



Digital-First Primary Care

Policy consultation on patient registration, funding and contracting rules

NHS England and NHS Improvement



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Preface

All around us, a new generation of technology is changing our lives. Each year more of us choose online routes to book GP appointments, order repeat prescriptions or view personal health records. Online and video consultations are available in a growing number of practices.

Digital innovations have the potential to support and empower patients, helping people to remain healthy and independent for longer. Used well, new technologies can also help to alleviate workload challenges in practices, ensuring appropriate use of appointments that will best address patient need and free up clinicians' time to support more complex patients and deliver continuity of care.

But the current contract rules weren't designed for digital-first services, and cause problems for the existing practices, the NHS and new providers alike.

The NHS is short of GPs. We know it can be attractive for some GPs to work for digital-first services, which have the potential to help increase overall GP numbers. And we also know that there are problems with the distribution of GPs, with some parts of the country much more under-doctored than others.

The NHS Long Term Plan commits that every patient in England will have access to digital GP services. We need to make it easier for existing GP surgeries to expand and improve their own digital services.

We need to change how the system works so we can ensure that the money continues to follow the patient - a long standing principle of NHS general practice.

And we need to ensure that digital-first providers can register new patients in areas where people can't currently access digital GP services.

This document therefore describes proposals to reform patient registration, funding and contracting rules to ensure patients have both choice as well as access to integrated care; and to harness the potential of digital providers to help with our workforce shortages in a way that helps our most under-doctored and deprived communities. It sets out options and proposals for reform and invite views.

Beneficiaries of these changes would include people in remote or deprived areas, people who don't live near a GP surgery, or don't have enough GPs in their area, and people with long-term health conditions, who need regular contact with a GP.

Executive Summary

1. The NHS Long Term Plan commits that every patient will have the right to be offered digital-first primary care by 2023/24.¹ The new five-year framework for GP contract reform describes the areas in which we expect early progress to be made in general practice.² For example, by April 2020 all patients should have online access to their full record and by April 2021 all patients should have the right to online and video consultations.
2. 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.
3. Recently there has been a growth in new digital GP providers offering a model which allows patients to register with them directly and contact the practice through an app. The app enables patients to check their symptoms, message the practice, monitor their health and undertake video consultations with GPs. These models are proving convenient and popular with some patients.³ It is important to support patients' active choice of a new service.
4. Under the current arrangements, the expansion of these models has taken place by registering patients across wide geographies from a single GP practice. The most significant example of this is the likely expansion of a practice in Hammersmith and Fulham to register patients in Birmingham, as it is permitted to do under longstanding GMS regulations.
5. However:
 - If large numbers of patients are registered with a practice that is unnecessarily miles away from their home, it will be more challenging to

¹ "The NHS Long Term Plan"; available from:

<https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

² "Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan"; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

³ "Evaluation of Babylon GP at hand. Final evaluation report"; available from:

<https://www.hammersmithfulhamccg.nhs.uk/media/156123/Evaluation-of-Babylon-GP-at-Hand-Final-Report.pdf>

deliver integrated local health services. It also creates complexities for delivering screening arrangements;

- Because of the way NHS funding currently flows following a patient's registration with a GP, Clinical Commissioning Groups (CCGs) with high numbers of out-of-area registrations become responsible for the healthcare costs of patients registering with a digital provider in their area in advance of the adjustment which is then made to funding allocations. In the example above, the patients in Birmingham with a GP practice in London would under current arrangements be funded by Hammersmith and Fulham CCG even if they live in Birmingham.
6. We need to address these issues to ensure:
- General practice providers remain connected, as far as practicable, to wider local services, including the new primary care network services that will be introduced from April 2020;⁴
 - CCG allocations and the distribution of general practice funding are fair.
7. Given our need for more GP capacity, we also need to make best use of all available tools which could reduce GP workload and maximise the participation of trained GPs in the workforce. New digital models offer further opportunities to improve access to services and bring additional capacity from part time GPs willing to work additional sessions from home.
8. This document sets out proposals and options to:
- Change how the system works so we can ensure the money follows the patient;
 - Make it easier for existing GP surgeries to expand and improve their own digital services;
 - Ensure that digital-first providers can register new patients in areas where people can't currently access digital GP services.
9. **Chapter one concludes that the current out-of-area registration rules need to change, and in a way that maintains patient choice. It therefore proposes 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 will separately be awarded a local primary medical care contract in that CCG through which to serve those patients.** This solves the problems identified whilst protecting the active choice being made by patients for a different service.

⁴ "Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan"; available from:
<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

10. **Chapter two sets out how we propose 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.
11. **Chapter three considers further changes to the GP payment formula** to ensure resources are distributed fairly. This builds on the changes introduced this year to the London adjustment and rurality index payment⁵. We have specifically considered whether we need to make changes to the new patient registration premium since digital-first providers typically see a higher number of patient registrations and de-registrations⁶. Given that new patients generate extra work for practices, it is proposed to maintain the premium but only pay it if a patient remains registered with a practice for a defined period. We are inviting views on that period, but propose six to twelve months.
12. **The fourth chapter considers whether we should allow other digital providers to set up and start registering patients in any part of England.** This could help increase overall GP capacity as well as increase the choices available to patients.
13. **It could also help address the inverse care law in general practice.** We could allow new digital-first practices into our most under-doctored geographies – for example, CCGs in the bottom 10% or 20%. And require these practices to meet key criteria: (i) demonstrate that the GPs they will be bringing into the local community are additional; (ii) ensure that the physical part of their service also includes 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.
14. **We also suggest that alongside 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. In chapter four we invite views on these propositions.**
15. We would welcome your feedback on the proposals set out in this document by **Friday 23 August 2019. Chapter five outlines how you can share your feedback, as well as the next steps we propose to take.**

⁵ “Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan”; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

⁶ Based on internal NHS England analysis.

