retention and recruitment, but this is for a workforce that will address the high health needs of multi morbidity, premature ageing, mental health problems, and holistic opportunistic care. Digital providers will not help with this by diverting workforce to their selective model.

The way patients are and will interact with healthcare will change, with more reliance on technology, on direct care pathways and tools that triage/navigate patients to relevant information and tests. We need to ensure all providers are enabled to provide digital access and are equipped with tools that patients can use.

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

Yes, but it can't just be a single room, it should be a proper health centre that is open for physical access in the same way as any other practice in the area. Any solution must not discourage practices from setting up in deprived areas however, there are enough difficulties in doing so already.

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?

It is unclear how this question is different to Q7b, therefore we would refer back to our previous answer.

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?

While this might seem like a logical proposal, it would be sensible to first allow and enable existing GMS providers to demonstrate they can deliver digital services before allowing new providers on APMS contracts.

It would also be helpful to understand what is meant by 'additional' in this context. If it means 'more than there would be without the provider' then everyone will pass that test. If it means 'additional to whatever service might have been there before' then this could have adverse consequences.

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?

This may help to address the issue of under doctored areas, but only if new contract holders don't see it as a bar to moving into such an area. It's hard to see how it would be regulated and enforced. We would be wary of endorsing any change that might deny some patients access (if they were to skew the representativeness of the practice), which goes against the NHS principle of patient choice.

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

While we do not agree with the plan to create more APMS practices, should that go ahead as a general principle we believe that national criteria should be used and agreed with the BMA, with the potential for local flexibility where appropriate.

Q8. 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?

We do not agree with the principle that PCNs should become the default means to maintain primary care provision. PCNs have been established to better integrate existing providers of primary care services. These providers, particularly GMS practices, should remain the route through which primary care services are provided.

PCNs should be fully supported, financially and practically, to assist primary care providers to rapidly absorb patients, some of who may be vulnerable or have significant unmet or unidentified needs, onto current GMS lists.

What is needed is for patients to join existing GMS practice lists, rather than newly set up commercial APMS providers, whether digital or otherwise, but this must be with GMS practices having the required resource, capacity and support to do so. It's important to acknowledge that PCNs cannot absorb patients. They can absorb activity, their practices can absorb patients.