Digital-first primary care and its implications for general practice payments

We have analysed current payment arrangements with the following principles in mind:

- As much healthcare as possible continues to be provided in the community through high quality primary care, with England's system of list-based general practice at its core
- We encourage online access to general practice and other innovation which, where beneficial, becomes available to as many patients as possible and as quickly as feasible
- Funding arrangements should continue to reflect what is best for patients and their care as a whole – through equitable payment for the work involved for practices. Any changes would redistribute available funding to general practice, not remove it
- Patient choice should be protected, including being able to register as out of-area.

Question 1: Do you agree that these principles should underpin any changes to how NHS England contracts and pays for general practice?

We do not agree that the out of area regulations being retained should be a principle; we do not think it would impact on patient choice as patients can already be refused registration if they are not within the boundary; similarly the impact that these regulations can have on walk-in centres and local home visiting services gives rise to concern. We believe that these regulations should be withdrawn as they are not in line with wider NHS England policy relating to Primary Care Networks and population-based health management; the regulations also give the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.

There is a clear difference between those practices using the OOA registration arrangements to retain longstanding patients who move relatively short distances away from the practice or for commuters, and services such as GP at Hand that are actively recruiting new patients using this method. We must ensure that any changes do not have an adverse impact on practices that are not intended to be captured within this consultation (ie non-digital first practices who have patients registered out of area).

The proposals contained within this consultation aim to legitimise digital first models, by not making the significant changes that would jeopardise those existing models, while simultaneously providing a disincentive to other practices in pursuing the digital first model (as they would lose the funding they currently receive). Given the direction of travel for technology and innovation, both generally and within the NHS, the proposals within this consultation are not appropriate. If online access and similar innovation (appropriately tested and added to the list of approved system providers) were made available to all practices on an equal basis, with appropriate resource and without delay, there would likely not be a requirement for these proposals to be made. As the sole provider of IT services to general practice, it is within the gift of NHS England and CCGs to make this a reality. As the NHS England Board meeting (4 July) highlighted, the provision of these resources in an equitable and timely manner would be of great benefit to practices, general practice as a whole and to patients. We believe if this were the reality, patients would remain with the practice whose boundary they reside within, and simply make use of the online services with their own practice, maintaining their continuity of care.

The general ethos of the remaining principles seems to be appropriate, although the specific wording is questionable. For example, we do not agree that as much healthcare as possible should be provided in the community – it must be appropriate healthcare that is appropriately resourced. Similarly, the implication of the third principle is that funding arrangements already reflect the work involved for

practices, when it does not. It is attempting to suggest that funding should be equitable across practices, when comparing their relative workloads.

It should also be noted that while these funding changes may result in a reduction for some practices and that this should be recycled within the GP funding pot rather than removing it, we do not agree with the general principle of redistribution of funding – any changes to funding should be a result of increasing funding for those who require it, rather than reducing funding for those who might have less expenditure.

It is important to highlight here that digital first models are not an 'add-on' resources for practices; without additional GPs to undertake the work, it would take GPs away from face to face consultations to provide online consultations. The reason some practices are able to offer the service as an 'add-on' resource is due to the increased funding they receive because of their front-runner status.

'Digital first' appears to be used interchangeably to mean the use of digital systems and tools such as symptom checkers, the use of triaging apps/forms, patient access to online prescription requests, online booking of appointments etc as well as for online direct interaction with a GP. We are aware of two distinct models: 1) where a front-end symptom checker acts as a pre-triage advice page before the patient accesses a more traditional model of geographically based care; 2) where the interaction with the clinician is more heavily mediated by the app and much higher percentages of cases are dealt with completely remotely.

A principle we believe should be included is for equality of access. While one might argue that both models noted above rely on patients being technologically adept, having a digitally enabled smart phone, able to read, write and comprehend health related conversation, as well as a working knowledge of the English language, the second model clearly fails to uphold the principle of health inequality, effectively enabling the refusal of patients with significant morbidity, using the out of area regulations out of context. Practices should not be able to refuse to register patients based on their characteristics or clinical history, no matter where they live – that is not in line with the patient choice policy, nor is it consistent with the regulations for registration and removal of in-area patients, which explicitly forbid discrimination based on medical condition.

We also believe that an important principle is to ensure there is minimal unintended impact, and therefore a comprehensive risk assessment and impact assessment should be conducted for these proposals.

