



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

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

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Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

Foreword	5
1 Context	6
1.1 Digital innovation at the forefront of primary care.....	6
Case study: Making use of e-consultations at Chelston Hall Surgery	7
Case study: Growth of digital-first services internationally	9
1.2 Paying for digital-first primary care.....	10
Case study: Digital-first Primary Care in London	13
2 Specific proposals for amendments to GP payments	15
2.1 Rurality index payment explained	16
2.2 London adjustment explained	19
2.3 Paying for in-hours urgent primary medical care (including home visits) to out-of-area patients explained.....	21
2.4 The cumulative impact.....	24
3 Wider future considerations for funding digital primary care services	25
3.1 Future support for the development and adoption of digital primary care	25
4 How to get involved and next steps	27
5 Glossary	28
6 Appendix: Detail of analytical evidence	30

Foreword

As we celebrate the 70th birthday of the NHS, we know that by the end of the next decade digital technology is likely to have transformed the service. Digital systems will be integral to a modern, efficient and responsive health service. Well-designed digital tools are already helping to provide care and services that are convenient for patients, efficient for the NHS and which get people the right care for them as quickly as possible.

One of the challenges is ensuring that the way we commission, contract and pay for care keeps up with the opportunities digital innovation offers – ensuring that new technology is safely integrated into health and care pathways, whilst not unfairly destabilising existing services. NHS England and the General Practitioners Committee of the British Medical Association (GPC) agree that finding the right balance in this respect is key to delivering the best outcome for patients and those that care for them. With that in mind, this document sets out a number of ways in which the payments for general practice may need to be updated to account for the emergence of digital-first access to primary care. The objective is to ensure that available resources are distributed in as fair a way as possible to general practices, reflecting the patients they serve. But it is important to recognise that this is a first step, informed by the evidence available, but inevitably followed by further debate as our understanding of new delivery models and their value evolve and mature. We also seek wider views about how primary care funding models can best support innovation.

We welcome the opportunity to engage with the public, primary care professionals, and digital innovators on this very important topic, and the proposals set out below which will inform further discussions between NHS England and the GPC about how and whether to take these proposals forward.

1 Context

1.1 Digital innovation at the forefront of primary care

1. The spread of technology has the potential to enhance the precision, personalisation and efficient delivery of care, improving the daily experiences of both patients and clinicians. To this end, GP practices are increasingly offering more online access to services. This is intended to result in greater convenience for patients, and may help manage increasing demand on general practice in a more efficient way by directing people to the right place, at the right time, to consult the right person and ensure they receive the care or advice they need. It chimes with a growing consumer trend in how people prefer to access services in many aspects of life.
2. Each year, more of us choose online routes to book appointments with our GP, order repeat prescriptions or view personal health records. In recent years, mobile apps and online platforms have started to facilitate patient contact with their practice for both clinical advice and administrative functions such as repeat prescriptions.
3. As set out in the Next Steps on the NHS Five Year Forward View, NHS England is committed to using technology to enable patients to take a more active role in their own health and care, whilst also enabling NHS staff to have the information they need to do their jobs more effectively. To do this we have set out a programme of work which will:
 - Make it easier for patients to access urgent care online
 - Enable 111 to resolve more problems for patients without telling them to go to A&E or their GP
 - Simplify and improve the online appointment booking process for hospitals
 - Make patients' medical information available to the right clinicians wherever they are
 - Increase the use of apps to help people manage their own health.
4. We have:
 - Allocated £45 million to support the implementation of online consultation systems by practices, through the GP online consultation systems fund of the General Practice Development Programme¹
 - Set out how we will invest in general practice facilities and technology through the Estates and Technology Transformation Fund²
 - Supported GP practices, through the Patient Online programme³, to offer online services to patients, such as booking and cancelling of appointments, ordering of repeat prescriptions and viewing of their GP record

¹ [Online consultations systems fund](#)

² [Estates and Technology Transformation Fund](#)

³ [Patient Online](#)

- Developed digital tools and services that connect people to the health information and care they need, when they need them through the Empowering the Person Programme⁴.

Case study: Making use of e-consultations at Chelston Hall Surgery

Chelston Hall Surgery introduced e-consultations in January 2017, as a pilot site for NHS South Devon and Torbay CCG. They used eConsult, an online triage and consultation tool, which can be accessed by patients via a practice’s website, on a computer, tablet or app.

Patients can be navigated to a list of over 100 common medical problems, offered self-help, pharmacy advice, given the option to get administrative help or to consult with their own doctor or another healthcare professional at their practice.

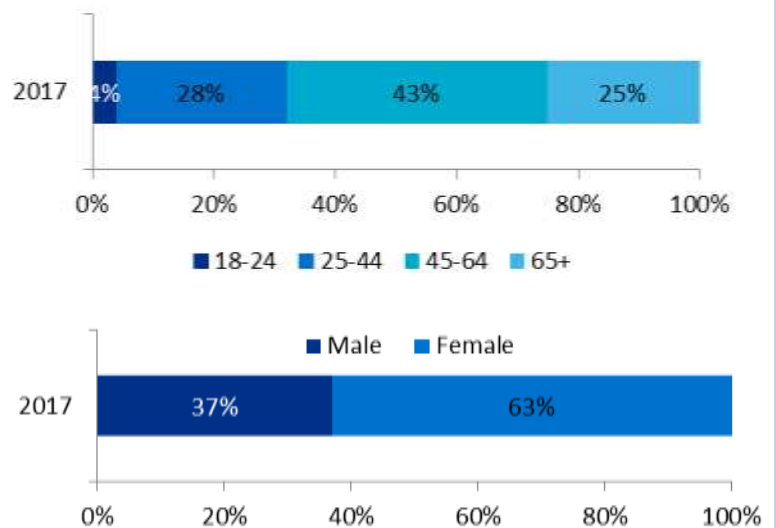
By January 2018, Chelston Hall had over 5,000 e-consultations, of which 1,000 required GP involvement. Nationally, each eConsult consultation takes approximately 3 minutes to process, with approximately 30% resulting in a face-to-face appointment and 30% to a telephone call-back, with the remaining 40% dealt with via online advice or a prescription.

In 2018, Chelston Hall anticipates that they will hold over 9,000 e-consultations. The e-consultations enable the practice to triage patients to the correct level of care, and as a result, more patients are being managed by specialist nurses, paramedics and pharmacists, reducing the demand on GPs.

Who uses the service and what are their characteristics?

The eConsult system is currently deployed in 465 practices serving a patient population of 4.4 million. In 2017 there were approximately 145,000 e-consultations, with more patients using either their phone or tablet compared to a laptop.⁵

The age and gender distribution of a sample of 4,339 surveyed patients that used the service between January – May 2017 can be seen in the graphic.



