Digital-First Primary Care

Response to policy consultation on patient registration, funding and contracting rules

NHS England and NHS Improvement

Digital-First Primary Care: Response to policy consultation on patient registration, funding and contracting rules

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Executive Summary

1. We undertook a public consultation on digital-first primary care between 27 June and 23 August 2019, which included proposals to change patient registration, payment and contracting rules.[1] This document summarises the feedback received, our response and next steps.

2. There were 234 written responses to the consultation, 210 of which were submitted via the NHS England Citizen Space online survey. Over 240 people attended the engagement events we held.

3. We have analysed and considered in detail the feedback received throughout the consultation.

4. Lots of people supported NHS England and NHS Improvement's commitment to do more to support existing practices to expand their digital offer. We will ensure that a core digital-first offer is available in general practice including core digital-first capabilities such as online and video consultation systems, triage mechanisms and symptom checkers for patients. As promised in the five year GP contract agreement, these core capabilities will be centrally funded for all of general practice and will be available from a national framework consisting of centrally accredited suppliers. Practices and PCNs will be involved in choosing suppliers and will be encouraged to collaborate to achieve economies of scale.

5. In addition, we will support all existing general practice to go through the business change necessary to make full use of these digital-first capabilities. Health systems will receive funding to provide the implementation support and training required for PCNs and practices to redesign how they deliver services to make best use of the technology on offer.

6. Some providers may choose to support their own services by buying additional clinical capacity from digital suppliers. We will consider establishing central accreditation for these services, potentially as part of the new supply

[1] https://www.england.nhs.uk/wp-content/uploads/2019/06/digital-first-primary-care-consultation.pdf

framework, to make it easier for all parties to use. Funding of clinical capacity will remain a matter for providers.

7. During our consultation lots of views were shared on digital-first clinical models more broadly. Concerns were consistently raised that to date, some digital-first providers have disproportionately attracted younger / healthier patients, leaving existing practices with an unbalanced mix of patients. Some raised concerns that digital-first delivery models might not support continuity of care, or good access to physical care, or connect with Primary Care Networks (PCNs). There were worries that vulnerable people may have poorer access to digital technologies. We take account of these points in our response.

8. In terms of the specific proposals:

    - Some argued that the out-of-area rules should be abolished altogether, whilst others strongly supported patient choice.

    - Lots of people supported the proposal to disaggregate a practice list and award a new APMS contract when a practice registers a certain number of out-of-area patients in another CCG. This was seen as a way of ensuring patients are better connected to local services. There was strong agreement that new digital-first practices should deliver a full spectrum of services including face-to-face services and ensure ease of access for patients. It was generally viewed as essential that new practices integrate with local services and pathways.

    - Views were split on whether the out-of-area payment level should be reduced. Of those in favour, most argued it should only be reduced for digital-first providers.

    - There was broad agreement that money should follow the patient in the NHS and for using a capitation approach to make the necessary adjustments to CCG allocations.

    - There was strong support for maintaining the new patient registration premium, given the additional administrative and clinical workload new patients generate. There was some support for setting stricter criteria for the payment of the new patient registration premium, but lots of people argued this should only be applied to out-of-area patients or digital-first practices and concerns were raised about the impact on practices with a

naturally high patient turnover. Some GPs pointed out that the majority of the additional workload for new patients occurs within the first three months of a patient's registration.

- There was broad agreement that if new opportunities for providers to set up services were to be created they should initially be targeted in areas in most need of capacity, and where access was worst. There was also broad support for widening the opportunities later, subject to successful evaluation.

- There was strong support for requiring providers to set up physical premises in deprived areas. Many flagged that people in deprived areas tend to have lower digital literacy and poorer access to digital technologies so access to physical services is vital. There was support in principle to require new contract holders to bring in *additional* GP capacity into the local area and ensure their lists reflected the makeup of the local population, but some were unclear about how this could be enforced. Many could see the benefits of running a national process for the award of contracts, but some argued for local commissioner involvement.

- There were mixed views on the proposal that PCNs should be the default mechanism for maintaining or expanding primary care provision. Some felt PCNs were well placed to deliver this, whilst others that they were not mature enough and this should remain solely a role for CCGs.

9. Following the support demonstrated through the consultation, we will take forward the proposal to disaggregate a patient list and create a new APMS contract, when a provider registers a certain number of out-of-area patients in another CCG. This will ensure that digital-first services are connected back wherever possible to local service delivery via a new APMS contract in that CCG. We will set the threshold at 1,000 patients.

10. We do not consider it would be appropriate to abolish the out-of-area registration rules as this would limit choice for all patients, nor reduce the out-of-area payment level at this time as this could act as a disincentive for providers to register out-of-area patients.

11. We will start with an adjustment to CCG budgets based on the age and gender of the patients registering with digital-first practices, plus the practice

they were previously registered with. The key decision for the long-term is setting the threshold below which no payments are made, and we agree we need to test the evidence further.

12. Following further consideration, we have decided not to take forward at this time the proposed changes to the new patient registration premium. But we will continue to monitor patient registration and de-registration levels, as we support more and more practices to deliver a comprehensive digital offer. We will review this position in 2021 to determine if further evidence exists that suggests the decision should be revisited.

13. We will target new providers at areas of greatest need (e.g., under-doctored areas or with poorest access and long waits for a GP practice appointment). We will implement further safeguards to address specific concerns raised. This includes (but is not limited to) ensuring that new practices deliver good access to physical services if needed, address the specific needs of the local population and integrate with local services and providers. We will run a national assessment process to create a list of approved providers that could set up services in these areas to minimise bureaucracy for local commissioners.

14. We will aim to implement the proposals to disaggregate a patient list and create a new local APMS contract when a practice registers over 1,000 patients in another CCG from April 2020 and create a list of approved providers who could set up new practices.

Introduction

Background and context

15. The NHS Long Term Plan commits that every patient will have the right to be offered digital-first primary care by 2023/24.[2]

16. 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.[3]

17. 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. Under the current arrangements, the expansion of these models has taken place by registering patients across wide geographies from a single GP practice.

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

    - Because of the way NHS funding flows, CCGs 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.

19. 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

[2] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[3] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf; https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

opportunities to improve access to services and bring additional capacity from part time GPs willing to work additional sessions from home.

20. In June 2019, we launched a public consultation on changing patient registration, contracting and funding 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.[4]

21. The consultation sought to solve four main questions:

- should we reform out-of-area registration rules to fit better with the world of digital-first providers and primary care networks (PCNs), and if so, how?
- linked to this, should we also improve the responsiveness of CCG allocation adjustments to reflect in-year patient flows, and if so how?
- should we change current premium for new patient registration?
- should we allow patients choice to register with a wider array of new digital-first providers, and if so, could we do so in a way that helps under-doctored areas and tackles inequalities, and also avoids current and future transaction costs of local APMS procurements?

22. The consultation document outlined five proposals:

- **Amend the out-of-area registration rules so that where a practice exceeds a threshold number of out-of-area patients in any CCG (we propose to fix this somewhere between 1,000-2,000 patients in any CCG, subject to views from consultees), then their main contract will be automatically disaggregated.** They would separately be awarded a local APMS contract in that CCG, through which to serve those patients, meeting all normal requirements including access to physical premises where required. Those patients would no longer be out-of-area patients.
- **Change the allocations system to enable quarterly recalculation of CCG funding to reflect patient movements of the sort which have**

[4] https://www.england.nhs.uk/wp-content/uploads/2019/06/digital-first-primary-care-consultation.pdf

been stimulated by registration with digital-first practices in London.

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

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

- **We also suggested that as part of these potential new national rules, we could remove the need for most local APMS procurements by looking to PCNs as the default mechanism for maintaining primary care provision.**

Summary of consultation approach

23. The consultation ran from 27 June 2019 to 23 August 2019.

24. In support of the consultation, we published a consultation document setting out our proposals: https://www.england.nhs.uk/wp-content/uploads/2019/06/digital-first-primary-care-consultation.pdf

25. The consultation document included 21 questions for feedback.

26. We ran an online survey via the NHS England Citizen Space to capture views on the proposals and received additional written feedback by post and email.

27. We also held engagement events for a broad array of stakeholders including groups representing the views of patients, commissioners, GP professional bodies, thinktanks and the tech industry.

