July 2019

Londonwide Local Medical Committees' response to "Digital-First Primary Care: Policy consultation on patient registration, funding and contracting rules" Consultation

Londonwide Local Medical Committees (Londonwide LMCs) is the clinically led independent voice of general practice in the capital, supporting Local Medical Committees; bodies recognised in statute (NHS Act) which represent the interests of all local GPs and their teams. We aim to secure the future of general practice in London through our work with all partners in the health and social care sector and beyond. We support and represent over 7,000 GPs and over 1,200 practice teams in London through our 27 locally elected committees. We ensure that London's GPs and their practice teams have access to the information and support they need to help them provide the best possible service to their nearly nine million patients.

We work with GPs across the breadth of their roles, from clinical provision to business services and patient engagement. GPs acknowledge the importance of engaging with patients in designing how to deliver services, making these as responsive as possible. We also recognise the power of information shared with patients in helping them make decisions about their treatment and to manage their own health through regular feedback at the practice, via technology, and through practice patient participation groups (PPGs).

Londonwide LMCs welcomes this opportunity to respond to the consultation on proposals to change how the system works and adapt regulations to take account of digital technology in general practice, and a series of points covering our thoughts and concerns on provider function versus structure, effectively meeting patient need, and safely identifying and addressing health inequalities are outlined below.

Summary Response:

- Since the introduction of the out of area registration rules, there have been a number of policy changes in the NHS; the most notable is a focus on place-based care in which services are brought together around patients with need and their local communities. **Digital initiatives that are currently in place, and ongoing innovation in digital accelerator sites, are increasing convenience of access to groups such as commuters rather than working toward the stated goal of effective digital technology that supports GP practices to deliver available and effective care on an equitable basis. These changes mean that the current out of area registrations can no longer be justified on the grounds stated in the consultation paper.**

- Any new delivery model must be designed with the aim of meeting the needs of people and communities. Commissioners are responsible for reviewing service provision, analysing needs and current legislation, performing a gap analysis, designing services to meet need and developing the market, and, once commissioned, commissioners must undertake thorough assessment and evaluation. **If funding is being diverted to deliver the new services, the impact on all populations must be evaluated. These processes do not seem to be in place. Indeed, perversely current evidence suggests that those with greater health need do not register with new digital first models, or re-register with their GP practice.**

- Given the parlous state of the general practice workforce and workload at present, **it is unreasonable to conclude that abolition of the out of area registration rules "…would unjustifiably limit patient choice…" (p9:23) when care close to the point of needs is a core tenet of general practice.** This point was also made in our earlier consultation response on digital first proposals, last year.

- In order **for investment in digital health tools to fit with the values of general practice, such tools must directly reduce health inequalities,** or free up resource which can be directed to other methods of care delivery which are proven to do so.

- Areas that are under-doctored may (and probably do) have patients with a high level of **complex need, patients who may struggle to use a digital first model, issues regarding IT literacy, and infrastructure and access challenges which add to health inequalities.** Digital services should be developed in an integrated way, alongside other services within existing practices so that they are there to be used if required.

- Evidence shows that **primary care is best delivered by expert generalists working with registered lists in defined geographic communities**. The core funding that allows and supports this care delivery at individual and population level must be maintained and, where possible, increased.

- GPs in London are adept at managing their practice resources and can adapt the services they offer to their practice lists, treating each patient as an individual, without the need to move patients between practices when their health care needs change. However, **there are significant workload pressures which must be addressed to allow all patients appropriate access to their chosen GP. There are significant infrastructure issues relating to digital working that also need to be addressed.** There are also additional costs – often referenced as the "Market Forces Factor" – borne by general practitioners operating within the greater London area, including elevated property and staffing costs, which are reflected in current resource weightings.

- There are concerns that **some of the proposals being consulted on might result in unintended financial risk to the delivery of core primary care services in the Capital and the stability of practices delivering them, since they equate to a redistribution, rather than any new digital technology-related investment**. In effect they amount to already finely balanced fixed practice resources being cut to pay for digital change. Before further decisions are reached, we believe that a full review of the financial impact of these changes should be provided, including regional breakdowns, rather than the single practice examples included in the consultation document. We are also concerned that the recommendations for amendment to the out of area registration rules contain calculations which have not been adjusted for patient characteristics (p12:37) and that later refers to age and gender as the sole characteristics affecting payment rates (p14:44). We believe that **there must be a full, independent and robust analysis of the clinical and cost effectiveness of diversion of funding, to any new delivery model, on all populations.**

- We are concerned that **APMS contracts are notoriously unstable and poor vehicles for the provision of the continuous and effective health care relationships which are so beneficial to patients and staff**. Considering the benefits of stable and continuous patient care and a sustainable and stable workforce, we believe that commissioners would see improved patient outcomes through increased investment and support for GMS contracts which are nationally negotiated, and provide long-term stability for patients and staff.