⁴ [Empowering people](#)

⁵ [What is eConsult](#)

5. NHS England recognises the importance of taking an evidence-based approach to supporting the future commissioning of digital technology. We have recently undertaken a survey to understand patient preferences for access to online consultations⁶, is supporting evaluations of various pilots including NHS 111 Online and, separately, an example of digital-first access to primary care, and is working closely with partners including Care Quality Commission (CQC) and Medicines and Healthcare products Regulatory Agency (MHRA) to ensure appropriate assurance and regulation of new digital products and services.
6. We use the term 'digital-first primary care' to refer to delivery models through which a patient can receive the advice and treatment they need from their home or place of work via online symptom checking and remote consultation. This means that a patient's first point of contact with a GP is through a digital channel, not a face-to-face consultation, although the latter remains an option if required. These emerging models are increasingly common and expected to evolve and expand with the availability, accessibility and acceptability of new technology.
7. Digital-first primary care was never envisaged when the current GP payment system was designed. The focus of this engagement document is on an initial set of proposals to update the GP payment system to take account of these models. There are three kinds of consequence that we need to plan for:
 - a) Inequitable redistribution of income between practices (the primary focus of this document)
 - b) Cost pressures arising to some Clinical Commissioning Groups (CCGs), if the costs associated with the lists of their member practices outstrips the primary care allocation which detracts from their ability to invest in other aspects of primary care
 - c) Cost pressures arising nationally.

⁶ [GP and practice team engagement](#)

Case study: Growth of digital-first services internationally

The provision of digital-first access to primary care is growing rapidly internationally. The number of internet-based consultations in Sweden has increased dramatically since the entry of two digital primary care providers in 2016, Min Doktor and KRY.

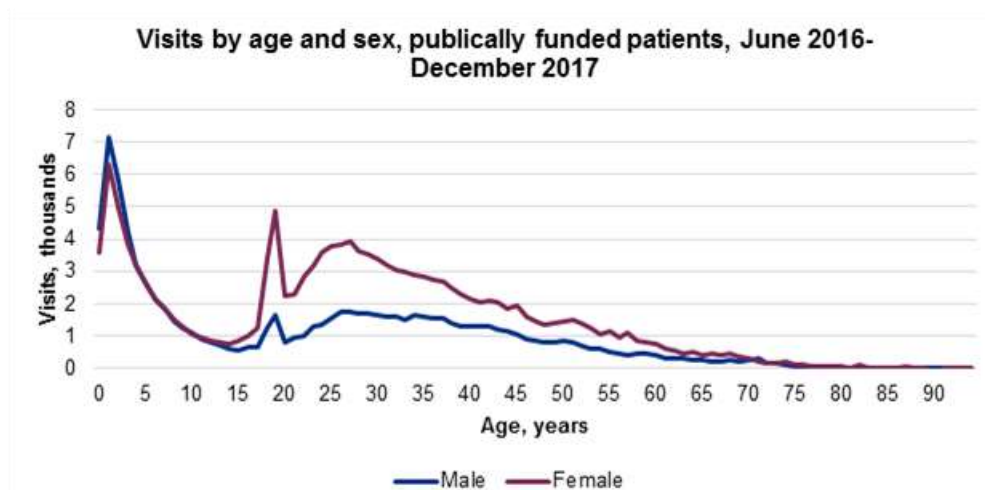
What is the operating model and what are the benefits?

Min Doktor and KRY are accessed using a smartphone app. KRY offers predominantly real-time video-based GP consultations while Min Doktor is mostly not real-time chat-based, but also offers video access.

Both providers have online triage tools for patients to answer a series of questions about their condition, and to then be directed for appropriate support. Both also have partnerships with other organisations that allow patients to have diagnostic tests carried out prior to their video consultation if necessary. Users of these digital models remain registered with their original practices, but can use these digital-first services for a sub-set of their needs.

Who uses the service and what are their characteristics?

Draft data from Sweden suggests that users are young, and more commonly female than male. Common health issues that patients are accessing digital services for relate to urinary tract infections and upper respiratory tract infections. This differs to the most common adult consultations for 'traditional' face-to-face primary care, which are for depression and hypertension. It is very similar to the pattern seen for out-of-hours services (Ekman et al., DRAFT 2018).



The growth of digital-first primary care in Sweden has been primarily driven by Min Doktor and KRY, but more recently other providers have initiated digital services, including Medicoo, Doktor, Doktor 24 and Capiro. Since 2016, around 300,000 digital consultations have been carried out, although this still only represents a small proportion of the overall number of GP visits in Sweden.

1.2 Paying for digital-first primary care

8. In England, perhaps the most well-known example of an NHS digital-first practice is GP at Hand, based in Hammersmith and Fulham CCG⁷. This practice has grown rapidly with the patient list expanding eight-fold in as many months, demonstrating its popularity with certain patients, many of whom live outside the practice catchment area. However, because our current payment system for general practice was not designed with these models in mind, concerns have been raised about the sustainability of wider primary care systems in the face of such change. There is disquiet in some quarters that digital-first models could result in 'cream skimming' by which providers attract or select less complex patients, and that they could thereby benefit from an over-generous share of GP funding, leaving other practices relatively under-funded for the workload associated with their remaining patients.
9. This engagement document focuses specifically on how we can ensure that the payment system for general medical services continues to support the development of digital services whilst ensuring that any inequities arising from anomalies in the current payment system are addressed. It describes a number of possible adjustments to payments and poses questions about how funding may need to change in the future to support digital service delivery. None of the proposals set out would result in a reduction to total funding for general practice. Instead, these proposals reduce the impact of the redistribution of funding towards digital-first practices, in line with current evidence.
10. The Carr-Hill formula is the current basis for calculating the majority of practice payments, and is based on an estimate of expected practice workload and associated cost. The formula was developed almost twenty years ago and predates digital delivery models. It captures a number of variables in the registered list of patients and location of the practice, adjusting the distribution of funding accordingly; it does not determine overall funding levels, only the distribution of that funding.
11. Thought was already being given to the Carr-Hill formula, prior to the emergence of digital-first access models. NHS England is working with the British Medical Association (BMA) to review it, with a view to ensuring that distribution of funding continues to take into account, as far as possible, key factors that increase demand for primary medical care services. No decisions have been taken and implementation of any changes to the formula would need careful planning so that they do not threaten stability or cause financial uncertainty for practices.