Who responded to the consultation?

28. We received 234 written responses to the consultation. These included:

    - 210 responses via the NHS England Citizen Space online survey
    - 24 responses by email / post

29. The table below breaks down the responses by different respondents (based on the categories used in the NHS England Citizen Space online survey):

Respondent Type	Citizen Space survey	Post / email
Other	15	4
Academic	1	
Clinical commissioning group	33	5
Clinician	3	
GP organisation	36	4
GP practice staff	17	
Individual GP	51	4
Member of the public	33	
Regulator	2	5
Patient/Family member	0	
Friend or carer of patient	0	
Patient representative organisation	6	2
Voluntary organisation or charity	0	1
NHS Provider organisation	2	
Industry	0	
Other NHS Organisation	0	
Other Healthcare Organisation	3	
Professional Representative Body	3	3
Local authority	1	2
Technology industry/supplier	4	2
Total responses:	**210**	**24**

30. Annex A provides a quantitative analysis of responses by question.

31. Approximately 240 people attended our engagement events, meetings and webinars. We held 19 external meetings/events during the consultation. Attendees included Healthwatch members and patients, NHS commissioners and their representative bodies, GPs and GP professional bodies, thinktanks, the tech industry, and colleagues working in national organisations such as Health Education England.

32. We thank everyone who has responded to the consultation.

Summary of feedback and our response

33. We have analysed and considered in detail the feedback received throughout the consultation. This section summarises the feedback and our response. Annex A provides a quantitative analysis of the responses received via the NHS England Citizen Space online survey.

Overarching themes

34. There was a strong argument that more should be done to support existing practices to digitise. For example, one GP said:

> "Priority should be given to supporting existing primary care GP services to enable them to offer digital services to patients in addition to comprehensive primary care".

35. The Royal College of GPs (RCGP) said:

> "NHS England must provide the appropriate premises upgrades, hardware, software, and broadband capacity to support practices in delivering a digital-first primary care offering to their patients in a way that is tailored to the local context and local needs."

36. Many respondents thought digital providers should collaborate or partner with existing practices to deliver digital-first services.

37. We agree with the points raised.

38. We will ensure that a core digital-first offer is available to general practice. This will include core digital-first capabilities such as online and video consultation systems, triage mechanisms and symptom checkers for patients. These core capabilities will be centrally funded for all of general practice and will be available from a national framework consisting of centrally accredited suppliers. Practices and PCNs will be involved in choosing suppliers and will be encouraged to collaborate to achieve economies of scale. The five year framework for GP contract reform committed that the framework will be

available for use from 2021.[5] The capabilities included will be developed by NHS England, in discussion with the GPC and suppliers.

39. In addition, we will support all of existing general practice to go through the business change necessary to make full use of these digital-first capabilities. Health systems will receive funding to provide the implementation support, training and backfill required for PCNs and practices to redesign how they deliver services to make best use of the technology provided.

40. Some providers may choose to support their own services by buying additional clinical capacity from digital suppliers. We will consider establishing central accreditation for these services, potentially as part of the new supply framework, to make it easier for all parties to use and funding of clinical capacity will remain a matter for providers.

41. We expect this will be the bigger opportunity for digital-first providers than directly registering patients in competition with existing practices.

42. With regards to GP IT infrastructure, CCGs must ensure that there is continued investment to maintain, develop and upgrade existing IT services and infrastructure, as outlined in *Securing Excellence in Primary Care (GP) Digital Services: The Primary Care (GP) Digital Services Operating Model 2019-21*.[6]

43. GP practices must have in place safe, secure, effective and high performing IT systems and services that keep pace with the changing requirements to deliver care. To support this ambition, additional funding of £57.5m has been allocated to address weaknesses in the GP IT estate infrastructure to ensure that it is sufficiently robust and resilient to threat. This will include provision of robust operating system patch and upgrade management processes, mobile device management systems and funding efforts to update systems and local networks.

44. Overall there was more support for the specific proposals than not, as expanded upon below.

[5] https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf
[6] https://www.england.nhs.uk/wp-content/uploads/2019/09/GP-IT-Op-Model-Sept-2019.pdf

45. Lots of existing GPs wanted to ensure that the proposals do not destabilise existing practices. They were worried that new providers would attract younger and healthier patients, leaving existing practices with an unbalanced mix of more complex patients.

46. There was strong support for:

- new services needing to be fully integrated with existing services; and
- new digital-first practices being required to deliver a comprehensive range of services (both face to face as well as digital).

47. Our responses below set out the detail of how we will address these issues.

Out-of-area registration proposals

We asked…

- 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?

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

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

- 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?

Summary of feedback

Approach

48. Over half of respondents to the online survey agreed 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 service.[7]

49. Many felt this would enable patients to be better connected to local services and would ensure funding stays within the local CCG. For example, one independent charity reflected:

[7] These figures only reflect the responses received via the NHS England Citizen Space online survey. They do not include the responses received direct (e.g., letters) since the majority of these did not respond to the “yes/no” question asked but provided qualitative feedback.

> “We strongly support restoring the link to place. Digital-first primary care cannot be seen in isolation from wider NHS policy, which is focused on place-based care centred around local communities”

50. One Clinical Commissioning Group reflected:

> “The implementation of some sort of cap on out of area patients feels like a pragmatic way of supporting choice and supporting integration. The CCG is concerned that the current commissioning regulations for GMS and the way that some providers have sought to work with these presents significant risks to the delivery of "place based" services.”

51. Although the consultation did not ask specifically about the future of the out-of-area registration system per se, there was lots of support for maintaining patient choice of GP. For example, a member of Healthwatch said:

> “We support the decision not to change the out-of-area rules to ensure that the patients continue to benefit from having the choice to register with a GP practice that is convenient for them for work, family and for other reasons”.

52. However, some argued that our proposal could act as a disincentive for practices to register out-of-area patients, particularly if they wanted to avoid triggering the threshold. Some argued that transferring patients to a new contract was against the principles of the choice policy.

53. Some incumbent GPs were concerned that by offering people a choice of these new models it could affect their existing practices negatively.

54. There were also some who argued that the out-of-area rules should be scrapped altogether on the grounds they were incompatible with place-based care. For example, the British Medical Association (BMA) said:

> “We believe that the out-of-area regulations should be withdrawn as they are not in line with the wider NHS England policy relating to population-based health management and are no longer required due to the greater use of telephone, and in future digital, consultations via existing practices.”

Threshold

55. There was not a strong consensus on what the threshold should be:

    - Some favoured the lower limit of 1,000 patients on the grounds it was more aligned with a place-based delivery model. For example, one independent charity reflected: “we agree with the principle that commissioning of health services is best done by the CCG in which patients are resident and so the starting assumption should be that the threshold to move out-of-area patients back to their local CCG is as low as possible”.

    - Others favoured a higher threshold because they felt it reduced the risk of generating too many new APMS contracts.

    - Some reflected generally that 1,000-2,000 patients is not a viable practice list size.

    - It was suggested by some that the threshold should be proportionate to the CCG’s population or practice list size.

56. Commissioners in particular wanted to ensure that new APMS contracts avoid additional complexity and bureaucracy.

57. There were concerns that this proposal might place a burden on university practices, and surgeries which are located along the borders of several CCGs. Some argued that the trigger should be optional for the practice and not automatic.

58. Some requested further modelling/analysis and some a feasibility study or pilot.

APMS Contract Terms

59. Lots of views were shared on the proposed APMS contract terms:

    - There was support for new practices to be obliged to follow the full spectrum of national and local contractual requirements and deliver a full service to patients (e.g. home visits, urgent same day appointments as well as digital services).

- It was emphasised that new practices must fully integrate with local services, with some arguing that it was essential they were embedded into primary care networks. For example, one GP provider organisation said:

  "Local facilities to see patients face to face is essential and the service must be integrated with local networks."

- Many felt that the new contract should ensure ease of access to physical services as well as digital ones.

- Some argued the APMS contract should cover an ICS/STP footprint rather than a CCG one. One digital provider said:

  "The benefits of digital healthcare are only fully realised when providers can operate at scale, making it easier to communicate a digital offer to patients and to create an integrated digital model. We therefore believe digital-first services work best at a population health level, such as STP/ICS, which more accurately reflects the ambition of the Long Term Plan."