1. Out-of-area registration

16. English GP practices have traditionally operated on the basis of a ‘catchment area’ from which their list of registered patients has been drawn. In January 2015, out-of-area registration rules were introduced to allow patients the choice to register with a practice in a more convenient location for them than near their home address. They were intended to enable commuters to register with a practice near their place of work, parents to register with a practice near their child’s school, a GP practice to continue to care for a patient who has moved into a care home or new house outside the practice boundary etc. We know many patients have benefitted from this flexibility and it is important we maintain and protect this. **There is no intention to restrict the choice exercised by these patients.**
17. But the out-of-area rules need revisiting. Out-of-area registrations have risen, partly as a result of the expansion of new digital-first primary care models.⁷ On 1 April 2019, there were 126,821 patients recorded as out-of-area registrations, a rise of over 53,000 over the past two years, and this trend is likely to continue.⁸

Date	# Out-Of-Area Registrations
1 April 2015	7,065
1 April 2016	50,103
1 April 2017	73,573
1 April 2018	98,755
1 April 2019	126,821

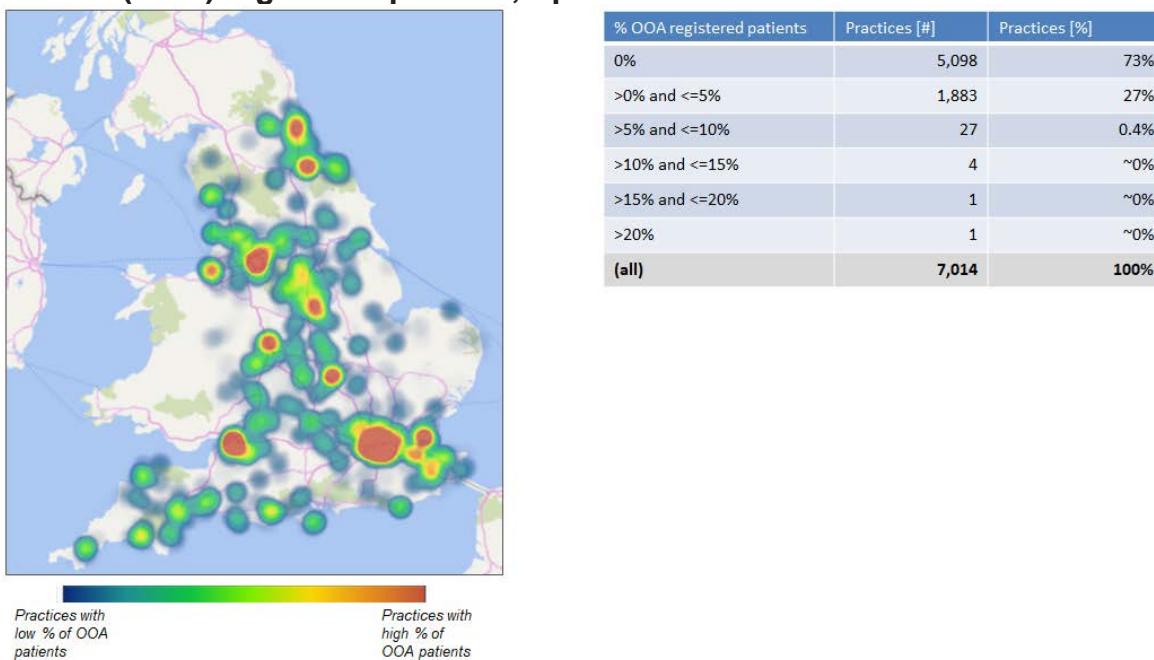
18. We also know, because of the manual processes in use by practices to record out-of-area status, that these figures will be higher in reality, reflecting patients who do live outside the catchment but are not formally recorded as such; the extent of this issue is not precisely known.
19. The majority of practices (73%) still have no recorded out-of-area patients, with only six practices having more than 10% and one practice more than 20%.⁹

⁷ Based on an internal NHS England analysis.

⁸ Based on an internal NHS England analysis.

⁹ Based on an internal NHS England analysis.

Figure 1: Geographical and numerical distribution of general practices by % out-of-area (OOA) registered patients, April 2019



20. The out-of-area system has been used and is likely to be further used by some providers to register increasing numbers of patients across vast geographical areas. However:
 - It is challenging to deliver integrated services and population-based care to patients who are registered with a practice at significant distance from their other local health and care services;
 - Though a solution is available as a workaround, the current system risks creating complexities in delivering reliable screening arrangements;
 - It makes it challenging for commissioners to plan and budget for local services because of the interaction between arrangements for charging costs to responsible commissioners and flows of funding allocations and the speed at which they reflect movements in GP registration.
21. Some digital-first models also rely on sub-contracting to expand into new areas. Commissioners currently have limited and different ability to object to sub-contracting of clinical matters (services) under a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract. For GMS contracts, the only grounds to object are if:
 - The sub-contracting arrangement puts the safety of the contractor's patients at serious risk;
 - The sub-contracting arrangement puts NHS England at risk of material financial loss; or
 - The sub-contractor would be unable to meet the Contractor's obligations under the Contract.

22. This means that commissioners have very little influence over sub-contracting from primary medical care contracts in their area, even if it is not in the best interests of patients and the local health and care system. This is very different to the position in other areas of the NHS.
23. We have therefore considered:
 - Abolishing out-of-area registration but this would unjustifiably limit patient choice of GP, which has been a defining attribute of the NHS since 1948. We therefore reject this possibility;
 - Option A: Limiting the number of patients that practices can register as out-of-area; or
 - Option B: Using the automatic award of new, local contracts: a forced disaggregation of the list.

Option A: Limiting the number of patients which practices can register as out-of-area

24. Limiting the number of out-of-area registrations could address the issues with expansion under the current rules whilst maintaining flexibility for those patients for whom the original out-of-area rules intended to support. It could be achieved by:
 - Preventing practices from registering patients who live more than a given distance away. However, catchment areas vary and this approach could penalise (as an example) commuters in a relatively arbitrary way;
 - Preventing practices from registering patients who reside outside their CCG or Sustainability and Transformation Partnership (STP)/Integrated Care System (ICS). However, some practice areas naturally span the boundaries of multiple STPs/ICS and this approach could penalise (as an example) those patients who live a short distance from a neighbouring STP/ICS;
 - Setting a cap on the proportion of patients who can be registered as out-of-area. Any cap could be relatively arbitrary and curtail the speed and agility by which digital-first models spread, leaving legacy issues to resolve.
25. Implementing these approaches would be challenging given the known issues in the recording of out-of-area registration status. Practices do not systematically collect data on the reasons why patients choose to register out-of-area. For all these options to work, particularly the cap, practices would need to undertake a significant administrative exercise to improve recording which would be time-consuming and burdensome. All variants of this option potentially involve some restriction of patient choice. We have therefore ruled this option out.
26. Even though this is not our preferred option, we intend to put steps in place to help practices to improve the recording of patients' registration status by:
 - Changing IT systems to make it easier to record out-of-area patients;

- Amending the new patient registration form to make it simpler to identify out-of-area patients and their rationale for registering with the practice;
- Issuing further communications to remind practices of the need to accurately record out-of-area patients; and
- Reminding the system about the processes around practice boundaries.