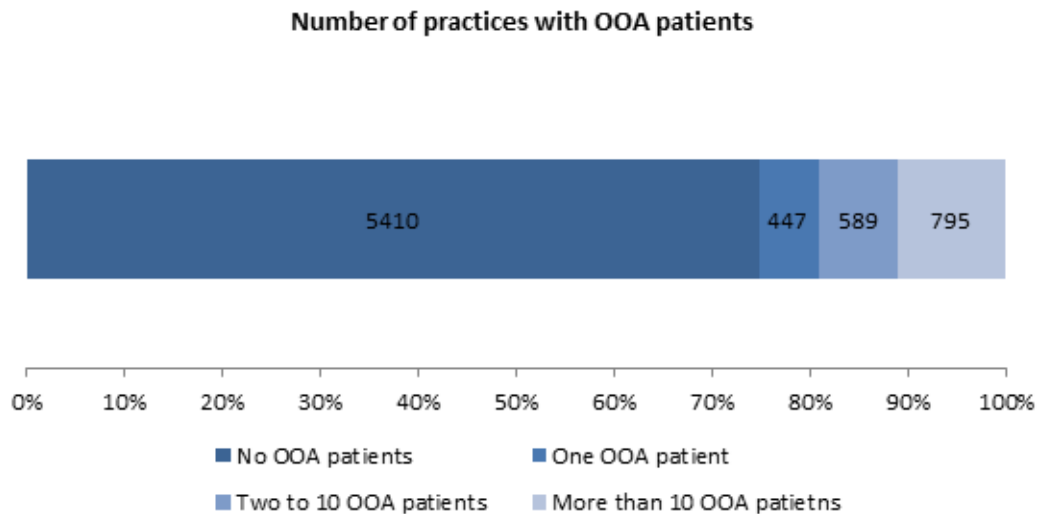
⁷ For more information see below and [GP at Hand fact sheet](#)

12. When the Carr-Hill formula was introduced it was based on assumptions which do not necessarily hold when provision is primarily digital. These are that:

- **The population of practices is relatively ‘standard’ with lists having, on average, patients with broadly similar characteristics, other than those expressly considered in the formula;**
Early findings suggest that registrations with one practice offering digital-first access include high proportions of younger patients, with a slightly lower prevalence of long-term conditions even when compared to an age and gender standardised population, although this may change over time.
- **A practice has a geographically focused service delivery model;**
Registrations with practices offering digital-first access can include patients from a much wider geography compared to the usually narrow practice registration boundaries, given that more services can be accessed remotely. This is made possible by the GP Choice policy introduced in 2015 (see section 2 below for complete explanation).
- **Patients often register when they have an active health need, and their registration with a practice then remains stable;**
Early findings from one practice suggest there could be a higher churn of registrations with practices offering digital-first access, which could be because digital registration is easier, patients choose to register and deregister as their health condition or access preferences change, or because patients are experimenting with a new service and this will stabilise over time. As context, in April 2017 practices had 5.2 million patients who had been registered in the past year, constituting 8.8% of the 59 million total registered population.

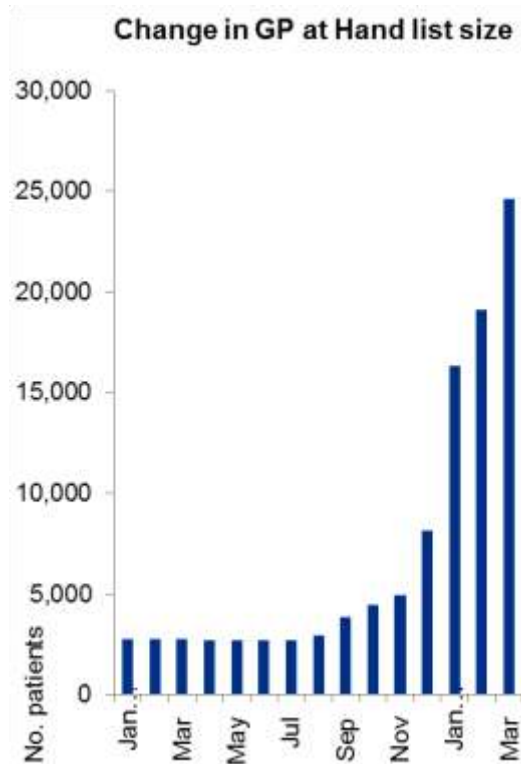
13. In 2015 we established a system by which patients could choose to register with a participating practice anywhere in the country, so long as the practice is assured it is clinically appropriate and accepts their registration. This policy was intended to allow commuters to register near work, to maintain continuity with an existing GP when moving house, and other similar scenarios. Patients registered in this way are known as ‘out-of-area patients’ because they live outside the practice’s natural catchment area. So far, approximately 99,000 people have taken the opportunity to register in this way, although most practices have no out-of-area patients at all, and those that do tend to have them in small numbers.

14. The graph below shows the number and proportion of practices with out-of-area (OOA) patients, to help illustrate usage of the policy:



15. Practices are not expected to deliver home visits for out-of-area patients, and where services deliver care to patients in a much more locally integrated way, patients who live further away are unlikely to receive the full benefit.
16. Because digital-first models utilise remote access, they are not as geographically limited as traditional general practice, and so far we have seen many more patients registering under the out-of-area provisions. Mass out-of-area registration was not foreseen when the policy was created, being mainly focussed on providing choice for commuters to register with a practice near work, and allowing patients that move home a short distance to retain continuity with their existing GP by staying registered with them.
17. The aims of this engagement are therefore to:
- Seek views on specific potential amendments to the GP contract regarding payments normally calculated based on the relationship between practices' and patients' location (section 2)
 - Hear how we can use contracting and payments to further support innovation and adoption of digital access in general practice (section 3).

Case study: Digital-first primary care in London



GP at Hand (GPaH) is a GP practice in NHS Hammersmith and Fulham CCG working with a digital health technology company, Babylon, to provide a model of digital-first primary care, through subcontracting arrangements.

GPaH will register people in the practice area for full General Medical Services (GMS) contract services but the practice has also chosen to utilise the GP Choice Policy to grow the list size through a digital and remote site offer. This means they can provide services to patients outside the practice area where it is 'clinically appropriate and practical' to do so. As GPaH is an NHS practice, patients who register with it automatically de-register from their existing practice.

What is the operating model?