- With regards to premises, it was argued that it may not be necessary for one physical premises to be established under each contract to deliver good access to physical services (if the provider has premises in a neighbouring CCG that patients could easily access). Some commissioners highlighted the importance of agreeing the location of new premises with the provider.

60. Patient representative bodies were keen to ensure patients were given proper information about the new contract and what it means for them. For example, one Healthwatch member said:

> "NHS England should make it very clear when communicating any changes to patients that those who can't or don't wish to use digital services or tools will still be able to access face to face appointments and health care in general practice."

Out-of-area payment level

61. Just over half of respondents to the online survey felt that the payment for out-of-area patients should not be the same as for in-area patients. The main

arguments by those in favour of keeping the payment level the same was that out-of-area patients receive the same care as in-area patients, and changing the payment level could negatively impact upon "traditional" practices with high numbers of out-of-area patients and potentially disincentivise practices from registering out-of-area patients. Others argued the payment level should be reduced, as providers deliver a reduced range of services e.g., they are not obliged to deliver a home visit for out-of-area patients. Some respondents argued that the out-of-area payment should be reduced for digital-first providers only, on the grounds these providers typically have younger and healthier patients.

Our Response

Approach

62. There is more support than not for disaggregating a practice list and creating a new, local APMS contract, if the practice registers a certain number of patients in another CCG and we intend to take this proposal forward. But the feedback reinforces the need to get the threshold and safeguards right. We set out below how we have refined the proposal.

63. Although some people called for out-of-area registrations to be abolished, we consider that this would unjustifiably limit patient choice of GP, which has been a defining feature of the NHS since 1948. Since its introduction in 2015, the out-of-area policy has benefitted many patients. In September 2019, there were 146,106 out-of-area patients. Roughly 1,000 patients register per month as an out-of-area patient, excluding digital-first models.[8]

64. It is not our expectation that many APMS contracts will be triggered via this mechanism (see section on the threshold below), and general practice funding is increasing. The NHS Long Term Plan and new five year framework for GP reform set out how resources for primary medical and community health services will increase in real terms by over £4.5bn by 2023/24.[9] This investment guarantee will fund demand pressures, workforce expansion, and new services to meet relevant goals set out across the NHS Long Term Plan.

[8] Based on internal NHS England analysis – based on data extracted on 1st September 2019

[9] https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf; https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

65. To mitigate any risk that new contracts would not be stable, and to reflect the automatic migration from GMS or PMS contract terms, we will offer the APMS contract 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. But if the provider's original APMS or PMS contract was time-limited, the new contract would need to be limited to the same term as the original contract. If a practice's patient list subsequently fell below the threshold after a contract had been awarded, it would not be removed.

Threshold

66. We proposed in the consultation that the threshold be between 1,000-2,000 patients and following further consideration of the feedback, we consider this should be set at 1,000 patients. Many agreed with setting a lower threshold if the proposal were to go forward, including the BMA.

67. We note the suggestion that the threshold should be proportionate to the CCG's population or practice list size but feel this would be overly complicated and could create confusion for providers and others.

68. By setting the threshold at 1,000 patients, we would limit the number of contracts triggered, mitigating the risk of creating additional complexity and burden for commissioners and practices which are using the out-of-area rules as originally intended.

69. Based on data from September 2019, only one digital-first provider would trigger the threshold if the threshold were set at 1,000 patients – and sixteen new APMS contracts would be created.[10] The next practice, closest to hitting the threshold, has 403 registered out-of-area patients recorded in another CCG.[11] It is therefore unlikely many practices would trigger the new APMS contract when using the out-of-area rules in the way they were originally intended. It is also unlikely a 1,000 threshold would result in many commissioners having extra APMS contracts to manage. We will introduce further safeguards in light of the specific concerns raised about practices which border two or more CCGs and those practices which are using the out-of-area rules as originally intended. This will include incorporating a right for a CCG to agree in specific circumstances, at the request of the provider, that it

[10] NHS England internal analysis – based on data extracted on 1st September 2019
[11] NHS England internal analysis – based on data extracted on 1st September 2019

would not be appropriate to award a new contract. We will define in guidance the specific circumstances when a waiver could be made, but expect it to be rarely used and it would not affect those providers expanding fast via the out-of-area rules. This will further eliminate the risk that providers stop registering out-of-area patients to avoid triggering a new contract.

70. It is our intention to keep the threshold under review and monitor its impacts over time. We will also work to improve recording of out-of-area patients, as set out in the digital-first primary care consultation document.[12]

APMS contract terms

71. It is our intention to issue a standard nationally fixed APMS contract so that it minimises the burden for local commissioners.

72. We received lots of helpful feedback relating to the terms of the APMS contract and will reflect further on this as we develop the specification.

73. Many of the responses supported our core principles that:

- Contractors holding a new APMS contract should offer a full primary medical service (as defined under GMS regulations) that includes both face-to-face and digital services;
- Providers should offer services for all cohorts of patients, so no groups are disadvantaged;
- New practice lists should be integrated with other local services. We fully agree with this;
- Existing patients transferred to the new list would not automatically trigger the right to the new patient registration premium.

74. We are conscious that some CCGs are in the process of merging and understand why some providers would prefer to be able to register patients across an ICS/STP footprint. Under the current legislation, CCGs cannot jointly commission primary medical services. Therefore, new contracts need to be held by individual CCGs.

[12] https://www.england.nhs.uk/wp-content/uploads/2019/06/digital-first-primary-care-consultation.pdf

75. If two CCGs were to merge, the APMS contract would transfer to the "new CCG" with its existing practice boundary. At this point, a provider could seek to agree a larger footprint with the newly formed CCG as per the current process for reviewing practice boundaries between a commissioner and provider.[13] There may be an opportunity for a provider to merge two disaggregated lists, with the agreement of the CCG and provider. We will do further work with CCGs, providers and the BMA to develop an appropriate process.

76. Some people in their responses queried whether it was necessary to require one physical surgery to be established under each new APMS contract. We agree that there may be some room for flexibility in how to meet the fundamental principle that patients can also have good access to physical services where they are required, as comprehensive primary medical services cannot be entirely delivered via digital means.

77. We would normally expect premises to be established under each new APMS contract, unless the local commissioner (who holds the new contract) agrees otherwise based on guidance likely to be based on reasonable travel times. This may lead to agreement that no premises are required, for example in particularly urban areas where premises are easily accessible in a neighbouring CCG.

78. Some providers will have already established premises when the threshold is reached, whilst others will need to arrange new premises. Those who need to set up new premises will need to do so within twelve months of the threshold being reached.

79. With regards to premises funding, there will be no default entitlement to rent and rates reimbursement under the APMS contract. However, a local commissioner would be able to offer additional funding as part of the APMS terms which act as an incentive to set up premises in a particular area, for example in areas of greatest need.

80. We support calls from patient representative groups for affected patients to receive appropriate information about the new contract and what it means for

[13] https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/

them. We will consider further how we can best support providers to do this in collaboration with patient representative bodies.

Out-of-area payment level

81. We have considered further whether to change the amount we pay practices to care for out-of-area patients, but do not intend to take this forward at this time. As set out in the consultation document, any reduction would likely be small.[14] It would require all providers 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 doing this.

82. We also cannot reduce the payment for digital-first providers only. There is currently no way of distinguishing on payment systems between different types of providers. This will become even more difficult as more and more practices expand their digital offer. Further when a practice list is disaggregated and a new local contract awarded, the patients transferred would become in-area patients.

83. But we will keep the payment level under review. We will continue to monitor out-of-area registration numbers as more and more practices expand their digital offer and review any emerging evidence on the utilisation of other local services by out-of-area patients e.g., A&E and urgent treatment centres, as well as prescribing spend.

Next Steps

84. Changes to GMS Regulations will be required to give effect to these changes. We will continue to engage with GPC England on the detail.

85. Further implementation work will be undertaken with relevant partners including providers and CCGs to develop the standard APMS contract terms, including technical specification.

We will work towards implementing the proposals from April 2020.