Option B: Disaggregating the patient list to create new, local practice contracts, linked to local CCGs and Primary Care Networks

27. We have considered whether there is a better way to reflect the fact that patients choosing new digital-first providers are almost certainly opting for the different service, rather than making an active choice to be registered as 'out-of-area'; the conflation of these two concepts is an artefact of the current system. Instead of limiting out-of-area registration, we propose to take steps to support patients' choice whilst addressing some of the issues identified in the current system.
28. For that reason, our preferred option is to determine a threshold number of patients who could be registered by a provider 'out-of-area' in any one CCG area before a new, local contract was awarded to the provider in question. That would mean:
 - Where small numbers of patients were registered, the system of out-of-area registration would continue as it does currently;
 - But if the number of out-of-area patients registered with the provider hit the threshold, the provision of services for those patients would automatically be transferred into a new contract held locally by the relevant CCG. This would ensure that contractual arrangements with the provider follow the flow of commissioner funding and local management;
 - We would ensure that the right to register truly out-of-area would always continue to exist for patients who wanted it, for example commuters.
29. As an illustrative example:
 - In July 2019, a number of patients who are resident in CCG X are registered out-of-area with a practice in CCG Y. They are patients of CCG Y. The practice may hold any type of primary medical services contract (GMS/PMS/APMS);
 - By April 2020 the number of patients resident in CCG X but registered with the provider in CCG Y reaches the agreed threshold for contract conversion;
 - The provider is automatically awarded a new contract in CCG X to which its patients resident in CCG X are transferred. These patients become patients of CCG X (again) rather than out-of-area patients;

- The provider continues to operate as before in CCG Y but its practice list does not include patients in CCG X, who from this point onwards would be registered to the new contract.
30. The key decision is the choice of threshold at which to trigger the creation of a new APMS contract. Set too low, the danger would be a series of contracts serving very few patients. Set too high, the danger is that the detractions of the current model are perpetuated for too many patients. We are therefore consulting on the correct threshold, but our starting proposition is that a threshold of between 1,000 and 2,000 patients might be used.
31. To avoid bureaucracy and uncertainty for GPs, CCGs and patients, the establishment of new contracts by this route would be an automatic process involving default bulk and automatic re-registration of patients with the same provider under its new contract.¹⁰ ¹¹ We propose that this is applied to all current and future GMS, PMS and APMS contracts (i.e. all providers). This may require changes to the Regulations and Directions governing them, made by the Department of Health and Social Care.
32. These changes would oblige the commissioner and provider to undertake this process. There is a precedent for conversion between different contract types serving the same patients in the existing right of PMS providers to request a GMS contract.¹² New APMS contracts established via this route would be on terms that ensured there was no advantage to the provider in this conversion; a digital-first provider would simply serve the same patients as before but in a more sustainable contract structure. Existing rules would apply with regards to contract transfers and sub-contracting. We propose that providers would not have the right to register out-of-area patients from these new APMS lists – otherwise we risk perpetually reintroducing the same problem we will have been seeking to solve.
33. We could require the physical premises established under new APMS contracts to be established in deprived areas of the relevant CCG and compel providers under the contract terms to take steps to ensure its list represents the cross-section of the local population in that area, with the aim of reducing inequalities. We would apply the Market Forces Factor for the new contract area. See chapter four for further discussion on proposed terms.

¹⁰ The APMS contract would remain in place even if the number of registered patients with the provider subsequently fell below the threshold after the contract was awarded. Any removal of the contract would be on prevailing national terms.

¹¹ The new patient registration premium would not apply to patients who are automatically re-registered under the new APMS contract.

¹² “The National Health Service (Personal Medical Services Agreements) Regulations 2015 Part 7, Right to a General Medical Service Contract”; available from: <http://www.legislation.gov.uk/ksi/2015/1862/contents/made>

34. Chapter four also explores whether there are also other circumstances in which new contracts should be available to digital-first primary care providers to further enable patient choice and tackle wider issues in the provision of primary medical services.

Amending the out-of-area registration payment level

35. When we engaged on digital-first primary care payments in 2018, some argued it was unfair that practices received the same payment for out-of-area patients as in-area patients.¹³ This is because practices are under no obligation to deliver home visits for out-of-area patients or urgent care during core hours. CCGs have to ensure urgent care arrangements are in place for out-of-area patients, which has a financial cost and requires careful commissioning to take account of the potential impacts on quality of care and patient safety.
36. This is not an issue when rates of out-of-area registration are low, as they have been historically. But as the use of out-of-area registration grows, it could become unsustainable.
37. We estimate that it might be reasonable for practices to receive somewhere between 72p and £2.93 less than the average global sum payment of £89.88 for an average out-of-area patient than an “in-area” patient, on the basis that practices are not required to deliver home visits for out-of-area patients:
 - 72p is based on the actual cost to CCGs for 2017/18 for the formal provisions made to deliver services to out-of-area patients via the “Out of area registration: In hours urgent primary medical care (including home visits) Enhanced Service” - £80,516.¹⁴ But this calculation does not take account of other types of arrangements put in place locally to support out-of-area patients and the wider impact of out-of-area registrations on other local open-access services, particularly urgent care.
 - £2.93¹⁵ is an estimate based on the current ratio of home visits to total appointments. 1 in 20 out-of-area registered patients have a home visit annually at an estimated cost of £60 per visit. However, this calculation has not been adjusted for patient characteristics.

¹³ “Digital-first primary care and its implications for general practice payments” public engagement report; available from:

https://www.engage.england.nhs.uk/survey/digital-first-primary-care/user_uploads/digital-first-access-to-gp-care-engagement-v2.pdf

¹⁴ Internal NHS England analysis based on “Payments to General Practice - England, 2017/18”; available from: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice/england-2017-18>

¹⁵ Internal NHS England analysis based on “Appointments in General practice, October 2018”; available from: <https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/oct-2018>

38. Given the proposed reduction in global sum is so small (78p would be a 0.8% reduction to global sum, whilst £2.93 a 3.2% reduction), we do not propose to change the payment level at this time. This is because it would require all practices to comprehensively review their patient lists to ensure accurate recording of out-of-area patients and we cannot justify the time practices would need to spend.
39. Further, in our recent engagement on digital-first primary care and its implications for general practice payments¹⁶, some respondents raised concerns that lowering the payment would discourage practices from accepting out-of-area patients. If the preferred option above is taken forward, patients could move between out-of-area and in-area status. Therefore, we propose to maintain the same payment level for out-of-area registered patients as in-area ones.

Consultation questions

- 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?
- Q1b.** Are there any factors which you think should be taken into account if this option were to be implemented?
- Q1c.** Please provide any views you may have about the proposed threshold of 1,000-2,000 patients for the triggering of this localisation.
- 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?