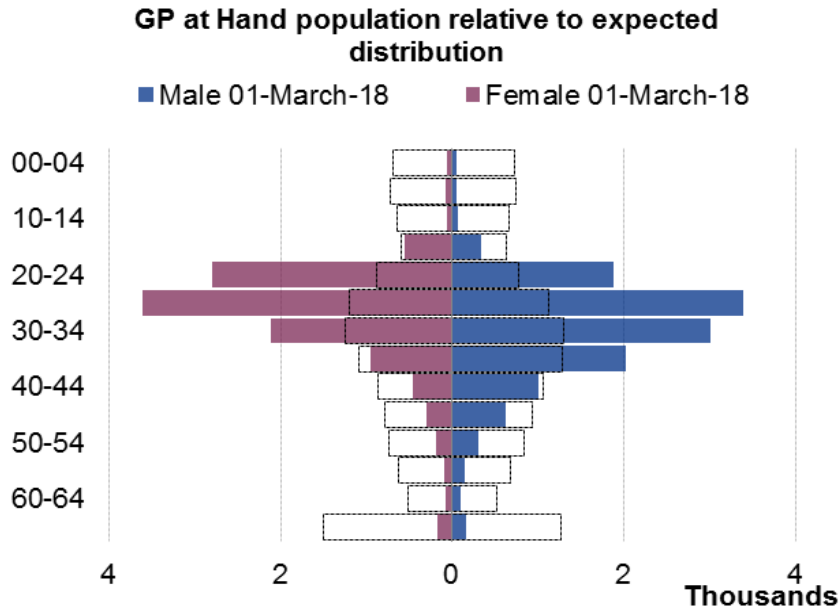
Patients can choose to contact the practice in a number of ways, including through an app which allows people to check their symptoms online, message the practice, monitor their health and undertake video consultations with GPs.

People register with GPaH and sign-up for a 'digital first' offer whereby they routinely access services online but also have access to face-to-face consultations at one of several practice sites across London.

[Continued below...]

Case study continued

Who uses the service and what are their characteristics



From July 2017 GPaH's list size has increased rapidly by about 22,000 as can be seen in the graph above.

Patients registering with GPaH are predominantly in the age band 15-44. The highest growth so far is in the age band 25-29, which is three times the expected size.

After adjusting for age and sex, QOF prevalence rates are slightly below NHS Hammersmith and Fulham CCG averages (except for asthma which is broadly as expected) suggesting that patients may have a lower burden of long-term conditions than is typical for their peers.

This is not unexpected, given that following a clinical review of the GP at Hand practice by NHS Hammersmith and Fulham CCG and NHS England, patients with long term conditions who require regular face-to-face appointments and care from a number of other local services are encouraged to seek advice before registering, until further analysis of the service has been performed to ensure this model is suitable for their needs. A broader evaluation of this service is currently underway, and there are ongoing assurance arrangements in place locally.

2 Specific proposals for amendments to GP payments

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

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

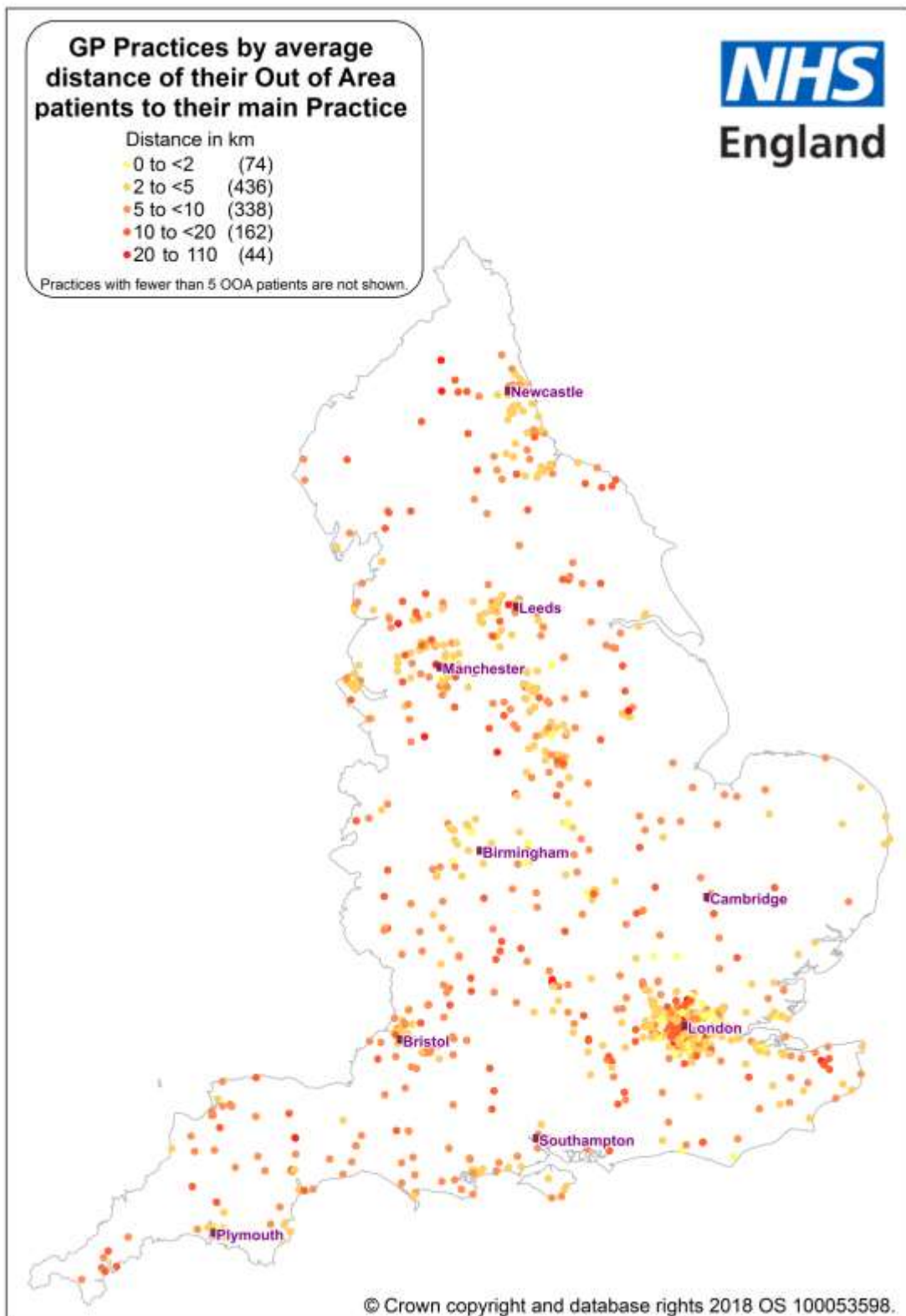
Question 1:

- Do you agree that these principles should underpin any changes to how NHS England contracts and pays for general practice?
19. Our work identified three payments on which we are seeking your views: the rurality index, the London adjustment and the payment to practices for out-of-area patients. We describe how these payments work and why change might be appropriate. There are other factors that the Carr-Hill formula takes into account for each practice, for example around patient characteristics and the costs of being based in different locations, on which we make no specific proposals in this document, because evidence is still emerging, but we welcome views.
20. However, we will consider whether these other factors should be adjusted to deliver a fairer distribution of funds once this evidence is available. Over the coming years we are likely to see further innovation in digital delivery and across primary care, and will remain alert and responsive to where the contract framework may need updating. Section 3 asks about how the payment system can, in general, fully support innovation in digital primary care over time.