[14] https://www.england.nhs.uk/wp-content/uploads/2019/06/digital-first-primary-care-consultation.pdf

CCG allocations proposals

We asked…

- 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?
- For these purposes, how do you think "significant" movements in registered patients should be defined?
- 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?
- Do you think it is necessary to cap or restrict the maximum deduction from any one CCG on an in-year basis?
- Do you agree that a capitation-based approach is the best way to determine the size of the adjustment required per patient?

Summary of feedback

86. There was widespread acceptance that the money should follow the patient, with many pointing out that this principle was already at the heart of the approach to both allocations and the General Medical Services (GMS) contract, recognising that those who had responsibility for commissioning or providing services for a population should have a fair share of resources to do so. In the case of digital-first primary care, around two thirds of those who responded believed that an adjustment was appropriate in this case.

87. Many of those who did not support the principle that resources should follow the patient were either (mistakenly) concerned that the adjustment would be done at the per head value without adjusting for the lower need of those registering for these services, or were more fundamentally opposed to the patient choice inherent in the out-of-area model.

88. Some respondents also noted that similar adjustments are not made for other population changes during an allocations round.

89. When asked about the scale at which movements should be considered, significant respondents variously referenced this to the size of a practice of the

size a CCG. Responses included “over 1,000 per practice” or “greater than 10% of the practice list”. The latter is about 800 patients for a typically sized practice. Others referenced the consultation document’s proposal that a new practice should be created when a digital-first practice has more than 1,000-2,000 patients resident in another CCG. They felt a similar definition of significant should be applied here.

90. Asking what threshold, if any, should be applied before making a deduction from a CCG prompted fewer quantified answers. Some respondents instead noted the challenges of setting the right threshold e.g., “There cannot be a general rule. This has to be assessed looking at local circumstances, ie, student population, migrant movements, student housing, availability of services.” Others felt unable to offer a view because they wanted to see more evidence. Perhaps because of this, where a scale was proposed, the range of proposals was so broad that no clear consensus emerged.

91. Approaching two-thirds of respondents felt that deductions from CCGs where patients had left to join other CCGs’ digital-first offer should be capped to avoid destabilising the CCG. For instance, “Programmes of work will have been committed too ...a significant change in funding will generate knee jerk savings and a loss of services and staff.” However, a further quarter suggested no cap was needed.

92. Given that there was widespread support for the principle that money should follow the patient, it is perhaps no surprise that there was also widespread support for the use of the capitation approach to make an adjustment. This was however caveated that it should only adjust for the needs of the people who choose to register with a digital-first practice.

93. A minority suggested a different approach, with an “adjustment fund” used to centrally compensate those hosting digital-first primary care, until the allocations could be coherently adjusted.

Our response

94. Given the widespread support that money should follow the patient and for using a capitation approach to make the necessary adjustment we will start here, with an adjustment based on the age and gender of the patients. This will go a long way towards ensuring that the per capita adjustment takes

appropriate account of the expected need of people choosing digital-first primary care.

95. We recognise the concern that such an adjustment is not made for other changes. However, the growth we have seen in Hammersmith & Fulham's registered population is unprecedented, and will undermine the robustness of the CCG if we do not make a sufficient adjustment in between allocation rounds.

96. We will implement a threshold level number of patients registering with the digital-first provider from another CCG; below this threshold no transfer would be made. This reduces the risk of a transfer being made for people who would have transferred away from their original CCG in any case, the kind of churn we try to take account of directly.

97. There was considerable support for a cap on the amount of resources a CCG could lose in year to support a digital-first provider in another CCG. In the longer term this will emerge naturally when a new practice is created when a digital-first practice has more than 1,000 patients resident in another CCG. Our latest estimates suggest that a typical CCG could then lose / gain a minimal amount. Any more than this, a new practice would be created in their own area, and the resources returned to them.

Next steps

98. The key decision for the long-term is setting the threshold below which no payments are made, and we agree we need to test the evidence further. We are now exploring datasets that will help us to understand the number of moves there are between CCGs that are also associated with a change in the CCG of residence. These are likely to be the business-as-usual moves we already take account of in allocations, and want to avoid including in the adjustment. This is important to protect areas with high turnover. But, if it is set too high, it will put an unnecessary pressure on the CCG hosting the digital-first provider.

99. From April 2020, the cap on the amount taken from one CCG to support others will emerge naturally from the wider policy of disaggregation. In the consultation we also noted the need in the meantime to make an adjustment to support Hammersmith & Fulham CCG.

New patient registration premium proposals

We asked…

- 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?

- 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?

Summary of feedback

100. Over half of the respondents to the online survey agreed that the new patient registration premium should only be paid if a patient remains registered with a practice for a defined period.

101. There were mixed views over what that timeframe should be, with responses ranging from one day to one year or more.

102. Some respondents thought we were seeking views on how long the premium should be paid for, rather than how long a new patient should be registered before the premium is applied.

103. The main argument for keeping the premium was that it reflects the additional administrative and clinical workload new patients generate. This extra work typically takes place in the first three months. For example, one GP said:

> "All the work in new registration takes place in the first 3 months with new patient checks, notes summarising and setting up all LTC checks and prescribing reviews".

104. Some argued it would be difficult to set a fair timeframe for payment, given some patients require a lot of care directly when they first register (for example, care home patients and those on the end of life care pathway), whilst others require no or little care.

105. A lot of people who supported the proposal in principle, argued that it should only be applied to digital-first practices. For example, the RCGP suggested:

"One solution to this would be to retain new patient registration premiums where patients move from one place-based provider to another, but not when they move to a digital-first provider."

106. A small number of respondents made the case for only applying the premium to out-of-area patients. For example, the BMA said:

"We believe this should only be the case for out of area registered patients. There should be no change for practices registered under the normal regulations, as this would represent a disadvantage to practices working in areas with a high turnover."

107. There were concerns about the potential impact the proposals could have on practices serving atypical populations such as university practices. One GP from a student practice said:

"Yes [in response to question 5a] but as a GP in a University practice with high turnover due to students coming for between 6 months and 5 years for various courses, it would destabilise University practices if this was set at 1 year - also as some students go on placements in year 3, they de-register and then re-register for their final year which may be 9 months"

108. Concerns were also raised about the impact on practices in urban areas that have a higher turnover of patients, as well as patients with higher needs. Particular concerns were raised about practices in inner-city areas with high deprivation, migrants, homeless people, patients with drug dependence and patients with mental health conditions as the patients often move practices frequently. An inner city LMC said:

"This [would discriminate...] against traditional General Practices in inner city areas who always experience a high turnover due to the nature of deprived populations, people moving in and out of temporary accommodation/homelessness etc", "some practices in […] have an annual turn over of 40%"

109. Finally, it was suggested by some that the premium could be replaced by distinct components to separately reflect the administrative workload of new patient registrations and the additional clinical utilisation.

Our response

110. The GP payment formula (the "Carr-Hill formula") recognises the additional clinical and administrative workload new patients generate. Practices receive an addition 46% payment for all new registrants in their first year of registration. As set out in the digital-first primary care consultation document, we do not propose to abolish the premium.[15] We also consider it would be too complex to separate out the administrative and clinical components of the premium.

111. We have reflected on the feedback received and whether now is the right time to implement a change in the payment criteria. We have decided to not take forward the proposal now for the following reasons:

- We note the feedback from GPs that the costs incurred with new patient registrations are typically in the first three months and there are very few patients who do not remain registered for fewer than three months.

- We note the concerns raised that the changes could destabilise practices with a high and fast turnover of patients such as those in inner-city urban areas and student practices, and those caring for nursing and care home residents in a way we do not fully understand at present. Attempting to account for this would require very complicated changes to payment and IT systems, disproportionate to the issue at hand.

- We are worried about the way "churn" works in practice and need further data on this as digital-first primary care services develops. One of the reasons we proposed the change was in light of emerging evidence from the GP at Hand evaluation that digital-first practices have a higher rate of registrations and de-registrations than other practices.[16] The latest evidence suggests an improvement in this provider's rate of de-registrations. It is too early to assume that the patient turnover rate will continue or increase and we need further data on this.

[15] https://www.england.nhs.uk/wp-content/uploads/2019/06/digital-first-primary-care-consultation.pdf
[16] "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

- Not making the changes will have no overall financial impact, as any small redistribution of funding happens within the allocation for primary care.