¹⁶ “Digital-first primary care and its implications for general practice payments” public engagement report; available from:

https://www.engage.england.nhs.uk/survey/digital-first-primary-care/user_uploads/digital-first-access-to-gp-care-engagement-v2.pdf

2. CCG allocations

40. Because of the way NHS funding currently flows following a patient's registration with a GP, CCGs with high numbers of out-of-area registrations become responsible for the healthcare costs of patients registering with a digital provider in their area in advance of the additional population being reflected in their funding allocations.
41. The increased volume, concentration and rate of out-of-area registrations described in chapter one can magnify the impact of the lag in funding adjustments and lead to a financial pressure. Though chapter one describes a mechanism by which this impact would be reduced by conversion of out-of-area registrations back to the 'right' CCG through APMS contracts, significant financial pressures could still arise for CCGs hosting a digital-first provider. It is right that the resources for out-of-area patients should flow as soon as is practicable from the CCG they were part of, and which no longer bears the financial responsibility for them, to the CCG they are now registered with.
42. The process for making this adjustment should be timely, perhaps once per quarter, prospective and proportionate, with a materiality threshold avoiding reopening allocations for all CCGs because of movements in registrations between a small number of practices.

Making the ongoing adjustment

43. Where the numbers of out of-area registrations are low and so the threshold to convert them back to the 'right' CCG has not been triggered we propose an adjustment using registration data to find the net flow of people registering with each digital practice from practices in other CCGs. The data are derived from the same datasets that underpin payments for primary medical care services and so are generally held to be of high quality.
44. We would then determine the financial value of the adjustment per patient. We propose that this should be based on the per capita allocation made to the original CCG, adjusted for the age and gender of the patients. From this, we would calculate a financial adjustment to be made from the subsequent quarter onwards. Considering the net flow would allow resources to flow back to the original CCG should the "pull" of the digital practice fluctuate, or should the threshold be breached, requiring the digital practice to operate through the originating CCG.
45. This capitation-based approach may not be sufficient to address concerns that digital-first models will attract patients with lower health needs (and hence costs).

46. We will explore two further options to address this concern. Firstly, using the practice-specific need indices; or, secondly, using the need indices of the digital practice itself. Using the originating practice would assume that people from each of its age-gender groups are attracted uniformly to the digital offer, which may not be the case. The latter will require the digital practice itself to have a sufficiently stable profile that its need indices can be robustly calculated. This is unlikely to be the case in the short term for a fast-growing practice, and the additional analysis required would take time to complete. In the context of a capitation-based approach, we will also consider whether the adjustments made should relate only to a subset of services, such as those to which pure activity-based payment applies under terms set in the National Tariff or prescribing costs, and not to other services such as community services which tend to be commissioned and paid for on a place basis.
47. An alternative approach to estimating the financial impact which takes account of the characteristics of the individual patients would be to use the actual costs incurred by the transferring individuals in the previous quarter and apply those to the forthcoming quarter. However, this would mean that fluctuations in usage by individuals will drive fluctuations in the resources transferred and result in greater financial uncertainty for CCGs affected by the adjustments. It is also inconsistent with the fairness principle of needs-based allocations. We therefore do not propose to take this approach.
48. There is a risk that small-scale registrations of out-of-area patients, in line with the original intention of the policy, could be affected by this policy and drive many burdensome low-value financial adjustments. This would be inefficient and risk deterring practices from accepting out-of-area registrations, and thus limit patient choice. We therefore propose to disregard patient flows where the accumulated flow to the CCG registering the out-of-area patients falls below a threshold. We would welcome views on where this threshold should be set.

Baseline adjustments

49. For patients moving during 2019/20, we propose to follow the process outlined above. However, we also need to make a baseline adjustment to take account of very rapid growth in Babylon GP at Hand (BGPaH) in 2018/19, from around 5,000 to around 33,000 registered patients, that has not been accompanied by an explicit adjustment to the funding allocations of the affected CCGs. We propose that a similar adjustment, based on registered patient flow and an age-gender adjusted capitation payment, should also be made for this baseline impact.
50. This will have a financial impact for CCGs whose patients have moved to register with BGPaH. However, we believe that in the context of material and rapid movements in registered population it is important that the resources follow the patient.

Consultation questions

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

3. New patient registration premium

51. This section considers whether we need to make any changes to the new patient registration premium, to ensure fairness in the distribution of resources. This builds on the public engagement we undertook last year on digital-first primary care and its implications for GP payments.¹⁷ This review led to the introduction of changes to the rurality index and London adjustment¹⁸ and highlighted the need to further consider the out-of-area registration payment (dealt with in Chapter 2) and the new patient registration premium.
52. When the current GP payment formula was established in 2004, the new patient registration premium¹⁹ was introduced to recognise the additional workload new registered patients generate, since they tended to be associated with a higher workload, including having more consultations in the first year than other patients with similar characteristics. Last year 10.7 million patients registered with a new practice (18%).²⁰ Based on patient turnover data from Jan 2015 to Dec 2018, 13% of newly registered patients leave the practice before completing a full year, while 6% do so within six months of registering.²¹
53. We need to review the premium in light of the expansion of digital-first primary care models because:
 - Digital-first providers have had a high number of new patient registrations in the past two years.²² This trend is likely to continue and could increase, particularly with any expansion of digital-first provision;

¹⁷ “Digital-first primary care and its implications for general practice payments” public engagement report; available from:

https://www.engage.england.nhs.uk/survey/digital-first-primary-care/user_uploads/digital-first-access-to-gp-care-engagement-v2.pdf

¹⁸ “Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan”; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

¹⁹ Also known as list turnover adjustment.

²⁰ Based on internal NHS England analysis.

²¹ Figures are derived from NHS England internal analysis of patient registration data and are gross figures, which include patient registrations and de-registrations for any reason, e.g. where patients need to move to a new practice following the closure or merger of GP practices.

²² Based on internal NHS England analysis.

- Digital-first providers have a higher rate of registration and de-registrations (patient churn). We know that the proportion of patients in London practices returning to their original practice within one year of moving to a new practice is 12%, while for digital models it is more than three times that rate.²³ The premium does not fully account for patient churn. This is because it is calculated at the end of each quarter, based on the proportion of a practice's registered list that joined during the previous twelve months;
 - We know that those registering with some digital-first providers are more likely to be younger and healthier.²⁴ We therefore need to consider whether it is still right to distribute funding towards new patient registrations rather than existing patients with co-morbidities and more complex needs.
54. We have considered several options including:
- Option A - Abolishing the new patient registration premium;
 - Option B - Retaining the new patient registration premium;
 - Option C - Keeping the new patient registration premium but setting stricter criteria for its payment.

Option A - Abolishing the new patient registration premium

55. When the Carr-Hill Formula was established, a 46% premium was considered to be about the right amount to pay practices for the additional workload a new patient generates over the course of a year. Abolishing the new patient registration premium would affect all practices but particularly those with naturally high list turnover rates (university practices, practices in urban areas or those with transient populations). It could also act as a disincentive for practices to register new patients or accept patients following practice closures, which could have a negative impact on patient choice and access. For these reasons, we do not propose to abolish the premium.