Question 2: Do you agree that the rurality index should be calculated differently by taking into account only in-area patients, and why? If not, what is your alternative proposal on rurality adjustment for GP practice populations?

This proposal would have a disproportionate impact on rural practices and those who do have out of area patients and provide a wide range of services to them. It could provide a perverse incentive for practices to review/widen their practice boundary. It is not clear from the proposals whether a distinction is being drawn between patients who are registered as out of area, and patients who are registered 'normally' but live outside the practice boundary (for whom practices retain an obligation to visit if necessary). This distinction is important and should be clarified before any proposals are agreed.

An alternative option could be to apply the rurality index only to the first (say) ten per cent of patients registered as out of area; all other patients registered as out of area would not attract a (full) rurality index. Please note that ten per cent is used as an example and appropriate analysis must be carried out to decide where the appropriate threshold sits.

However, we believe removing the out of area regulations would be a better way of dealing with the reasons behind each of these proposals.

Question 3: Do you agree that the London adjustment should only be paid for London resident patients, not based on the location of the practice headquarters, and why? If not, what is your specific alternative proposal on London adjustment for general practice populations?

This proposal would have a disproportionate impact on practices in London who register OOA patients (either commuters or former patients who have moved outside the practice boundary and wanted to stay with their previous practice) and could also impact practices on the boundary of London who have patients residing within and outwith London.

We do not agree that London adjustment is simply to deal with extra burden of London population characteristics; it is much more to do with the higher infrastructure costs of running a building in London and employing staff who have a higher living cost than the rest of the country. However, we are concerned about practices basing themselves in London in order to attract the London adjustment for patients who are not resident in London and who would not travel to London to see their GP (note we have used the term London adjustment while the report seems to use London Weighting and London Adjustment interchangeably).

An alternative could be to retain the London Adjustment for only for the first (say) ten per cent of patients living outside of London with all other patients registered outside of London not attracting a (full) London Adjustment. Please note that ten per cent is used as an example and appropriate analysis must be carried out to decide where the appropriate threshold sits.

However, we believe removing the out of area regulations would be a better way of dealing with the reasons behind each of these proposals.

Question 4 : Do you agree that practices should receive a lower payment for out-of-area patients and by how much? If not, what is your alternative proposal?

Should practices be able to opt-in to deliver home visiting services for out of area patients and therefore continue to receive full funding? Could they be required to offer or arrange home visits for out-of-area patients?

This proposal would impact practices who do have out of area patients and deliver 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); therefore reducing the payment for such patients would be inappropriate. Providing an opt-in for those practices may resolve this however it is difficult to understand how this would be managed and monitored.

An alternative could be to provide an even lower payment (than proposed) for out of area patients, for practices who have greater than (say) ten per cent of patients registered as out of area (again retaining the full payment for the first ten percent). Please note that ten per cent is used as an example and appropriate analysis must be carried out to decide where the appropriate threshold sits.

However, we believe removing the out of area regulations would be a better way of dealing with the reasons behind each of these proposals.

Question 5: When you think about digital-first models of general practice, what do you consider the potential benefits and disbenefits to be for:

i) Patients, including considerations around equality and inequality

Benefits: simpler access to general practice, potentially swifter triage, more convenient (less travel to the practice), more cost effective (less travel).

Disbenefits: If OOA applies then loss of continuity of care, loss of personal relationship with their doctor/practice, potential risk to patient safety (more difficult to assess without seeing the patient in person, reliant on the patient to adequately explain/examine etc).

Those who are tech savvy will be more likely to use (and possibly abuse) as suggested in recent research which shows patients ability to game the system, which may be an issue for certain demographics (deprived patients may not have access). Communication issues for those who don't have English as a first language, those with learning disabilities etc. It may also have a disproportionate impact of vulnerable groups who already have worse health outcomes (which should be considered in an equality impact assessment).

There are also practical issues around network and internet connections, security and confidentiality (ie a consultation could take place where a patient is in a public environment)

ii) GPs, their staff and practices

Benefits: Potential to reduce the number of home visits if video consultation was appropriate, potentially better than telephone consultations as would provide a visual rather than just audio, potential to triage out the more 'well' patients to free up face to face appointments (for triage digital first systems), potential (if used correctly) to better manage demand.