112. We do not think it would be appropriate to amend the new patient registration premium for digital-first practices only. As outlined earlier, it is not currently possible to distinguish clearly between different types of providers. This will become even more challenging as more practices take up the digital support NHS England offers.

113. We also do not think it would be appropriate to only amend the new patient registration premium for out-of-area patients, given practices go through the same registration process for “in-area” patients as out-of-area ones and may have the same clinical need. Further this could act as a disincentive for practices to register out-of-area patients and impact upon patient choice.

114. That said, we do intend to keep the new patient registration premium under review. We will continue to monitor levels of patient registrations and de-registrations for different types of primary care models over the next few years and assess their impact.

Next steps

115. We will consider in 2021 if there are any obvious reasons we should look at the new patient registration premium again.

Harnessing digital-first primary care to cut health inequalities proposals

We asked…

- Do you agree that we should not create a right to allow new contract holders to set up anywhere in England?
- 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?
- What methodology could we apply to identify these areas, specifically those that are under-doctored?
- Do you think that opportunities should be made available to a wider range of local areas in future following any successful evaluation?
- Do you agree with the proposal to require new contract holders to establish physical premises in deprived areas of a CCG?
- 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?
- Do you agree with the proposal to require new contract holders to demonstrate that they will bring additional GP capacity to the local area?
- Do you agree that we should require new contract holders to seek to ensure that their registered list reflects the community they are serving?
- Do you agree with the proposed approach to avoiding local bureaucracy by awarding contracts on the basis of satisfying agreed national criteria?
- 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?

Summary of feedback

Creating a right to allow new contract holders to set up anywhere in England

116. 76% of respondents to the online survey said that we should not create a right to allow new contract holders to set up anywhere in England. Concerns were raised that digital-first practices would “cherry pick” patients and leave existing practices with an unbalanced portfolio of complex patients, creating a two-tier general practice system. Those in favour of enabling new contract holders to set up anywhere in England argued it would expand patient choice and create

healthy competition in the market. For example, one representative organisation for digital healthcare providers stated:

> "New contract holders should be able to set up anywhere that patients choose. It is hard to justify restricting access to new services on the basis of geography given that, by definition, patients have expressed a clear preference to choose something that has not previously been available to them."

117. Others argued that new services should open in areas where there is genuine need and that the proposal could help to support areas with gaps in provision. One LMC said:

> "NHS England and CCGs should target areas with gaps in service provision and high health inequalities. New contracts should not be established without restrictions […]"

118. Some argued that local commissioners should assess their needs and ensure a digital practice would benefit the local health care system. For example, one CCG said:

> "[…] the provision of new contracts should be under local commissioner control as part of the primary care strategy for that area."

Targeting new entry to the most under-doctored areas

119. 48% of respondent to the online survey agreed that 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, compared to 39% who disagreed (and 13% who did not respond).

120. Those who were not supportive often expressed doubt about how digital-first services would benefit deprived communities, which typically have poorer access to digital technologies and about implications for vulnerable patients and those with highly complex needs and non-English speakers. One GP organisation said:

> "Need to ensure that more deprived patients have digital access. Patients in deprived areas are likely to be more demanding in terms of chronic disease."

121. Some argued that existing GMS contract holders should be supported to provide services in these areas with an appropriate balance of digital provision to reflect the needs of the patient, or that commissioners should be supported to address the issue in the first instance, prior to any provider being brought into the area.

122. Those in favour of targeting under-doctored areas argued that it could help increase access and capacity within the system where it was most needed. One medical group said:

> "Digital first has the potential to support and enhance care in rural areas where a practice may be some miles (and with poor public transport) away from a patient. Incentivising set up in these areas would be a positive step. However, account must also be taken of the poorer digital infrastructure that there currently is in more rural populations."

123. Various safeguards and caveats were recommended if the approach were taken forward. For example, it was argued new practices must take all patients, deliver high quality services and have proper governance and assurances in place to protect patients and staff.

124. One CCG said:

> "New entrants need to take responsibility for giving back to the community they enter - whether that be that they have to include the care of a broader range of patients...or provide digital training for the population...or invest 20% of turnover in the area in which they deliver services supporting those with LTC inc. dementia, frailty etc."

Methodology for identifying areas of need, specifically those that are under-doctored

125. There was a range of views on what methodology we should apply to identify areas of greatest need.

126. The majority of respondents suggested using metrics that can be drawn from national data sets. Suggestions (in varying combinations) included:

- Population per GP FTE, although some argued it should be wider than this and include nurse FTEs as well etc.;

- Deprivation levels;
- Socio-demographic characteristics;
- Health needs measures (e.g., mortality rates);
- Access to general practice, including appointment lead times and GP patient survey results;
- GP and training post vacancies;
- Access to emergency services;
- Staff turnover;
- Digital maturity.

127. Some argued that the assessment should involve local stakeholders and apply local criteria. For example, CCGs, PCNs, local GPs, LMCs etc.

128. There was also debate about whether the data should be aggregated at CCG level, sub-CCG level (e.g. Lower Layer Super Output Areas[17]) which would be even more targeted or STP/ICS level to ensure the services are financially viable.

Expanding opportunities to a wider range of local areas following any successful evaluation

129. Just over half of the respondents to the online survey argued that opportunities should be made available to a wider range of local areas in future, following successful evaluation.

130. There was support for further research to ensure that digital-first models improve access, health outcomes and patient satisfaction. Some suggested the evaluation should consider the stability of the service and impact upon health inequalities. Others queried what we would view as successful.

131. Some argued the evaluation should be at national level. Others supported local evaluation that involved local stakeholders appropriately.

[17] https://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/l/lower_layer_super_output_area_de.asp?shownav=1

132. Some respondents reinforced that practices and PCNs should be supported to develop their own digital-first offer as per existing NHS England and NHS Improvement plans.

Premises

133. 72% of respondents to the online survey agreed with the proposal that new contract holders should establish physical premises in deprived areas of a CCG.

134. One member of the public said:

> "It must be close to people who need help the most. By developing a new focal point that should have a boosting effect on the local population and start the improvement process."

135. One digital-provider stated:

> "Providers should be permitted to choose the site location of a new APMS list within the STP/ICS to maximise accessibility and patient choice and to ensure sustainable delivery of digital-first primary care."

136. There was a strong argument that new practices must be required to deliver a full spectrum of services. Some emphasised premises must be adequate to care delivery. For example, the BMA said:

> "Yes [to question 7d], but it can't just be a single room, it should be a proper health centre that is open for physical access in the same way as any other practice in the area."

137. The difficulties of setting up physical premises in deprived areas were highlighted. Some commissioners emphasised premises must be in line with local estate strategies.

138. With regards to methodology, respondents shared a range of views on how deprivation levels could be measured. It was argued that local knowledge and expertise should be sought.

139. Some argued there is not a clear and consistent link between under-doctored areas and deprivation.

Requirement for new contract holders to demonstrate that they will bring additional GP capacity into the local area

140. 80% of respondents to the online survey were supportive of requiring new contract holders to demonstrate that they will bring additional GP capacity to the local area.

141. Many thought this was necessary and fair to address local capacity issues and avoid placing further strain on existing practices, who could lose their workforce to the new providers. One CCG said:

> "[Yes] Otherwise this will not address the local workforce issues and simply place further strain on existing providers. There should also be some rules around the use of locums as ideally there would be a way of ensuring a sustainable staffing model with continuity for patients".

142. Some argued the principle should be extended to all general practice staff e.g., practice nurses etc. One CCG said:

> "The proposal focusses on GP capacity, new contract holders should be able to demonstrate how the they will bring additional primary care capacity to a local area, by using an appropriate skill mix of primary healthcare professionals – in line with the LTP."

143. Some queried whether providers could be expected to recruit additional capacity given the overall shortages of GPs. One digital-provider agreed with the principle, but only if it referred to digital GP capacity. They said:

> "It would however be unreasonable to put the onus on digital-first providers to bring more 'in-person' GP capacity to an area."

144. Others were sceptical about how it could be monitored and enforced. There were concerns the system could be "gamed" and it could become a tick box exercise.

145. Some reinforced that it was necessary for new providers to demonstrate how they will work with local GPs and the other services such as access hubs, 111, out of hours services etc. A few people raised that workforce plans should set out how staff will be trained to deliver remote consultations etc.