Option B - Retaining the new patient registration premium

56. Retaining the new patient premium in a world of increasing digital-first primary care risks diverting increasing levels of activity and funding to younger working age patients, rather than those with long term conditions, co-morbidities etc. It is conceivable that two practice moves within a few months might become

²³ Based on internal NHS England analysis.

²⁴ “Digital-first primary care and its implications for general practice payments” public engagement report; available from:

https://www.engage.england.nhs.uk/survey/digital-first-primary-care/user_uploads/digital-first-access-to-gp-care-engagement-v2.pdf

more common and there is a need to ensure that the funding formula takes account of this.

57. One option would be to vary the premium level in a more dynamic way to take account of potential or actual churn, ensuring spend on the premium is more predictable overall. But given the uncertainties and complexities, it would be difficult both to make these calculations and to determine a fair value. We therefore think the best option would be to maintain the premium but set stricter criteria for payment.

Option C - Applying new criteria for payment of the new patient registration premium

58. We propose that the new patient registration premium is only paid **if a patient remains registered with a new practice for an agreed period**. This approach would ensure that practices which spend more time seeing newly registered patients will be duly recompensed. We would welcome your views on the exact time period we should set, but propose this be between six and twelve months.

Consultation questions

- 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?
- 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?

4. Harnessing digital-first primary care to cut health inequalities

59. The NHS Long Term Plan commits that all patients will have the right to digital-first primary care over the next five years.
60. A key way this will be achieved is by supporting existing general practice to expand and develop its digital-first offer, as some practices are already doing by partnering with suppliers of digital technology to deliver a digital offer to their patients. A new programme will be introduced in 2019/20 to support ICSs, STPs, CCGs, PCNs and practices to develop an integrated digital-first offer that supports both patients and staff. The programme will ensure a new framework is available for digital suppliers to offer their platforms on standard NHS terms.
61. But we recognise that change takes time and this approach alone is unlikely to maximise take-up and innovation in digital-first services at pace, ensuring delivery of The NHS Long Term Plan commitment. We also need to continue to improve access to general practice services in some geographies, and digital-first providers could help achieve this.
62. Chapter one has already proposed a mechanism to convert lists of out-of-area patients held by existing providers into a separate, local contract. But this only applies where a digital-first provider already holds a local contract and may not fully honour the principle in The NHS Long Term Plan that patients should be able to choose to register with a digital-first practice.
63. In this chapter, we consider whether we could go further to facilitate new digital and physical services to be set up via an APMS contract in a way that would help to address issues in access to services.
64. This chapter also sets out further details of the possible terms of future APMS arrangements of both sorts.

Overview of proposed service model for new APMS contracts

65. Before a new APMS contract for digital-first provision is established, any provider would need to:
 - Offer a full primary medical care service (i.e. essential services as defined under GMS Regulations) throughout core hours from a zero-based list²⁵. This would include both digital and face-to-face services as patients will always need some physical contact with practices, even if more and more patients opt for digital consultations in future;
 - Establish physical premises from which to offer face-to-face services in the CCG area in which the contract is held - we propose that this includes areas identified as deprived to help reduce health inequalities and improve access to services;
 - Provide services for all cohorts of patients so no groups are disadvantaged. We want to ensure that digital services are promoted and accessible to all patients. We expect the provider to take steps, making every effort to ensure that its list reflects the demographics of the local population;
 - Integrate with other local services;
 - Co-operate with the relevant local PCN;
 - Become a member of the local CCG as the Health and Social Care Act 2012 (as amended) requires all GP practices to be members of a CCG;
 - Agree to APMS contract terms, specification and pricing. In the case of APMS contracts created under the proposals in chapter one particularly, this would be on terms no more generous than the contract from which the conversion occurred.
66. In addition, we expect the provider to offer comprehensive digital offer including, for example:
 - The ability for patients to book appointments online;
 - An evidence-based symptom checker;
 - Video consultations;
 - Asynchronous (online) consultations e.g. via text, email;
 - Management of repeat prescriptions online;
 - Full and integrated access to a GP medical record and personal health record.
67. We would expect providers to commit to working with other parts of the local health and care system to provide streamlined digital access for patients to all relevant services. We would also expect providers to innovate for the benefit of patients.

²⁵ This means that practices would not have any patients on their list until they register them.

68. The APMS contract would be offered on a rolling basis without a fixed length, subject to acceptance that the provider would deliver against prevailing national APMS terms which could be amended by commissioners.²⁶ The burden of the costs of set up would be for the provider to meet. Funding for each practice would otherwise mirror that for existing practices, be based on patient registrations with capitated payments using the Carr-Hill Formula. APMS providers would not as a default have access to funding through the Premises Costs Directions.²⁷

Where should we create new opportunities?

69. Except where indicated, the rest of this chapter applies only to possible opportunities for new providers to set up, rather than the proposals set out in chapter one.
70. In this regard, we have considered whether we should:
 - Allow providers to set up anywhere in England from April 2020;
 - Restrict new entry to only those areas facing the greatest GP capacity gaps.

Option 1: Enable expansion anywhere

71. One option would be to create new opportunities for providers to set up new services anywhere in England. This approach could help to expand the digital-first offer quickly. It could bring more capacity into the system and encourage a greater number of GPs into the workforce; who may want to work part-time or more flexibly as the BGPaH evaluation has shown.²⁸
72. But it marks a fundamental shift in how we commission services. Provider appetite would need to be tested, but it is possible that the approach would lead to an unequal spread of providers with providers more likely to be attracted to specific areas (such as urban areas) and not those in need of capacity. As such, it could lead to over-provision in some areas and potentially exacerbate the issues of under-doctoring in other areas.
73. There is also a risk, depending on patient appetite for new services, that the approach could:

²⁶ If the APMS contract was offered, by conversion, under the scheme set out in chapter one and the provider's original contract was a time-limited APMS contract, the new contract would need to be limited to the same term as the original contract

²⁷ Premises Cost Directions do not apply to APMS contracts.

²⁸ "Evaluation of Babylon GP at hand. Final evaluation report"; available from: <https://www.hammersmithfulhamccg.nhs.uk/media/156123/Evaluation-of-Babylon-GP-at-Hand-Final-Report.pdf>

- Destabilise existing providers if new providers attracted their patients or staff. This could lead to an increase in the rate of closure of existing practices;
 - Be inefficient when first established if new providers struggle to attract sufficient patients to be viable. This could lead to workforce inefficiencies at a time when general practice is stretched.
74. For these reasons we think it could be more beneficial to target any opportunities in areas of identified need, balancing the risks against the opportunity to tackle health inequalities and testing the real-world effects of the new model before further decisions are made.