- For the potential of digital health to be realised, all practices need the infrastructure to provide it, the knowledge to use it effectively, and the patient demand to justify the investment of time/money in new systems and ways of working. Online access and consulting could reduce the need for attendance at GP practices and appointments in the long-term. **How to apply the technology in ways which actually do this needs to be established by rigorous evaluation, rather just the belief that rolling out more online services will somehow inherently reduce workload.**

- **More focus is needed on understanding the high turnover rate for patients registered with digital first providers.** Noting the figures quoted, it would appear that these national proposals show a disproportionate impact on London.

- Any and all **proposals should be considered against the quadruple aims of care**, health, cost and meaning in work to prevent any unintended consequences which might destabilise existing general practice and patient care.

Additional Points:

In addition to the overarching comments above, we have chosen to respond to specific points within the consultation. See below:

- **Patient choice and cutting health inequalities**

Given the parlous state of the general practice workforce and workload at present, we believe it is reasonable to conclude that abolition of the out of area registration rules "…would unjustifiably limit patient choice…" (p9:23) when limitations are already in place regarding the provision of care close to the point of needs as a core tenet of general practice. Similarly, the citation of patient choice being the prima facie justification for retention of the out of area registration rules is unreasonable.

The consultation makes frequent reference to patient choice. The reality of "choice" in this context is that access for those who appear to need it least is being prioritised at the expense of those who need it most. This was recently underlined by the results of the Ipsos Mori evaluation of Babylon GP at Hand which showed that by far the biggest users of GP at Hand are younger and more affluent patients who are generally well but are high volume users of the health service. The digital first offer is an inequitable one based on the wants of commercial providers rather than the needs of patients. To address health inequalities, it must be adapted to adequately address true patient need. We also believe that the model fails to address the unmet health needs of those with health anxiety who, in the absence of the continuity of care offered through the traditional general practice model, risk repeated digital first GP engagements. These fail to identify and address underlying anxiety or mental health related concerns which may be masked by repeat digital engagement with different practitioners, in the absence of a relationship of continued care.

There is a single cursory reference (p14) to the fact that the proposed capitation approach does not adequately allow for the attraction of patients with lower health needs and costs to digital first providers. This is a crucial consideration, given that the very nature of the digital first offer attracts patients with less need (p15:43-46). Noting the reference to the Needs Indices (p15:46), we want further detail on how this point will be considered/ assured.

We remain concerned that the onus driving this agenda is on the speed with which digital first primary care can be rolled out, rather than considering and evaluating ways in which the technology can be utilised to benefit patients and practices in both urban and remote areas, and across deprived communities, and ensuring an equitable service for all.

Whilst we recognise the stated aspiration of utilising technology to help improve access to general practice services in some geographies, there is no evidence given to support the statement that "digital first providers could help achieve this" (p20:61).

Areas that are under-doctored may (and probably do) have patients with a high level of complex need, patients who may struggle to use a digital first model, issues regarding IT literacy, and infrastructure and access challenges which add to health inequalities. Digital services should be developed alongside other services within existing practices so that they are there to be used if required, but they should not be the only means of access and there should not be providers who can just offer digital first services, this is not comprehensive, allows cherry picking of easier patients, destabilises general practice and prioritises access for those who need it least at the expense of those who need it most.

People expect to be able to access more and more services via mobile devices, which suggest there may be demand for online GP services. However, there will only be significant uptake if these services meet public expectations of how an online service should work, namely: that they are simple to sign-up for, what users can and cannot expect from the service is clearly outlined, and the quality of service that is promised is consistently delivered. To create a reliable service the NHS needs to fund user research (both patient and clinical), significant IT infrastructure investment and improvements in practices, software development and/or procurement, training and roll-out support.

The NHS needs to consider that, as cited in the Ipsos Mori evaluation of the Babylon GP at Hand service, "It will also remain important to ensure marginalised groups do not experience barriers to using online services eg those unable to afford smartphones, or access to the internet)". Such marginalised groups are likely to have different needs compared to people with high technological literacy and access to modern mobile devices, who often come from socio-economic groups which already have above average health outcomes. Demand for online access from this cohort may not be proportionate to their actual need for improved access to NHS services. The inverse care law would suggest that the greatest need for improved access actually lies elsewhere in the population, in particular in this city, to those experiencing the greatest health inequalities directly related to their life circumstances, ie the wider determinants of their health.