Requirement that new contract holders seek to ensure that their registered list reflects the community they are serving

146. 75% of respondents to the online survey agreed that new contract holders should seek to ensure that their registered lists reflect the community they are serving.

147. Many felt this was fair to avoid new practices from “cherry picking” younger and healthier patients. One GP organisation said:

> “This is a must to prevent the cherry picking of 'easy patients' and to support the Long Term Plan of multi-disciplinary teams serving a population which (including population health segmentation) will be impossible if existing practices are just left to care for the hard to manage, multi morbid patients.”

148. Some argued this would be very hard to implement as ultimately patients choose their practice. One independent charity reflected:

> “We agree in principle but think it will be difficult to implement as the list will be dependent on patients who have chosen to register so may well not reflect the community at that point.”

149. In addition, one GP said:

> “Absolutely. The NHS is founded on the principle of equality so any GP list should reflect the community it serves. However it is unclear how you would ensure this as the demographics of two neighbouring practices can sometimes be surprisingly different. Which registered list will reflect the community?”

150. There were also concerns it could impact upon patient choice. The BMA said:

> “We would be wary of endorsing any change that might deny some patients access (if they were to skew the representativeness of the practice), which goes against the NHS principle of patient choice.”

151. Some made further suggestions to ensure local needs are addressed by new providers. One Local Authority argued:

> “We agree with the proposal that contract holders should ensure that their registered list reflects the community they are serving and would further

propose that contract holders be required to conduct an Equality Impact Needs Assessment (EINA) and engage with local health and care partners and local residents in designing the service, to ensure that it is reflective of the needs and wishes of the community they are serving."

Proposed approach to awarding contracts

152. 50% of respondents to the online survey agreed with the proposed approach to avoiding local bureaucracy by awarding contracts on the basis of satisfying agreed national criteria.

153. The BMA said:

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

154. One digital-first provider said:

> "Yes, this is the most cost-effective and efficient way to run this process."

155. There was support for local organisations to be involved and calls for national criteria to take account of local factors. One CCG said:

> "I think this needs to be a joint approach. A national contract and finance structure with the ability for local commissioners to add in the nuances that influence their local population. A one size all approach will not work in its entirety, but it would help local commissioners to have a starting basis so they don't have to send time on the bureaucracy."

156. Some argued that new contracts should be set up on a case-by-case basis by local organisations particularly CCGs and LMCs. Some felt local areas have a much better understanding of where gaps of service are in their area, so are best placed to identify where to set up digital practices.

157. But some flagged the potential benefits national criteria could have in ensuring commissioners engaged in a consistent way. One independent sector provider of primary care said:

"Our experience is that there remains significant unwillingness from some CCGs to engage with digital first providers even where we can demonstrate that patients face material, comparative under provision. Even where some engagement has been achieved, our experience is of a time consuming local process, with multiple decision points, forums and other requirements, all of which impede progress and improvement. This has been the case even regarding relatively modest extensions to existing services. Use of national criteria may help overcome this as well as tackling the protectionism that still exist in the system."

Primary care networks (PCNs)

158. 53% agreed in the NHS England Citizen Space online survey that PCNs could become the default means to maintain primary care provision, thus removing the need for most local APMS procurements.

159. Some felt PCNs were not mature enough to exploit these opportunities and needed more time to develop. Some argued that PCNs do not have sufficient capacity and resources to deliver this and called for extra investment.

160. It was argued that it could drive protectionism. One independent sector provider of primary care said:

"Without proper competition there is a risk that there will be no pressure to improve service provision and that a local "lowest common denominator" approach to access will emerge."

161. Others felt they should have a role since they have an accurate knowledge of local needs and therefore felt to be in an ideal position to maintain primary care provision. One GP said:

"Yes the PCNs are the local primary care and often know what's best whilst being enough that they be objective"

162. Some argued CCGs must share responsibility and provide oversight. Some felt this felt important because community services are delivered at a bigger footprint than PCNs. Some argued CCGs should keep the right to procure services that develop the strength and breadth of local primary care provision and ensure value for money.

Our response

163. We hear the concerns about enabling new entry everywhere at this time and agree it should be targeted. There is support for targeting the potential of digital-first providers to tackle the inverse law and we intend to proceed with creating new opportunities in areas which lack GP capacity and / or have poor patient access, but with safeguards to ensure new practices bring additional capacity into the local healthcare system and their patient lists seek to reflect the demographics of the local population.

164. New contracts would be expected to deliver a full primary medical service to patients in the local CCG who they will hold a contract with, which includes necessary face to face services (as defined under GMS Regulations). Patients will always need face to face services and it is essential they have good access to physical care. Providers will be required to demonstrate that they can deliver a complete service as part of the assessment process.

165. We will also ensure that patients can access the new services through non-digital channels as well as digital ones. We know this is important for many patients and especially those with long term conditions. It is also vital in areas that are deprived where we know access to technology can be lower than other parts of the country.

166. Lots of people favoured a partnership approach to the expansion of digital-first models. We expect the approved providers list could include a range of partnership models. This may, in the first instance, include partnerships between NHS Trusts or Foundation Trusts, whether acute or community, and digital 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. Indeed, we expect this route will provide a useful opportunity for people wishing to innovate in primary care.

167. We note the calls for more investment to go into under-doctored areas. The NHS Long Term plan sets out how we will "increase investment in primary medical and community health services as a share of the total national NHS revenue spend across the five years from 2019/20 to 2023/24" and promises more action on health inequalities.[18]

[18] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

168. We also note the concern about the impact new providers could have on existing practices in areas they establish. As we set out in the consultation document our aim is to help bring additional capacity into under-doctored areas and deliver improvements in access. This supports our wider goals to reduce health inequalities.

169. We note the views shared on the methodology we use to identify "under-doctored" areas, including the need for local variation to be taken into account. Some people queried the link between "under-doctoring" and "deprivation". There is evidence to suggest that most deprived CCGs have a higher number of registered weighted patients per GP. Evidence from the 2017 GP survey also shows that patients in the most deprived areas find it harder to get a GP appointment.[19]

170. We suggested in the consultation that we could target the 10-20% most under-doctored CCGs. Of those who commented on this specifically, most favoured 20% or 25%. Therefore, our current expectation is that these opportunities will be opened in around 20-25% of CCGs, where patient access to primary care is worst.

171. We note that lots of people supported widening opportunities following successful evaluation. We will commission a rapid-cycle evaluation of the approach during 2021/22. This will consider the impact new practices are having on local systems and populations – including how the providers have brought in additional capacity and reduce waits for appointments. We will draw learning from this to inform our future approach.

Premises

172. At least one physical premises should be set up within twelve months of a provider indicating they intend to take up any new opportunity – where possible and appropriate in a deprived area. Providers may need to arrange more than one physical practice to meet the needs of their registered patients, depending on the footprint of the practice.

[19] https://www.england.nhs.uk/wp-content/uploads/2019/06/digital-first-primary-care-consultation.pdf

173. We note the requests from digital providers for fair rent and rates reimbursement. We will consider this further as we develop the APMS contract terms.

Requirement for new contract holders to demonstrate that they will bring additional GP capacity into the local area

174. There was clear support in principle for including this requirement in the new APMS contract as a means of addressing under-doctoring. But there were doubts about how in practice this could be assured. We will develop this expectation taking account of feedback as part of the new APMS contract terms, based on setting a reasonable requirement around the increase in total GP capacity that new providers should be required to demonstrate.

175. We would expect providers to submit credible workforce plans for review during the assessment process. We will consider further how we can best monitor and enforce this expectation in light of the concerns raised and reflect this in the APMS contract.

Requirement that new contract holders seek to ensure that their registered list reflects the community they are serving

176. There was also support in principle for including this requirement but also concern that it could be inconsistent with patient choice. Requiring providers to demonstrate they have made reasonable efforts to ensure their registered list reflects the communities they are serving and ensuring that people from deprived communities have opportunities to learn about the service and how it operates would be one approach we will consider.

Proposed approach to awarding contracts

177. We are conscious of the additional burden it could create for CCGs to run individual procurement exercises to let a new APMS contract. We are also conscious of the potential impact on providers.