2.1 Rurality index payment explained

What is it and what is its purpose?

21. The rurality index is an additional payment to practices with a higher average distance between patients' homes and the practice location. Practices in less populated (rural) areas tend to have patients registered across a bigger area.
22. The rurality index is designed to support the sparser populations served by rural practices and reflect the increased cost of delivery to a dispersed population, for instance when delivering home visits or the cost of establishing satellite or outreach services. In remote populations, there may also be increased demand due to lack of other services nearby.
23. Most patients live close to their practices, with 90% of practices having an average patient distance to practice between 800 metres and 3.9 kilometres. There are a few practices which are significant outliers, often practices serving rural areas, or specialist practices serving a population that may be small, dispersed or with specific needs. There are notable regional patterns too. The average distance to practice is, as we would expect, shorter in metropolitan areas.
24. The map below shows practices with 5 or more registered out-of-area patients, colour-graded according to the distance of these patients to the practice.



Why might this not be appropriate in its current form?

25. Out-of-area patients, who may be more numerous at practices that provide digital-first access, generally live further from their practice. This makes the practice appear more rural than it is, and the practice receives additional payments as a result. However, this distance is not as relevant to the cost of delivering digital services because they are more often choosing to access services remotely and are not receiving some services such as home visiting. Instead, patients are often travelling longer distances to attend specified locations for their face-to-face care.
26. We propose that the rurality adjustment is based on average distance between the practice and its 'in-area' patients, rather than to all patients. This is to better reflect costs and reduce the financial incentive and associated risk that practices actively advertise to and register patients who live a long way from the practice, in order to maximise income.

What does that look like in practice?

27. If the rurality payment was to be calculated based on practices' in-area patients only, then rural practices would continue to receive the additional funding associated with the bigger catchment area they have to cover, but more urban practices, with patients registering from outside their natural catchment area would see a reduction in funding.
28. The changes would be net neutral nationally, with over 7,000 practices unaffected. There are a very small number of practices (see table below) whose income reduces, and this income is all redistributed across other practices.
29. In summary, the impact would be as follows.

Worked example:

- The illustrative traditional practice has a registered list of all in-area patients (so the average distance between the practice and its in-area patients is exactly the same as the distance between the practice and all patients – a ratio of 1). This practice will see no change to its income.
- The illustrative digital practice has lower average distance between the practice and its in-area patients than between the practice and all its patients. This is because it has a large number of patients registered but living along way from the main practice, outside its catchment area. This practice would see a reduction in its funding; in this example that would be around 4.5 %. This money would be redistributed to other practices.

Ratio of 'in-area distance to practice' to 'all patient distance to practice'	Impact on GMS	No. practices affected	
1	0.0%	7010	← Illustrative traditional practice
0.95	-0.1%	187	
0.9	-0.3%	24	
0.85	-0.5%	8	
0.8	-0.6%	5	
0.7	-1.0%	2	
0.6	-1.5%	1	
0.5	-2.0%	0	
0.4	-2.6%	0	
0.3	-3.4%	0	
0.2	-4.5%	0	← Illustrative digital practice
0.1	-6.3%	0	

Note: Percentages are relative to main GMS payment excluding MPIG, temporary residents and London weighting payments. The number of practices affected is based on a real estimate. The illustrative digital practice is a hypothetical, not a real, practice. For ease of reading, each category represents an approximate mid-point within a range of values, with the full range in the Appendix.

Question 2:

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

2.2 London adjustment explained

What is it and what is its purpose?

30. The London adjustment is an additional flat payment of £2.18 per patient, to all practices within a defined London boundary, for all their registered patients, irrespective of whether the patient is in-area or out-of-area or whether the patient also lives in London.
31. The additional payment is meant to reflect additional burden to London practices arising from London population characteristics and wider circumstances. The London adjustment is in addition to a higher Market Forces Factor (MFF) for London practices, which adjusts for the higher costs of being London-based.

Why might this not be appropriate in its current form?

32. Patients who do not reside in London but register with London practices may be less likely to present the London-specific complexities that the London adjustment partially addresses.
33. With digital-first access to general practice, more care is being delivered remotely across a bigger geography, so an additional payment based on the location of the practice may be inappropriate. Payment based on where patients live, rather than where the practice headquarters are, may better reflect the costs of delivering their care.
34. Currently a practice could seek to maximise income by basing itself in London and actively attracting non-London residents onto its list. This would create a national cost pressure, and would divert funding from other priorities in primary care.

What does that look like in practice?

35. Our proposal is that the London adjustment is applied to London residents, rather than to patients who are registered with a practice headquartered in London.
36. The impact of this would be as follows (please see Appendix for further detail):

Worked example:

- The illustrative traditional London practice has a registered list made up entirely from patients living in London, and therefore sees no impact on income.
- The illustrative digital London practice has a registered list made of 50% London residents and 50% residents from outside of London. This practice would see a reduction in its income of 1.1% of the main General Medical Services (GMS) payment.

MFF 1.3		Impact on income	No. practices affected	
Practice in London				
% resident in London (assuming fixed age make-up)	100%	0.0%	1224	← Illustrative traditional practice
	90%	-0.2%	32	
	80%	-0.4%	7	
	70%	-0.7%	1	
	60%	-0.9%	0	
	50%	-1.1%	3	← Illustrative digital practice
Practice outside London				
% resident in London (assuming fixed age make-up)	50%	1.1%	54	
	40%	0.9%	1	
	30%	0.7%	3	
	20%	0.4%	5	← Illustrative digital practice
	10%	0.2%	6	
	5%	0.1%	21	
	0%	0.0%	5884	← Illustrative traditional practice

Note: Percentages are relative to main GMS payment excluding MPIG, temporary residents and London weighting payments. The number of practices affected is based on a real estimate. The illustrative digital practice is a hypothetical, not a real, practice. For ease of reading, each category represents an approximate mid-point within a range of values, with the full range in the Appendix.

Question 3:

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

2.3 Paying for in-hours urgent primary medical care (including home visits) to out-of-area patients explained

What is it and what is its purpose?