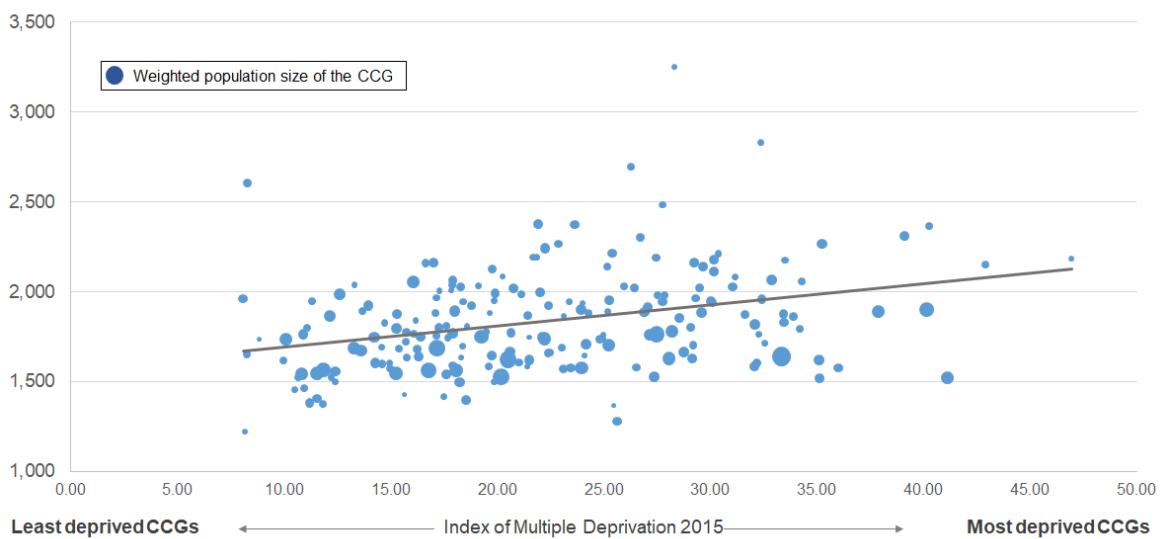
Option 2: Restrict expansion to areas which lack GP capacity

75. Numerous studies in recent years have highlighted a shortage of GP workforce as a result of population growth and increased need for care due to an ageing population.²⁹ Recent research suggests this issue disproportionately affects areas of deprivation, as GPs tend to care for more patients in areas of high deprivation.³⁰
76. This can be seen in the analysis we have undertaken of the number of registered GP Full Time Equivalents (FTEs) per weighted population. See Figure 2.

²⁹ “Securing the future: funding health and social care to the 2030s”; available from: <https://www.ifs.org.uk/uploads/R143.pdf>

³⁰ “Are parts of England 'left behind' by the NHS?”; available from: <https://www.nuffieldtrust.org.uk/news-item/are-parts-of-england-left-behind-by-the-nhs>

Figure 2: Registered weighted population per GP FTE

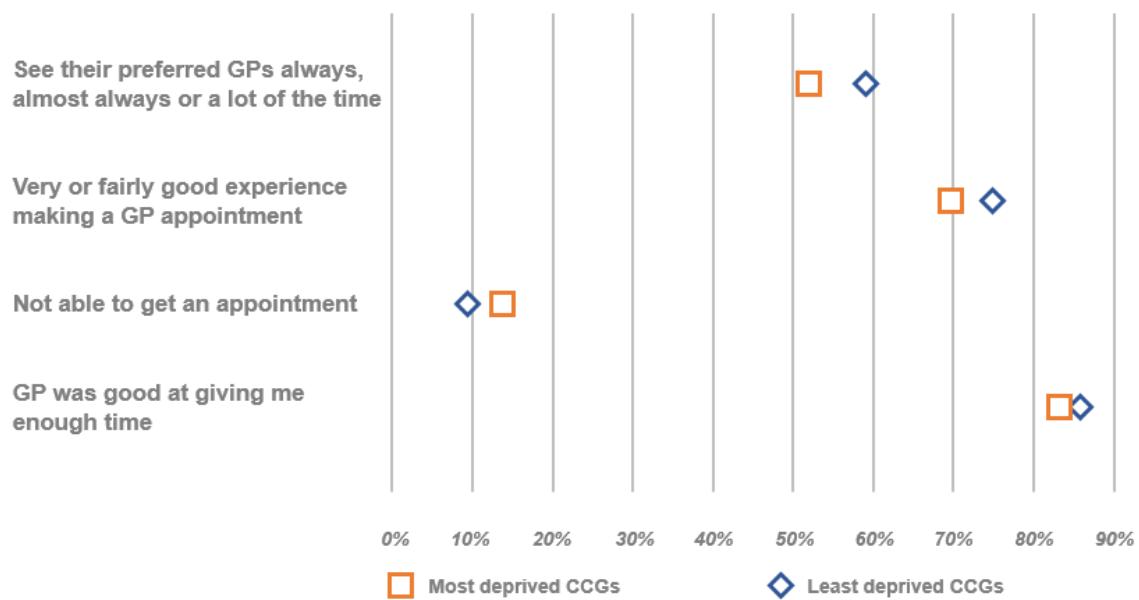


Note

NHS England analysis. Sources: NHS Digital General Practice Workforce December 2018, Index of Multiple Deprivation 2015. 'GP FTE' refers to all full time equivalents from fully qualified general practitioners including registrars; weighted population is as of January 2019.

77. Furthermore, the 2017 GP Patient Survey shows that patients in the most deprived areas find it harder to get a GP appointment. See Figure 3.

Figure 3: GP Survey 2017, selection of indicators related to access



Source: GP Patient Survey 2017 and English Indices of Deprivation 2015. Dayan M (2018) "Are parts of England 'left behind' by the NHS?" Nuffield Trust comment.
<https://www.nuffieldtrust.org.uk/news-item/are-parts-of-england-left-behind-by-the-nhs>