In order for investment in digital health tools to fit with the values of general practice, such tools must directly reduce health inequalities, or free up resource which can be directed to other methods of care delivery which are proven to do so. It is essential to preserve and protect the core values of general practice such as continuity of care, which is recognised as critical to the delivery of holistic patient care and has been the topics of recent research by RCGP, Kings Fund and others (see ANNEX).

Any commissioning decisions regarding different aspects of primary, community and secondary care must take care that actions benefiting one sector do not have negative unintended consequences elsewhere.

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- **Out of Area Registration**

Further to our response to the Digital First consultation exercise in August last year, we still maintain that clarity is needed as to whether the proposals distinguish between patients who are registered 'normally' and within a practice's delivery area, for whom a practice would continue to hold an obligation to visit should the need arise, and those patients who are registered as 'out of area', such as commuters previously registered to their home-based practice, and who therefore live beyond existing practice boundaries, for whom there is no obligation to visit.

Out of area registrations fragments health care and runs counter to the network working of the new Primary Care Networks (PCNs), and their geographically contiguous. Integrated care between local teams, with continuity of care and coordination, has been shown to improve outcomes.

The reference to "truly out of area" (p10:28) suggests an addition measure is being considered, creating a two tier out of area registration system. It is not uncommon for practice areas to cross CCG and other administrative boundaries in servicing natural patient populations. By focussing on CCG administrative boundaries the document does not reference current practice, and we call for further clarification. As written, there is scant detail about how practitioners and commissioners would distinguish between the two groups. The final point in Chapter one which says that "patients could move between out of area and in area status" is also confusing and needs further detail.

These national proposals (Fig 1, p8) may have a disproportionate impact on urban areas such as London, where we know that there are a number of practices with patients who are registered "normally": ie they reside outside the London postcode areas but within the practice delivery area agreed with their CCG/NHS England, such as the significant number of practices who operate on the boundaries of Greater London but are still subject to a higher MFF.

Having surveyed practices working across such boundaries, we found that from the responding practices up to 11.9% of patients would be considered as non-London residents. We have a keen interest in how the proposals for revised funding would impact on practices and primary care services across London.

Any and all proposed options should be considered against the quadruple aims of care, health, cost and meaning in work to prevent any unintended consequences which might destabilise existing general practice and patient care. It is surprising to note that these are not cited in Chapter 1, but that measures which are seen as potentially impeding the speed and agility of the spread and growth of digital first models are. We would question how reasonable this is.

It is unclear how any new APMS contract holder would effectively engage with existing PCNs in a given geography or join the CCG if operating across multiple areas (p21:65). What requirement would there be for local physical engagement and intelligence sharing, and how does this work alongside the statement.

- **New patient funding**

London has a highly mobile and transient population. As such, we do not agree with removing the additional funding for newly registered patients and need more evidence on the impact of any change. There are likely to be unintended consequences for patient groups who are more transient and/or vulnerable, such as the homeless, migrants, temporary workers or students.

There are good reasons for the payment of additional funds to new practices registering new patients, reflecting practice administrative and clinical time spent with each new patient and their records. Removal of new patient funding would disadvantage a range of practices including those in areas with high numbers of rented properties and homes of multiple occupancy, those who have a high turnover (university practices), and those with new high-density housing developments either in development or planned. In addition, London practices incur higher employment and infrastructure costs when delivering patient care. We are concerned about the payment mechanism if timescales are set for new patients. How and when would the registration period be enforced: deferred payment? Claw back?

More focus is actually needed on understanding the high turnover rate for patients registered with digital first providers.

In light of recent information and communications measures introduced by GDPR, further detail on how the “automatic” and “default”, “bulk” re-registering of patients in the event of a new APMS contract could be considered compliant, were it to be challenged, and who would be accountable for managing securing permissions from affected patients for the transfer of their records and notes, even if deemed to be a strictly administrative act. And would patients registered directly with such new APMS attract a different rate of patient premium to the transferred list?

We are concerned that there is no reflection, in Chapter 3 which looks at the new patient registration premium, that the high number of new patient registrations seen with digital first providers is a direct result of aggressive and targeted marketing seeking to take advantage of the out of area registration rules as written. Noting the figures concerning London’ higher rate of registration and de-registration (p18:53), it would appear that these national proposals (Fig 1, p8) show a disproportionate impact on London. We strongly question whether it is acceptable for over a third of London practices (12% normally, more than three times that for digital models) to be subject to such financial disruption.