178. We therefore intend to progress with a national assessment process and will look to develop this process, and the assessment criteria, with commissioners and providers.

179. We recognise though the need to ensure new providers are embedded into local areas and will set out further details on how we expect providers to work with local commissioners to set up services prior to contracts being awarded.

Primary care networks (PCNs)

180. We recognise aligning this approach with the ongoing development of PCNs has the potential to cause implementation issues. As set out in the digital-first primary care consultation document, the intention behind our proposals is to ensure that the same principles/rules as currently in place for all other providers would appropriately apply to all new APMS contractors.

181. We will further consider the responses received – in relation to whether PCNs could become the default means to maintain primary care provision – as we develop PCN policy going forward.

Next steps

182. NHS England and NHS Improvement will launch a programme of work to deliver the revised proposal. Over the next few months, we will:

- Identify CCGs in which new providers could initially establish. We intend to publish further details by the end of March 2020;
- Develop the standard APMS contract terms, taking into further consideration the feedback shared;
- Design the national assessment process and associated criteria.

183. The policy is intended to help address health inequalities. We have undertaken an initial equality impact assessment and will keep this under review to ensure the policy has the positive impacts we intend.

184. We will initiate the creation of a new national provider list in 2020/21. Once accredited, providers would be able to set up new services in areas of greatest need, subject to meeting agreed terms and conditions.

185. A rapid cycle evaluation will commence in 2020 to review the impacts and outcomes of the new contracts. This will conclude in 2021/22 and we will use it to consider whether the opportunities should be made available to a wider range of local areas.

Annex A: Quantitative analysis of the responses received via the NHS England Citizen Space Survey

186. This annex provides a quantitative analysis of responses received via the NHS England Citizen Space online survey.

187. We received 214 responses between 27 June and 23 August 2019 via the online survey. However, four responses were excluded because their content did not relate to the topics being consulted upon.

188. Please note this analysis only reflects the responses received via the NHS England Citizen Space online survey. It does not include responses received direct (e.g., emails and letters) since the vast majority of these only provided qualitative feedback.

Summary of respondents

Respondent Type	Number of respondents	As a % of all respondents	% responding as organisation	% responding as individual
Other (please specify below)	15	7.1%	60%	33%
Academic	1	0.5%	0%	100%
Clinical commissioning group	33	15.7%	85%	15%
Clinician	3	1.4%	0%	100%
gp organisation	36	17.1%	92%	8%
GP practice staff	17	8.1%	41%	59%
Individual GP	51	24.3%	14%	86%
Member of the public	33	15.7%	0%	97%
Regulator	2	1.0%	50%	50%
Patient representative organisation	6	2.9%	67%	33%
NHS Provider organisation	2	1.0%	50%	50%
Other Healthcare Organisation	3	1.4%	33%	67%
Professional Representative Body	3	1.4%	100%	0%
Local authority	1	0.5%	100%	0%
Technology industry/supplier	4	1.9%	75%	25%
Total	**210**	**100%**	**47%**	**52%**

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?

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	8	5	2	53%	33%	13%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	19	11	3	58%	33%	9%
Clinician	1	2	0	33%	67%	0%
gp organisation	16	18	2	44%	50%	6%
GP practice staff	9	8	0	53%	47%	0%
Individual GP	26	25	0	51%	49%	0%
Member of the public	21	11	1	64%	33%	3%
Regulator	1	1	0	50%	50%	0%
Patient representative organisation	6	0	0	100%	0%	0%
NHS Provider organisation	1	1	0	50%	50%	0%
Other Healthcare Organisation	2	1	0	67%	33%	0%
Professional Representative Body	2	1	0	67%	33%	0%
Local authority	0	1	0	0%	100%	0%
Technology industry/supplier	3	1	0	75%	25%	0%
Count/Average:	**116**	**86**	**8**	**55%**	**41%**	**4%**

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?

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	5	7	3	33%	47%	20%
Academic	0	1	0	0%	100%	0%
Clinical commissioning group	9	16	8	27%	48%	24%
Clinician	1	2	0	33%	67%	0%
gp organisation	12	21	3	33%	58%	8%
GP practice staff	8	8	1	47%	47%	6%
Individual GP	16	32	3	31%	63%	6%
Member of the public	16	15	2	48%	45%	6%
Regulator	1	0	1	50%	0%	50%
Patient representative organisation	3	3	0	50%	50%	0%
NHS Provider organisation	2	0	0	100%	0%	0%
Other Healthcare Organisation	2	1	0	67%	33%	0%
Professional Representative Body	1	1	1	33%	33%	33%
Local authority	0	1	0	0%	100%	0%
Technology industry/supplier	4	0	0	100%	0%	0%
Count/Average:	**80**	**108**	**22**	**38%**	**51%**	**10%**

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?

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	10	3	2	67%	20%	13%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	30	3	0	91%	9%	0%
Clinician	3	0	0	100%	0%	0%
gp organisation	25	10	1	69%	28%	3%
GP practice staff	11	5	1	65%	29%	6%
Individual GP	30	17	4	59%	33%	8%
Member of the public	24	7	2	73%	21%	6%
Regulator	1	1	0	50%	50%	0%
Patient representative organisation	6	0	0	100%	0%	0%
NHS Provider organisation	1	1	0	50%	50%	0%
Other Healthcare Organisation	3	0	0	100%	0%	0%
Professional Representative Body	1	1	1	33%	33%	33%
Local authority	0	1	0	0%	100%	0%
Technology industry/supplier	4	0	0	100%	0%	0%
Count/Average:	**150**	**49**	**11**	**71%**	**23%**	**5%**

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

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	7	6	2	47%	40%	13%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	22	5	6	67%	15%	18%
Clinician	1	1	1	33%	33%	33%
gp organisation	17	10	9	47%	28%	25%
GP practice staff	11	3	3	65%	18%	18%
Individual GP	32	11	8	63%	22%	16%
Member of the public	18	13	2	55%	39%	6%
Regulator	2	0	0	100%	0%	0%
Patient representative organisation	5	0	1	83%	0%	17%
NHS Provider organisation	1	0	1	50%	0%	50%
Other Healthcare Organisation	1	2	0	33%	67%	0%
Professional Representative Body	2	0	1	67%	0%	33%
Local authority	0	1	0	0%	100%	0%
Technology industry/supplier	2	2	0	50%	50%	0%
Count/Average:	**122**	**54**	**34**	**58%**	**26%**	**16%**

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?

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	9	4	2	60%	27%	13%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	19	13	1	58%	39%	3%
Clinician	3	0	0	100%	0%	0%
gp organisation	15	18	3	42%	50%	8%
GP practice staff	4	12	1	24%	71%	6%
Individual GP	33	17	1	65%	33%	2%
Member of the public	25	5	3	76%	15%	9%
Regulator	2	0	0	100%	0%	0%
Patient representative organisation	4	2	0	67%	33%	0%
NHS Provider organisation	0	1	1	0%	50%	50%
Other Healthcare Organisation	0	2	1	0%	67%	33%
Professional Representative Body	0	1	2	0%	33%	67%
Local authority	1	0	0	100%	0%	0%
Technology industry/supplier	3	1	0	75%	25%	0%
Count/Average:	**119**	**76**	**15**	**57%**	**36%**	**7%**

Q5b. What time 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?

Respondent Type	% Six months	% Nine months	% Twelve months	% Other (please specify below)	% Not Answered
Other (please specify below)	33%	7%	20%	20%	20%
Academic	0%	0%	100%	0%	0%
Clinical commissioning group	15%	3%	36%	39%	6%
Clinician	33%	33%	33%	0%	0%
gp organisation	22%	8%	8%	50%	11%
GP practice staff	35%	6%	6%	35%	18%
Individual GP	35%	4%	14%	39%	8%
Member of the public	27%	15%	21%	9%	27%
Regulator	0%	0%	50%	0%	50%
Patient representative organisation	50%	0%	17%	33%	0%
NHS Provider organisation	0%	0%	0%	0%	100%
Other Healthcare Organisation	33%	0%	0%	67%	0%
Professional Representative Body	0%	0%	0%	67%	33%
Local authority	0%	0%	0%	100%	0%
Technology industry/supplier	0%	0%	75%	25%	0%
Count/Average:	**27%**	**7%**	**19%**	**34%**	**14%**

Respondent Type	Six months	Nine months	Twelve months	Other (please specify below)	Not Answered
Other (please specify below)	5	1	3	3	3
Academic	0	0	1	0	0
Clinical commissioning group	5	1	12	13	2
Clinician	1	1	1	0	0
gp organisation	8	3	3	18	4
GP practice staff	6	1	1	6	3
Individual GP	18	2	7	20	4
Member of the public	9	5	7	3	9
Regulator	0	0	1	0	1
Patient representative organisation	3	0	1	2	0
NHS Provider organisation	0	0	0	0	2
Other Healthcare Organisation	1	0	0	2	0
Professional Representative Body	0	0	0	2	1
Local authority	0	0	0	1	0
Technology industry/supplier	0	0	3	1	0
Count/Average:	**56**	**14**	**40**	**71**	**29**

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?