78. The NHS Long Term Plan promises stronger action on health inequalities, in line with NHS England's legal duties.³¹ As such, we think there is a stronger case for introducing extra capacity in areas considered to be under-doctored e.g. the most under-doctored 10% or 20% of the country.
79. This would not be the first time the NHS has developed approaches to try to address under-doctoring. The Medical Practices Committee (prior to the 2002 NHS Act) tried to ensure more equitable distribution of GPs, while the short-lived Equitable Access to Primary Medical Care programme offered incentives for practices to be opened in under-doctored areas.³²
80. **But the development of digital general practice now offers the possibility that has never before existed – to expand GP capacity for patients in an area even when the GP sessions are provided at some distance.** By targeting under-doctored areas, it could help to bring additional capacity into these areas and deliver improvements in access. This would support our wider goals to reduce health inequalities. **We would therefore require any such providers to have a credible plan for bringing additional GPs into the area from outside, and to deliver this additionality as an ongoing contractual requirement.**
81. Identifying under-doctored areas is challenging as there is no standard definition or methodology. We could take a simple approach and analyse the average number of weighted patients per GP and aggregate this data to CCG level. We could restrict entry to the lowest 10% or 20% of CCGs.
82. Or we could consider other factors that affect access to services. For example, the Equitable Access to Primary Medical Care programme assessed under-doctoring on the basis of:
 - Number of primary care clinicians (WTE GPs and WTE nurses per 100,000 population);
 - Health outcomes: life expectancy, cancer mortality amongst under 75s, cardiovascular mortality amongst under 75s, index of multiple deprivation; % of patients with diabetes in whose HBA1c is 7.5 or less, % of patients with hypertension in whose BP reading is 150/90 or less;
 - Patient satisfaction: % of patients seen within 48 hours; % able to book an appointment more than two days in advance; % satisfied with their practice telephone system; % able to see a specific GP; % satisfied with the practice opening hours.

³¹ Including duties under the Equality Act 2010 and section 13G of the NHS Act 2006.

³² The programme sought to invest £250 million towards establishing new general practices services in the 38 most under-doctored areas.

83. In addition to under-doctoring, other factors are indicative of constrained GP capacity including numbers of closed practice lists. These factors could be used to determine where opportunities should be available. We envisage having a rolling list of areas in which new providers can be established, reflecting the prevailing position as circumstances changed.
84. We would welcome your views on the methodology we could apply to identify areas lacking GP capacity as part of this engagement exercise, particularly the methodology around under-doctoring. A full methodology would be developed following this consultation, depending on its outcome
85. The location of physical premises would also need to be agreed with the relevant local commissioner. **We think there would be a strong case to require at least some of the face-to-face services to be set up in a deprived part of the CCG; while ensuring patients have adequate access to face-to-face services across the whole practice footprint.** This would help bring in extra capacity, improve access to services and support our wider goals to reduce health inequalities by giving patients in the most deprived parts of the country more choice. We propose to identify areas of deprivation on the basis of Index of Multiple Deprivation (IMD) scores at Lower Layer Super Output Area (LSOA) geographical level.³³ The full methodology would be developed following the consultation. We are keen to hear your views on the methodology we should use and whether it should also be applied to contracts established under the proposals in chapter one.
86. In addition to this, **we would expect providers not only to establish services in deprived communities but also to take steps to ensure that their registered population reflects the wider population which they are being asked to serve.** These requirements would be reflected in the APMS contract.

Evaluation and review of entry criteria

87. We could initially enable new providers to set up in areas which lack GP capacity from April 2020 as per Option 2. Simultaneously we would support existing general practice to expand its digital-first offer via a national framework as well as a national funding and support programme. Subject to the successful evaluation of such new opportunities having been made available, there could then be future reasons to expand the list of CCGs in which contracts could be offered. These might include for example consistent failure to make an offer of digital-first primary care to a specified standard.

Possible commissioning routes

88. We have considered three possible ways to award an APMS contract to new providers:
 - Via a standalone procurement exercise, with each commissioner responsible for designing and initiating a call to competition, open to any provider;
 - Via a call off exercise, with each commissioner using a framework or other purchasing system to select from a range of pre-approved providers;
 - By creating a new opportunity for providers to set up new practices in defined circumstances.

Standalone procurement exercise

89. This is where commissioners run a process to select a provider(s) to deliver a service. Typically, commissioners procure around 100 individual APMS contracts each year for core GP services e.g. to replace existing contracts. However, there are significant transactional costs associated with this type of procurement, which typically take between six to nine months and it would be very inefficient as a means for securing similar services.

Framework or other purchasing systems

90. Procurement processes can be organised more effectively and efficiently at scale for similar services, particularly where needed across the country. Traditional provider frameworks are more commonly recognised in response to very defined needs (but lock in only qualified providers at the point of establishment). However, just like individual procurements, these necessarily take time to establish and call-off still requires procurement/mini-competitions.
91. NHS England has been working to establish in 2019/20 more streamlined procurement arrangements to support local commissioners to secure APMS and urgently needed (caretaker) GP services. This would use a Dynamic Purchasing System (DPS), an online procurement system comprising pre-approved GP providers (who can join the DPS at any time unlike a traditional framework), which local commissioners would be able to use to invite bids more quickly to deliver APMS or caretaker services when these needs arise.

An opportunity to set up new practices in defined circumstances

92. Under this model, all approved providers meeting a set of criteria would be able to set up and deliver services to patients who choose to register with them as their GP practice. This approach would in our view be more practical and simpler and would be our preferred option as it would reduce

transactional costs associated with running multiple local procurement processes.

93. The approved providers list would likely include NHS trusts, whether acute or community, who may also be partnering with digital-first providers. It could also include groups of salaried or sessional GPs who want to set up their own new independent partnerships on a digital-first model, thus creating a new additional route to maintaining independent contractor status of the profession.

Implementation

Qualification criteria

94. We would expect the national qualification criteria to consist of the following elements:
 - Eligibility to hold a GP contract including ability to deliver “essential services” for primary medical care;³⁴
 - Suitability to hold a GP contract;
 - Ability to deliver a digital-first service (in addition to physical care when necessary).
95. In terms of the entitlement to hold a contract, we envisage using the standard APMS eligibility criteria. We would assess suitability of the provider to deliver full primary medical care to their registered population. For example, capability and experience, financial standing and stability, and governance amongst other things.
96. We would require the provider to have a credible plan to bring additional GP capacity from outside the local area. This would form part of the assessment process discussed below.
97. The provider would also need to demonstrate its capability to deliver a full digital-first service. We expect this would include as a minimum:
 - The ability for patients to book appointments online;
 - An evidence-based symptom checker;
 - Video consultations;
 - Asynchronous (online) consultations e.g. via text, email;

³⁴ The NHS Act does not list persons who may (or may not) enter into an APMS contract. However, the APMS Directions contain provisions relating to circumstances in which certain types of persons or organisation may not enter into an APMS contract (Direction 4). Further information can be found in Annex 3 of the “Primary Medical Care Policy and Guidance Manual”; available from: <https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/>

- Management of repeat prescriptions online;
 - Full and integrated access to a GP medical record and personal health record.
98. Providers will also have to demonstrate that they meet new IT standards for data security and interoperability currently being developed.³⁵
99. A full technical specification would be developed if it is agreed to take this approach forward. It is likely this specification would need to be regularly updated to ensure providers are offering the appropriate digital services to their registered population. Providers would need to continue to meet an updated and contemporary technical specification to remain eligible to provide services.