- **APMS and local procurement**

We are concerned that the key general practice tenet of continuity of care will be in danger if the following issues flagged within the consultation are not adequately addressed: the lack of detail regarding the mechanism for transferring funding and a portion of list to a new contract; the means by which staff would be recruited; the mechanisms to deliver these changes; compliance with communication and permission regulations contained within GDPR and other regulations; and associated assurance and compliance checks on staff and premises in a timely manner. It is also essential to consider the impact on other practices and PCNs in any location likely to have an APMS created within it. Is the APMS able to operate before suitable premises are acquired and fitted-out, for example? And would a new patient fee be payable for patients switched between contracts in this way? It is concerning that these considerations are not reflected in the document, which instead states (p11:30) "The key decision is the choice of threshold at which to trigger the creation of a new APMS contract". What discussions have been held with regulators and inspectors regarding the feasibility of the preferred option of disaggregating the patient list to create new APMS contracts?

Noting the reference that "We expect the provider to take steps, making every effort to ensure that its list reflects the demographics of the local population." (p21:65), what does this mean in reality for the existing digital first model providers, such as Babylon GP at Hand? Similarly, how would the requirement that the provider have an "evidence-based symptom checker" match up with existing providers who have to date refused independent scrutiny of such AI symptom sorter technology? We are concerned that a reliance on un-evaluated AI would fail to routinely and safely identify the care and treatment needs of patients with co-morbidities.

Any and all proposals should be considered against the quadruple aims of care, health, cost and meaning in work to prevent any unintended consequences which might destabilise existing general practice and patient care.

We would also note that APMS contracts are notoriously unstable and considering the benefits of stable and continuous patient care and a sustainable and stable workforce, we believe that commissioners would see improved patient outcomes through increased investment and support for GMS contracts which are nationally negotiated, and provide long-term stability for patients and staff.

Regarding the proposal to introduce a threshold for registered patients in order to create APMS contracts, we reiterate that we are opposed to the creation of such additional contracts without full evidence and consideration of local provision options. In such circumstances as commissioners were considering awarding an APMS contract, any threshold would need to be determined based on a robust review of existing patient need and care, and soundly evidenced.

- **Costings**

The proposed amendments may result in unintended financial risk to the delivery of core primary care services in the Capital. Before further decisions are reached, we believe that a full review of the financial impact of these changes on all populations should be provided, including regional breakdowns.

Further detail is needed on how the money flow identified in the document would impact on related community-based services and whether local health economies would be unduly affected by changes to the current funding mechanisms. We are particularly concerned about unintended consequences on the funding of community and mental health services.

Chapter 2 identifies that payments might be made quarterly, but there is no clarity on how such backdated payments would enable contractors to deliver against requirements for premises, equipment and staff unless they are in a position to pump prime their contract, which would benefit largescale private providers at the expense of practising GPs collectives, despite the inclusion of that model in the document. The suggestion that it is unacceptable for CCGs to bear cost fluctuation, and that this is a sufficient reason to omit consideration of individual patients' characteristics and associate the actual costs incurred by the transferring individuals (p15:47), is to reveal that the intent is to save money and time for commissioners rather than for providers.

Chapter 2 also indicates that adjustments may only be applied to a subset of services, but if the intent is that any new provider base be located within a CCG area and operating on a place-based system within a PCN it is difficult to understand any disparity.

- **Spread of digital providers nationwide**

At the core of general practice is the provision of locally based care, with the primary health care team understanding the circumstances in which the patient lives. Existing practices within an area understand the nuances of their local population and their needs and should be supported to develop their own digital offer, rather than having one imposed from above.

We are concerned at unevidenced assertions regarding the possible impact of the extension of digital providers into other parts of England. Given recent concerns flagged in the Ipsos Mori evaluation of the Babylon GP at Hand service in West London concerning effectiveness, operational capacity, and transparency, we believe that evidence is needed before the assertion can be made that "This could help increase GP capacity…" (p6:12).

It is unclear what provision would be in place to allow supervised return to work/ practice were such measures to encourage return to practice for GPs who have left the profession or take a prolonged break and need to return to the Performers List.