37. Currently, practices receive the same payment for both in-area and out-of-area patients, even though they do not have to deliver home visits or (if the practice still provides it) out-of-hours care for the latter. It is worth noting that home visit rates will vary widely for people depending on aspects of their health, healthcare needs, mobility and more.

38. However, in addition, to ensure that out-of-area patients can still receive face-to-face GP care in-hours, either at home or near their homes, if they are too ill to visit their registered practice, the patient's local CCG (where they live) has

to make alternative arrangements. For all other care the patient's registered CCG (the CCG in which their practice is a member) is responsible for their care.

39. Many CCGs have contracted via an Enhanced Service contract with participating local providers, including local practices, to provide face-to-face appointments and in-hours home visits for patients who live in their area, but are not registered there. The Enhanced Service guidance suggests that every such in-hours GP consultation is charged £15.87 for a practice visit and £60 for a home visit. In addition or as an alternative to such Enhanced Service, patients can also be directed to other services such as their local walk-in centre.

Why might this not be appropriate in its current form?

40. The payment to practices for their out-of-area patients does not reflect:

- The reduced set of activities a practice has to deliver to its out-of-area patients, namely the home visits in-hours; or
- That, when these patients need a home visit or to visit an alternative primary care provider closer to home, there is an additional cost to the system, including potentially a per-visit fee paid by the patients' home CCG to near-home providers or due to increased use of urgent care.

41. Overall, having large volumes of out-of-area registrations redistributes money towards the providers who register these patients (but do not have to provide some services) and creates a cost pressure for CCGs (who are responsible for making alternative arrangements). This decreases the funding available to be spent on other primary care priorities. It is not an issue when rates of out-of-area registration are low, as they have been historically, but it would be an issue if they rapidly increase, which is a trend we have seen in recent months.

What does that look like in practice?

42. Under this proposal the payment to practices for their out-of-area patients would be reduced by a fixed percentage for each out-of-area patient. The change would be net neutral, as the money would be recycled back into the payment for in-area patients, and money would be redistributed towards practices with more in-area patients, although this affect may be too small to notice for an individual practice.

43. We estimate that on average a patient receives a home visit once every three and a half years, suggesting that if GMS payments were reduced to take account of the alternative provision of home visits for out-of-area patients it would need to be reduced by about £17 which is approximately 20% of the average global sum per capita payment.

44. It is likely that home visiting rates differ significantly across population cohorts. We would generally expect that out-of-area patients registering with digital-first practices are more likely to be of working age and healthier than the average population, therefore making less use of home visits. If the change we propose was implemented, further research would be required to optimise the adjustment over time.

45. The impact of this would be as follows (please see Appendix for detail):

Worked example:

- The illustrative traditional practice has 1% of its patients registered as out-of-area and will therefore see a maximum reduction in income of 0.2% of its main GMS payment.
- The illustrative digital practice has 80% of its patients registered as out-of-area, and will therefore see a reduction in income of 13.9% of its main GMS payment.

MFF 1.3		Deduction for home visits for out-of-area patients	Number of practices affected	
	0%	0%	5410	
	1%	-0.2%	1770	← Illustrative traditional practice
	5%	-0.9%	52	
	10%	-1.7%	7	
Proportion of out-of-area patients	20%	-3.5%	1	
	30%	-5.2%	0	
	40%	-7.0%	1	
	50%	-8.7%	0	
	60%	-10.4%	0	
	70%	-12.2%	0	
	80%	-13.9%	0	← Illustrative digital practice

Note: Percentages are relative to main GMS payment excluding MPIG, temporary residents and London weighting payments. The number of practices affected is based on a real estimate. The illustrative digital practice is a hypothetical, not a real, practice. For ease of reading, each category represents an approximate mid-point within a range of values, with the full range in the Appendix.

Question 4:

- Do you agree that practices should receive a lower payment for out-of-area patients and by how much? If not, what is your alternative proposal?
- Should practices be able to opt-in to deliver home visiting services for out-of-area patients and therefore continue to receive full funding? Could they be required to offer or arrange home visits for out-of-area patients?

2.4 The cumulative impact

46. To get a sense of how our proposed changes would affect digital-first practices, we can combine the impacts shown above.

Consider, for instance a digital-first practice:

- Based in outer London with an Market Forces Factor (MFF) of 1.3;
- 80% of their registered list are out-of-area;
- 50% are outside London; and
- The in-area patients have an average distance that is 20% of the all-patient average distance.

47. The adjustments for this practice for our proposed rurality, London weighting and home visit changes would be -4.5%, -1.1% and -13.9%. Combined the effect of the changes we are proposing would be a reduction of approximately 19.5%.

3 Wider future considerations for funding digital primary care services

3.1 Future support for the development and adoption of digital primary care

48. Digital-first access to primary care is popular with patients and is evolving quickly with a number of possible delivery models. Over the coming years we anticipate that all patients will have the option of online access to services, fully integrated with their local care offer.
49. NHS Hammersmith and Fulham CCG is undertaking an external evaluation of GP at Hand to provide robust, independent, and rapid analysis of the outcomes and impact of the service, which will help to inform the kinds of services to be commissioned in future.
50. Currently, the costs of developing and delivering digital-first access to general practice are not well understood and there is an argument that we will only be able to design an appropriate funding model if we make routine the collection of data about costs and delivery. Some costs may go down, and others may go up, for example some streams of the funding we provide general practice (such as for premises) could be less important for digital delivery models but funding for IT systems and infrastructure may be much more important.
51. One particular aspect of payments which may need updating is the adjustment for new registrations. Practices currently receive a 46% additional payment for patients in their first year of registration with a practice. This is calculated at the end of each quarter, based on the proportion of the registered list that joined during the previous twelve months. The churn of patients through digital practices could be higher than in traditional practices for many reasons.
52. For example, the reasons could include:
- It is a new offer and patients are experimenting to find out whether it suits them. They may move back to their original practice or to another provider – this may stabilise over time, depending on the rate of innovation
 - The process of registering may be easier (being done online rather than in-person)
 - Patients may repeatedly move registrations as their health needs and access preferences change and different providers are better able to meet their needs. For example, they may become pregnant, and want or are advised to shift from a digital-first model of care, to a more traditional model.
53. Allocating funds towards these new registrations means that they are not spent on other priority areas, and this may not be achieving the best outcomes for patients.

54. Another aspect of funding which may need updating is the Market Forces Factor (MFF) which takes into account the costs of delivering services in different areas. However, if more services are delivered remotely then the MFF may be more appropriately linked to where patients are based than where providers are based.