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	10	4	1	67%	27%	7%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	24	4	5	73%	12%	15%
Clinician	1	2	0	33%	67%	0%
gp organisation	30	5	1	83%	14%	3%
GP practice staff	13	3	1	76%	18%	6%
Individual GP	42	6	3	82%	12%	6%
Member of the public	25	4	4	76%	12%	12%
Regulator	0	1	1	0%	50%	50%
Patient representative organisation	5	1	0	83%	17%	0%
NHS Provider organisation	1	0	1	50%	0%	50%
Other Healthcare Organisation	3	0	0	100%	0%	0%
Professional Representative Body	2	0	1	67%	0%	33%
Local authority	1	0	0	100%	0%	0%
Technology industry/supplier	1	3	0	25%	75%	0%
Count/Average:	**159**	**33**	**18**	**76%**	**16%**	**9%**

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?

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	4	8	3	27%	53%	20%
Academic	0	1	0	0%	100%	0%
Clinical commissioning group	17	8	8	52%	24%	24%
Clinician	2	1	0	67%	33%	0%
gp organisation	11	21	4	31%	58%	11%
GP practice staff	7	8	2	41%	47%	12%
Individual GP	26	24	1	51%	47%	2%
Member of the public	18	8	7	55%	24%	21%
Regulator	1	1	0	50%	50%	0%
Patient representative organisation	6	0	0	100%	0%	0%
NHS Provider organisation	1	0	1	50%	0%	50%
Other Healthcare Organisation	3	0	0	100%	0%	0%
Professional Representative Body	1	0	2	33%	0%	67%
Local authority	0	1	0	0%	100%	0%
Technology industry/supplier	4	0	0	100%	0%	0%
Count/Average:	**101**	**81**	**28**	**48%**	**39%**	**13%**

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

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	12	2	1	80%	13%	7%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	18	3	12	55%	9%	36%
Clinician	2	1	0	67%	33%	0%
gp organisation	15	13	8	42%	36%	22%
GP practice staff	7	5	5	41%	29%	29%
Individual GP	21	23	7	41%	45%	14%
Member of the public	20	6	7	61%	18%	21%
Regulator	1	1	0	50%	50%	0%
Patient representative organisation	3	1	2	50%	17%	33%
NHS Provider organisation	0	1	1	0%	50%	50%
Other Healthcare Organisation	3	0	0	100%	0%	0%
Professional Representative Body	1	0	2	33%	0%	67%
Local authority	1	0	0	100%	0%	0%
Technology industry/supplier	4	0	0	100%	0%	0%
Count/Average:	**109**	**56**	**45**	**52%**	**27%**	**21%**

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

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	11	3	1	73%	20%	7%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	21	3	9	64%	9%	27%
Clinician	2	1	0	67%	33%	0%
gp organisation	25	11	0	69%	31%	0%
GP practice staff	10	4	3	59%	24%	18%
Individual GP	41	7	3	80%	14%	6%
Member of the public	24	5	4	73%	15%	12%
Regulator	1	1	0	50%	50%	0%
Patient representative organisation	6	0	0	100%	0%	0%
NHS Provider organisation	1	0	1	50%	0%	50%
Other Healthcare Organisation	3	0	0	100%	0%	0%
Professional Representative Body	2	0	1	67%	0%	33%
Local authority	1	0	0	100%	0%	0%
Technology industry/supplier	2	2	0	50%	50%	0%
Count/Average:	**151**	**37**	**22**	**72%**	**18%**	**10%**

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?

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	11	2	2	73%	13%	13%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	26	2	5	79%	6%	15%
Clinician	2	1	0	67%	33%	0%
gp organisation	29	4	3	81%	11%	8%
GP practice staff	12	3	2	71%	18%	12%
Individual GP	41	3	7	80%	6%	14%
Member of the public	28	1	4	85%	3%	12%
Regulator	2	0	0	100%	0%	0%
Patient representative organisation	6	0	0	100%	0%	0%
NHS Provider organisation	1	0	1	50%	0%	50%
Other Healthcare Organisation	2	1	0	67%	33%	0%
Professional Representative Body	2	0	1	67%	0%	33%
Local authority	1	0	0	100%	0%	0%
Technology industry/supplier	3	1	0	75%	25%	0%
Count/Average:	**167**	**18**	**25**	**80%**	**9%**	**12%**

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?

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	8	4	3	53%	27%	20%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	24	2	7	73%	6%	21%
Clinician	2	1	0	67%	33%	0%
gp organisation	30	4	2	83%	11%	6%
GP practice staff	14	1	2	82%	6%	12%
Individual GP	42	4	5	82%	8%	10%
Member of the public	21	8	4	64%	24%	12%
Regulator	1	1	0	50%	50%	0%
Patient representative organisation	6	0	0	100%	0%	0%
NHS Provider organisation	1	0	1	50%	0%	50%
Other Healthcare Organisation	3	0	0	100%	0%	0%
Professional Representative Body	2	0	1	67%	0%	33%
Local authority	1	0	0	100%	0%	0%
Technology industry/supplier	1	3	0	25%	75%	0%
Count/Average:	**157**	**28**	**25**	**75%**	**13%**	**12%**

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

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	10	3	2	67%	20%	13%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	15	10	8	45%	30%	24%
Clinician	2	1	0	67%	33%	0%
gp organisation	19	13	4	53%	36%	11%
GP practice staff	6	8	3	35%	47%	18%
Individual GP	24	22	5	47%	43%	10%
Member of the public	18	9	6	55%	27%	18%
Regulator	1	1	0	50%	50%	0%
Patient representative organisation	2	4	0	33%	67%	0%
NHS Provider organisation	1	0	1	50%	0%	50%
Other Healthcare Organisation	3	0	0	100%	0%	0%
Professional Representative Body	0	1	2	0%	33%	67%
Local authority	1	0	0	100%	0%	0%
Technology industry/supplier	3	1	0	75%	25%	0%
Count/Average:	**106**	**73**	**31**	**50%**	**35%**	**15%**

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?

Respondent Type	Yes	No	Not Answered	% Yes	% No	% Not Answered
Other (please specify below)	5	6	4	33%	40%	27%
Academic	1	0	0	100%	0%	0%
Clinical commissioning group	20	3	10	61%	9%	30%
Clinician	2	1	0	67%	33%	0%
gp organisation	15	21	0	42%	58%	0%
GP practice staff	11	4	2	65%	24%	12%
Individual GP	28	20	3	55%	39%	6%
Member of the public	15	10	8	45%	30%	24%
Regulator	1	1	0	50%	50%	0%
Patient representative organisation	6	0	0	100%	0%	0%
NHS Provider organisation	1	0	1	50%	0%	50%
Other Healthcare Organisation	2	0	1	67%	0%	33%
Professional Representative Body	1	0	2	33%	0%	67%
Local authority	1	0	0	100%	0%	0%
Technology industry/supplier	3	1	0	75%	25%	0%
Count/Average:	**112**	**67**	**31**	**53%**	**32%**	**15%**

Glossary

APMS	Alternative Provider Medical Services
CCG	Clinical Commissioning Group
FTE	Full-time equivalent
GMS	General Medical Services
GP	General Practitioner
ICS	Integrated care system
LMC	Local Medical Committee
PMS	Personal Medical Services
PCN	Primary Care Network
STP	Sustainability and transformation partnership