Disbenefits: potential loss of continuity of care (if OOA still applies), increased risk of complaints due to lack of personal relationship with GP/practice, potentially increase in liability if patient cannot adequately provide information in a digital setting, potential for misdiagnosis and subsequent legal claims for compensation if a physical examination or appropriate investigations have not been carried out, potential to increase demand – more workload on practices if patients' expectations for access increase. Digital first models are likely to lead to increased consultations due to the ease at which they may be provided.

There is also potential for patient behaviours to dictate doctor behaviours (eg a new style of defensive risk averse medical practice arising) potentially with more tests, higher rates of prescribing of antibiotics and drugs that could potentially be abused etc.

Consideration also needs to be given to patient ID verification, patients accessing from abroad and what indemnity issues arise for practices as a result of this.

iii) Do your answers to i.) and ii.) differ depending on whether the digital first practice is local, or if it is serving patients across a wide geography?

To an extent – where OOA regulations still apply there may be a loss of continuity of care and a loss of patient access.

What wider potential is there to make savings and efficiencies from the adoption of digital-first primary care? How could this be reflected in the way we distribute funding to general practice?

Efficiencies are likely to be made in the provision of care to patients, rather than in a financial sense. However, as mentioned earlier increased demand could result, as has been seen with walk-in centres and with the widespread use of telephone consultations.

The above proposals will create a two-tier system where those who register as out of area are worth less than those registered as in area. While this would not impact the overall funding pot, as stated the reductions for OOA patients would be recycled, the iterative process of recycling would widen the difference in value of patients.

What additional costs do you consider arise in the provision of digital-first primary care services? How could this be reflected in the way we distribute funding to general practice?

Additional IT infrastructure (and maintenance thereof), high speed internet connections, adequate bandwidth, training for staff, would all be an additional cost pressure. These are costs for the CCG and NHSE as the providers of IT services to practices.

Should the payment for newly registered patients be reconsidered, and if so, how do you think it could best be adjusted?

We do not agree with removing the additional funding for newly registered patients, as to do so would disadvantages those who have a high turnover (university practices and practices in urban areas) and would affect all other practices equally (and probably digital first practices less than others)

An alternative would be to remove this payment for those patients who register as out of area. This would not disadvantage those practices who have a high list turnover, or those who register patients as out of area for the purposes of continuity of care when the patient moves out of the practice boundary.

Are there any other ways in which you feel the funding model for general practice can best be adjusted to support the widest possible take up of proven digital delivery mechanisms?

These proposals will not support the take up of digital delivery mechanisms, if anything they will discourage them, if the OOA regulations are retained. The ability and funding for digital first mechanisms should be made available to all practices equally, and provided by NHS England and CCGs who are responsible for providing IT services to practices.

The proposal for Market Forces Factor being related to where patients are based rather than where practices are based does not seem to fit with the earlier statement that MFF is to account for the higher costs of practices operating in different areas.

It is difficult to understand how the system could work practically, if the above proposals were to be approved. The recycling, of deductions for out of area patients, into global sum would become an iterative process and would require national level calculations based on individual patient characteristics, which would be difficult. For example, at present global sum is valued at £88.96 per patient – this is then applied, using the Carr Hill formula, to each practice based on the make-up of their patients to provide the total amount payable to that practice. This amount would then be reduced for those practices who have out of area patients registered. The total sum reduced (for all practices who see a deduction under these proposals) would then need to be recycled back into the original determination of global sum, increasing it marginally and the calculation repeated.

Question 6: Do you agree that we should mandate the reporting of activity and costs of digital provision in general practice as a contractual requirement? If not, are there better ways of understanding the costs of delivering digital services?

Including something as a contractual requirement should not be the 'go to' for data on costings that may be difficult to source.

NHS England and CCGs are responsible for providing IT services to practices and so should be able to account for the costs. As mentioned earlier if online access and similar innovation were made available to all practices on an equal basis, with appropriate resource and without delay, not only would there likely not be a requirement for these proposals to be made but NHS England and CCGs would be able to account for the cost and activity involved.

If the intention is for NHS England to understand these costs in order to provide the systems and resources for practice then an alternative is for a specific piece of research to be conducted, possibly by an academic department or potentially AISMA in order to understand the costs of delivering digital services. This would likely also be timelier and create less bureaucratic work for practices.

The immediate cost implications of such a service has been seen in the H&F GP at Hand model, however until the financial modelling is more closely scrutinised the wider cost implications may not come to light until much later.