Question 5:

- When you think about digital-first models of general practice, what do you consider the potential benefits and disbenefits to be for:
 - i. Patients, including considerations around equality and inequality
 - ii. GPs, their staff and practices
 - iii. Do your answers to i.) and ii.) differ depending on whether the digital-first practice is local, or if it is serving patients across a wide geography?
- What wider potential is there to make savings and efficiencies from the adoption of digital-first primary care? How could this be reflected in the way we distribute funding to general practice?
- What additional costs do you consider arise in the provision of digital-first primary care services? How could this be reflected in the way we distribute funding to general practice?
- Should the payment for newly registered patients be reconsidered, and if so, how do you think it could best be adjusted?
- Are there any other ways in which you feel the funding model for general practice can best be adjusted to support the widest possible take up of proven digital delivery mechanisms?

Question 6:

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

4 How to get involved and next steps

55. We have worked closely with stakeholders to develop these proposals and are committed to working collaboratively to finalise them.
56. During the engagement exercise we will seek to gather views from a range of people, including GPs and other primary care clinicians, the public, charities, the technology industry, Clinical Commissioning Groups (CCGs) and others.
57. If there are particular events, conferences or meetings where you think our input would be helpful, please email england.gpcontracts@nhs.net
58. Throughout the engagement process you can find out about the events and meetings we will be attending, as well as any webinars we will host, at [GP contract](#).
59. The engagement closes on 31st August. You can respond using the [online Citizen Space survey](#).

5 Glossary

Carr-Hill Formula

- The Carr-Hill formula is used to calculate the core payments (see global sum) to General Medical Services (GMS) practices. Payments are made to practices according to the list size of patients adjusted using the Carr-Hill formula to provide a weighted count of patients by taking into consideration a range of factors which reflect characteristics of these patients, for example, age and gender, levels of morbidity and mortality and patient list turnover.

Global sum

- The global sum has been used as the basis of core funding for General Medical Services (GMS) practices since the inception of the new GMS contract in 2004. This funds a practice for delivering essential medical services to its registered list of patients. The bulk of these payments are determined by an allocation formula which funds practices based on workload and circumstances (see Carr-Hill formula).

Digital-first primary care

- Digital-first primary care refers to care delivery models through which a patient can receive the advice and treatment they need via online symptom checking and remote consultation. This means that a patient's first point of contact with a GP is usually through a digital channel.

Enhanced services

- Enhanced services are those which require an enhanced level of provision above what is required under core General Medical Services (GMS) contracts. Directed Enhanced Services are those that NHS England and CCGs are required to commission. They are mostly commissioned locally and practices can choose whether or not to provide these services.

GP Choice Policy

- The Choice of GP Practice scheme was introduced in 2015 to enable patients to choose to register with a participating practice anywhere in the country. This policy was intended to, for example, allow commuters to register near work or to maintain continuity with an existing GP when a person moves house.

In-area and out-of-area registered patients

- Registered patients who live within a general practice's natural catchment area are referred to as 'in-area' patients. Registered patients who live outside the practice's natural catchment area and are registered under the Choice of GP Practice scheme are referred to as 'out-of-area' patients. Practices are not obliged to provide general practice services including home visits to these out-of-area patients if they are ill at home, and may choose not to register an out-of-area patient for clinical or operational reasons.

Market Forces Factor (MFF)

- The Market Forces Factor (MFF) is an estimate of unavoidable cost differences between healthcare providers, based on their geographical

location. The MFF is used to adjust resource allocations to each NHS organisation in proportion to these cost differences, so that patients are neither advantaged nor disadvantaged by the relative level of unavoidable costs in different parts of the country.

Minimum Practice Income Guarantee (MPIG)

- Following the new General Medical Services (GMS) contract in 2004, the Minimum Practice Income Guarantee (MPIG) was introduced to top up the core payments for some practices. The payments made under MPIG are called correction factor payments and are being reduced each year and will eventually be eliminated by 2021.

NHS contracts for primary medical services:

- **Alternative Provider Medical Services (APMS) contracts**
 - The Alternative Provider Medical Services (APMS) contract is a contract between NHS England and any qualifying body, including general practices, NHS trusts, voluntary and private sector providers, for delivering a range of services. This allows NHS England and CCGs to commission locally flexible and innovative solutions for patients. The provider does not necessarily have to hold a registered list of patients for example when providing GP out-of-hours services.
- **General Medical Services (GMS) contract**
 - The General Medical Services (GMS) contract is the nationally agreed contract between general practices and NHS England for delivering primary medical services. The majority of practices are currently on GMS contracts.
- **Personal Medical Services (PMS) contract**
 - The Personal Medical Services (PMS) contract is a locally agreed contract between NHS England or delegated CCGs and qualifying bodies, including general practices, for delivering primary medical services. PMS contracts offer local flexibility compared to the nationally negotiated General Medical Services (GMS) contract.

Quality and Outcomes Framework (QOF)

- The Quality and Outcomes Framework (QOF) was established in 2004 as a key component of the General Medical Services (GMS) contract. It is a pay for performance scheme which provides funding to practices on the basis of the quality of care delivered to patients as described by a set of quality indicators.

6 Appendix: Detail of analytical evidence

The analysis in this document is based on detailed datasets used to set payments under the Carr-Hill formula. We assume that all practices are using General Medical Services (GMS), rather than Personal Medical Services (PMS) contracts. The GMS contract effectively provides a floor for PMS payments; since practices on a PMS contract have a right of return to GMS, we therefore assume that PMS contract payments always exceed GMS payments and so basing the proportional impact on assumed GMS payments is likely to be an over-estimate of the change in income.

Our analysis excludes a number of other payments, including the Quality Outcomes Framework (QOF), temporary registrations, Minimum Practice Income Guarantee (MPIG) and seniority payments.

Rurality

The Carr-Hill dataset includes the average distance that patients live from their practice. A separate dataset allows us to estimate the average distance out-of-area patients might live from their practice, and so we are able to estimate the change in GMS payment, where the average distance to practice is replaced by the average distance to practice for in-area patients only.

To give a sense of how this might affect a broader range of practices than those highlighted in the main text we have estimated how GMS payments could change based on the ratio of the in-area average-distance-to-practice distance to the all-patient average-distance-to-practice.