Assessment of providers

100. All providers wishing to take up the opportunity to offer services in this way must go through an assessment process in order to become an accredited provider, ensuring that meet the qualification critiera.
101. To avoid unnecessary duplication and placing too significant a burden on local areas, we propose to undertake as much of the assessment as feasible. There are three possible assessment approaches:
- i. NHS England could establish a single national provider list, accredit providers onto the list and then the providers would be contracted with NHS England to deliver a national service model in agreed areas.
 - ii. NHS England could require CCGs to establish a provider list. Providers would have to apply to be put on each provider list with CCGs undertaking the assessment of providers to ensure they meet the conditions set nationally. This would be time consuming for CCGs and potential providers who may be forced to apply to a large number of CCGs, as well as duplication and risk of inconsistency.
 - iii. The alternative, and our preferred approach, would be for NHS England to run a national approvals process for providers and require CCGs to establish services from the national provider list.³⁶ In doing so, each CCG would automatically give a contract on the agreed terms to providers that have been approved by NHS England and express a desire to provide in their area.

³⁵ They would also have to, for example, operate in line with the fully digital standards: “BETA - NHS digital, data and technology standards framework”; available from: <https://digital.nhs.uk/about-nhs-digital/our-work/nhs-digital-data-and-technology-standards/framework>

³⁶ Ultimately this could be a direction under Section 98A of the NHS Act 2006.

Local implementation

102. There would be a need to ensure appropriate local input into the establishment of the new services. Similar requirements would be needed in relation to the contracts established under the proposals in chapter one. Local commissioners would need to supplement the core terms of provision with details of local arrangements necessary to secure integration of the new service into the local offer. This could include:
- Requirements in relation to out-of-hours and extended access provision;
 - Any enhanced or local incentive scheme requirements;
 - Compliance with local referral processes and procedures that are currently in place;
 - Requirements around digital integration.

Participation in Primary Care Networks (PCNs)

103. The same principles/rules as currently in place would apply to all new APMS contracts, however established:
- Contract holders would be offered the PCN Network Contract Directed Enhanced Service (DES);³⁷
 - There would be a requirement for the new provider to co-operate with established PCN(s) and vice versa – this could require amendments to contract arrangements;
 - If new providers 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;
 - If the provider chose not to sign up to the DES, the relevant CCG would need to make alternative arrangements for provision of network services and associated funding to the provider's patient list by commissioning delivery from another PCN.

The role of PCNs

104. **NHS England could increasingly look to PCNs as the default to maintain or expand primary care provision. PCNs could support practices in their network when, for example, partners are retiring or seeking to hand back their contract.** Patient and public engagement would be part of those decisions. We are looking to simplify procurement processes as far as possible, and will consider what can be done under the existing legislative

³⁷ “Network Contract Directed Enhanced Service (DES) Specification 2019/20”; available from: <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-des-specification-2019-20/>

framework and what might require change. A public engagement exercise was recently undertaken about the future of procurement rules.³⁸

Consultation questions

- Q6.** Do you agree that we should not create a right to allow new contract holders to set up anywhere in England?
- 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?
- Q7b.** What methodology could we apply to identify these areas, specifically those that are under-doctored?
- Q7c.** Do you think that opportunities should be made available to a wider range of local areas in future following any successful evaluation?
- 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?
- 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?
- 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?
- Q7h.** Do you agree with the proposed approach to avoiding local bureaucracy by awarding contracts on the basis of satisfying agreed national criteria?
- 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?

³⁸ “Implementing the NHS Long Term Plan. Proposals for possible changes to legislation”; available from: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/02/nhs-legislation-engagement-document.pdf>

5. How to get involved

105. During the consultation, we will seek to gather views from a range of people, including GPs and other primary care clinicians, the public, charities, representative bodies, the technology industry, CCGs and others.
106. We will undertake appropriate assessments of the impact of the proposals as the consultation progresses and proposals are finalised.
107. The engagement exercise closes on **Friday 23 August 2019**.
108. You can respond using NHS England's online Citizen Space survey:
<https://www.engage.england.nhs.uk/consultation/digital-first-primary-care-consultation/>
109. If you prefer, we would be happy to receive views in writing to:

Digital-First Consultation
Primary Care Strategy and NHS Contracts Group
NHS England
Floor 2D
Skipton House
80 London Road
London
SE1 6LH

110. We are grateful to individuals and organisations who take the time to respond to this consultation.

Annex A: Summary of consultation questions

Please note this is an adapted version of a questionnaire designed for an internet web page. To view the questionnaire in its intended format and submit responses please visit: <https://www.engage.england.nhs.uk/consultation/digital-first-primary-care-consultation/>

You can respond with your name and/or organisation, you can remain anonymous or ask that your details are kept confidential and excluded from the published summary of responses. If you would like any part of the content of your response (instead of or as well as your identity) to be kept confidential, please let us know and make it obvious by marking in your response which parts we should keep confidential.

If you provide us with any personal information (i.e. name or email address) we will process, hold and store this in accordance with the General Data Protection Regulation and the Data Protection Act 2018. Your details will be kept for the minimum time necessary.

Introduction

In what capacity are you responding?

- Patient/Family member, friend or carer of patient/Member of the public/Patient representative organisation/Voluntary organisation or charity/Clinician/Clinical Commissioning Group/NHS Provider organisation/Industry/Other NHS Organisation/Other Healthcare Organisation/Professional Representative Body/Regulator/Other (please specify)

Have you read the document: Digital-First Primary Care: Policy consultation on patient registration, funding and contracting rule?

- Yes
- No

Chapter 1 – Out-of-area registration

- 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?

- Q1b.** Are there any factors which you think should be taken into account if this option were to be implemented?
- Q1c.** Please provide any views you may have about the proposed threshold of 1,000-2,000 patients for the triggering of this localisation.
- 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?

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

Chapter 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?
- 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?

Chapter 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?
- 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?
- Q7b.** What methodology could we apply to identify these areas, specifically those that are under-doctored?
- Q7c.** Do you think that opportunities should be made available to a wider range of local areas in future following any successful evaluation?
- 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?
- 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?
- 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?
- Q7h.** Do you agree with the proposed approach to avoiding local bureaucracy by awarding contracts on the basis of satisfying agreed national criteria?
- 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?

Glossary

APMS	Alternative Provider Medical Services
BGPaH	Babylon GP at Hand
CCG	Clinical Commissioning Group
DES	Directed Enhanced Service
DPS	Dynamic Purchasing System
FTE	Full-time equivalent
GMS	General Medical Services
GP	General Practitioner
ICS	Integrated care system
IMD	Index of Multiple Deprivation
LSOA	Lower Layer Super Output Area
PMS	Personal Medical Services
PCN	Primary Care Network
STP	Sustainability and transformation partnership
WTE	Whole Time Equivalent

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