NEW OPPORTUNITIES
Distinguishing comments on the consultation proposals above from the "possible opportunities" outlined in Chapter 4 (p22-p31), we have the following comments:

- Allowing providers to set up anywhere in England from April 2020 would be counter to the suggestion that the model assists with under-doctored areas and/ or those with unmet needs, and providing unfettered access would be tantamount to allowing cherry picking, which we believe would be hugely destabilising to general practice in England.
- We agree that the concerns outlined regarding destabilisation (p23) are significant concerns.
- The assertion that under-doctored areas' health needs can be met by digital general practice (p25:80) is not evidenced and does not reflect the different health needs of a blended patient community which may include pockets of need, inequality and deprivation next to, or surrounded by, affluent communities which can, when considered as data at a borough level rather than holistically at a practice level, be masked or hidden. And it is particularly hard to understand when further paragraphs identify that the definition of an under-doctored areas is yet to be agreed, and these areas are as yet undefined (p25:81, p26:84).
- There is also no suggestion that the effect of recruiting clinical staff into new practices might be problematic, only that the plan to recruit is evidenced (p25).
- Concerning that the firm(er) requirement earlier in the document that physical provision be provided in disadvantaged areas is softened to read "at least some of the face-to-face services" in this further section (p26:85).
- We would suggest that new contractual opportunities be offered first to existing local GP providers in identified under-doctored areas before being extended to new/ national providers (p26:87). And that this is counter to the proposal further expanded on regarding a call-off system of national providers (p27 & p29). We firmly believe that any such commissioning process would need to enable local practices to engage in planning to meet the needs of their patients and communities.
- The suggested procurement methods would not necessarily give comfort that the most appropriate quality service is being sought to meet the needs of patients and the needs of their communities, rather than the cheapest (p27:88).
- There are concerns that the measures outlined regarding NHS trusts partnering with digital first providers would damage continuity of care and result in inferior primary care services for patients, and an erosion of the independent contractor model which enables GPs to flex their service delivery to meet the needs of local communities. An ability of which general practice is rightly proud (see ANNEX). What is the case for already struggling NHS trusts (many of whom have massive financial deficits) to take on further responsibility for a service out-with their expertise, and for which they lack the core community links and capacity? (p28:93)

- Similarly, we are concerned at the language of NHS England "requiring" GP-led CCGs to establish/ adopt provider lists and/or the "requirement" that CCGs automatically contract with nationally agreed providers who "express a desire to provide in their area" regardless of local knowledge, patient need, or provider suitability (p29:101,iii).
- Related to the above point, it is unclear what would happen under circumstances where a digital first provider not on the national list rolled over any agreed patient threshold requiring the creation of an APMS site (p29:101,iii).
- The point re new providers who "meet the minimum criteria of the network contract DES [they] could become a PCN without partnering with other practices, subject to commissioner approval of the footprint." (p30:103) appears to be counter to earlier recommendations/ requirements that any potentially newly formed APMS be required to work with/ join existing local, place-based, PCNs where they can engage in information sharing for the benefit of patient care and local health provision. Propagation of national PCN networks (a la Babylon GP at Hand) is a retrograde step which runs totally counter to the ethos of the new contract and its focus on local health planning and multi-agency partnership working (p30:103).

Contacts

For further information about Londonwide LMCs' response to this consultation please contact Sam Dowling, Director of Communications on sam.dowling@lmc.org.uk.

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- **ANNEX**

The core values of general practice

1 The registered list – individuals and practice population.
2 Expert generalist care of the whole patient.
3 The consultation as the irreducible essence of delivery.
4 Take into account socio-economic and psychological determinants of disease and the inverse care law.
5 The therapeutic relationship.
6 Deliver safe, effective long term and preventative care, balanced with timely episodic care by promoting access to relationship continuity.
7 Advocacy and confidentiality

Research into continuity of care

In 2019, the Health Foundation launched a new funding programme to help to improve patient care and outcomes by exploring the potential to increase continuity of care within general practice. This programme is inspired by a study published in August 2018, conducted by the Health Foundation team. This **study** concluded that 'strategies that improve the continuity of care in general practice may reduce secondary care costs, particularly for the heaviest users of healthcare […] and that promoting continuity might also improve the experience of patients and those working in general practice.

The RCGP's **Continuity of care in modern day general practice** report published in 2016 asked whether continuity is still important in modern day practice and assessed how it can be delivered in the context of changing demographics, work patterns and models of care. In addition, the paper established key principles that general practice should adhere to, if continuity is to remain at the core of the primary care as it continues to evolve.

In March 2011 The Kings Fund published **Continuity of care and the patient experience**. The report was commissioned for an inquiry into the quality of general practice in England commissioned by The King's Fund. Its aims are to: define continuity of care and assess its importance as a dimension of quality explore patients' and clinicians' perspectives; define good practice in relation to continuity of care; assess whether and how continuity might be measured in general practice.