In-area patients average distance to practice (km)														
		0.75	1.00	1.20	1.30	1.40	1.60	1.80	2.00	2.50	3.90	Number of practices		
All patients average distance to practice (km)	0.75	0.0%										<0.9km	347	
	1.00	-0.8%	0.0%									≥0.9km and <1.1km	743	
	1.20	-1.3%	-0.5%	0.0%								≥1.1km and <1.25km	910	
	1.30	-1.6%	-0.8%	-0.2%	0.0%							≥1.25km and <1.35km	521	
	1.40	-1.8%	-1.0%	-0.4%	-0.2%	0.0%						≥1.35km and <1.5km	537	
	1.60	-2.2%	-1.3%	-0.8%	-0.6%	-0.4%	0.0%						≥1.5km and <1.7km	906
	1.80	-2.5%	-1.7%	-1.2%	-0.9%	-0.7%	-0.3%	0.0%					≥1.7km and <1.9km	706
	2.00	-2.8%	-2.0%	-1.5%	-1.2%	-1.0%	-0.6%	-0.3%	0.0%				≥1.9km and <2.25km	561
	2.50	-3.4%	-2.6%	-2.1%	-1.9%	-1.7%	-1.3%	-0.9%	-0.6%	0.0%			≥2.25km and <3.2km	865
	3.90	-4.6%	-3.8%	-3.3%	-3.1%	-2.9%	-2.5%	-2.2%	-1.9%	-1.3%	0.0%		≥3.2km	1145
		<0.9 Km	≥0.9km and <1.1km	≥1.1km and <1.25km	≥1.25km and <1.35km	≥1.35km and <1.5km	≥1.5km and <1.7km	≥1.7km and <1.9km	≥1.9km and <2.25km	≥2.25km and <3.2km	≥3.2 km			
Number of practices		745	769	775	513	766	813	606	759	859	636			

Note: Percentages are relative to main GMS payment excluding MPIG, temporary residents and London weighting payments.

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Ratio of in-area distance to practice to all patient distance to practice	Impact on GMS		Number of practices
1	0.0%	<0.975	7010
0.95	-0.1%	≥0.975 and <0.925	187
0.9	-0.3%	≥0.925 and <0.875	24
0.85	-0.5%	≥0.875 and <0.825	8
0.8	-0.6%	≥0.825 and <0.75	5
0.7	-1.0%	≥0.75 and <0.65	2
0.6	-1.5%	≥0.65 and <0.55	1
0.5	-2.0%	≥0.55 and <0.45	0
0.4	-2.6%	≥0.45 and <0.35	0
0.3	-3.4%	≥0.35 and <0.25	0
0.2	-4.5%	≥0.25 and <0.15	0
0.1	-6.3%	≥0.15	0

London Weighting

The Carr-Hill dataset flags those practices that are considered to be in London and so receive an additional payment of £2.18 per head.

A separate analysis has allowed us to estimate the number of patients registered in each practice that are resident in London. This allows us to estimate the impact of moving to a residence basis for this analysis.

The table below gives an estimate of the detrimental impact on practices inside London who register patients outside London, and vice versa. This assumes that all other patients' characteristics match the England average, but we give the estimates for different Market Forces Factors (MFF), as many of the affected practices are in or around London. The MFF is an adjustment of the GMS payment according to the costs of being based in different locations. If a practice's population is, say, younger or has a lower mortality ratio than the England average then the impact will be greater than estimated here, or vice versa.

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	MFF	1.0	1.1	1.2	1.3	1.4	1.5		Number of practices
Practice in London									
% resident in London	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	>95%	1224
	90%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	≤95% and >85%	32
	80%	-0.5%	-0.5%	-0.5%	-0.4%	-0.4%	-0.4%	≤85% and >75%	7
	70%	-0.7%	-0.7%	-0.7%	-0.7%	-0.6%	-0.6%	≤75% and >65%	1
	60%	-1.0%	-1.0%	-0.9%	-0.9%	-0.8%	-0.8%	≤65% and >55%	0
	50%	-1.2%	-1.2%	-1.1%	-1.1%	-1.0%	-1.0%	≤55%	3
Practice outside London									
% resident in London	50%	1.3%	1.2%	1.2%	1.1%	1.1%	1.0%	>45%	54
	40%	1.0%	1.0%	0.9%	0.9%	0.9%	0.8%	≤45% and >35%	1
	30%	0.8%	0.7%	0.7%	0.7%	0.6%	0.6%	≤35% and >25%	3
	20%	0.5%	0.5%	0.5%	0.4%	0.4%	0.4%	≤25% and >15%	5
	10%	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%	≤15% and >7.5%	6
	5%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	≤7.5% and >2.5%	21
	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	≤2.5%	5884

Note: Percentages are relative to main GMS payment excluding MPIG and temporary residents.

Deduction for home visits

As noted above, we have a separate dataset of the number of out-of-area datasets registered by each practice. This allows us to estimate the impact of making a deduction based on the assumed number of home visits. Our analysis assumes that all other characteristics (age etc.) are at national the average, but, because out-of-area patients are more common in London we allow the MFF to vary. If a practice's population is, say, younger or has a lower mortality ratio than the England average then the impact will be greater than estimated here, or vice versa.

Proportion of out-of-area patients	MFF	1.0	1.1	1.2	1.3	1.4	1.5	Number of practices	
	1%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	-0.2%	<3%	7180
	5%	-1.0%	-1.0%	-0.9%	-0.9%	-0.8%	-0.8%	≥3% and <7.5%	52
	10%	-2.0%	-1.9%	-1.8%	-1.7%	-1.7%	-1.6%	≥7.5% and <15%	7
	20%	-4.0%	-3.8%	-3.6%	-3.5%	-3.3%	-3.2%	≥15% and <25%	1
	30%	-6.0%	-5.7%	-5.5%	-5.2%	-5.0%	-4.8%	≥25% and <35%	0
	40%	-8.0%	-7.6%	-7.3%	-7.0%	-6.7%	-6.4%	≥35% and <45%	1
	50%	-10.0%	-9.5%	-9.1%	-8.7%	-8.4%	-8.0%	≥45% and <55%	0
	60%	-12.0%	-11.4%	-10.9%	-10.4%	-10.0%	-9.6%	≥55% and <65%	0
	70%	-13.9%	-13.3%	-12.7%	-12.2%	-11.7%	-11.2%	≥65% and <75%	0
80%	-15.9%	-15.2%	-14.5%	-13.9%	-13.4%	-12.9%	≥75%	0	

Note: Percentages are relative to main GMS payment excluding MPIG, temporary residents and London weighting payments.

The illustrative digital practice

There is no stable digital-first practice currently operating. However, to get a sense of how our proposed changes would affect we can combine the impacts shown above.

Consider, for instance a digital-first practice:

- Based in outer London with an MFF of 1.3;
- 80% of their registered list are out-of-area;
- 50% are outside London; and
- The in-area patients have an average distance that is 20% of the all-patient average distance.

The adjustments for this practice for our proposed rurality, London weighting and home visit changes would be -4.5%, -1.1% and -13.9%. Combined the effect of the changes we are proposing would be a reduction of approximately 19.5%.