HFMA response
August 2018

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

Consultation by NHS England

Who are we

The Healthcare Financial Management Association (HFMA) is the representative body for finance staff in healthcare. For the past 60 years, it has provided independent and objective advice to its members and the wider healthcare community. We are a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through our local and national networks. We also analyse and respond to national policy and aim to exert influence in shaping the wider healthcare agenda. We have a particular interest in promoting the highest professional standards in financial management and governance and are keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

Our comments

Q1. Do you agree that the principles below should underpin any changes to how NHS England contracts and pays for general practice?

- 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.

We agree that these principles should underpin any changes to payments for general practice. It is important that the funding arrangements for primary care reflect the way that it is being delivered and takes into account not only innovations such as digital provision but also the way that lifestyles change. For example, an increase in the number of students and employees who work away from home – these people effectively have two home addresses. We therefore welcome the wider review of the Carr-Hill formula.

However, consideration must also be given to the impact on the commissioners of those services and their ability to forecast and fund any changes. Our members would support a phased approach to change, ensuring that service provision is not destabilised whether that be within primary care or the wider sector, if funding has to be diverted from elsewhere.

It should be noted that CCGs are currently developing 5 year financial plans from 2019/20; changes to GP payments will need to be modelled within this, or provision made for later changes to the plans as a consequence of this work.

Q2. 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?

The rurality index should recognise the higher cost of delivering care to dispersed rural populations. We therefore agree that it should only take in-area patients into account.

However, where the rurality payment for out-of-area patients is fundamental to the resilience of the GP practice and its ability to support those on the practice list, any change to funding must be phased with an agreed flexibility on the services delivered.

Q3. 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?

We agree that the London adjustment should only apply to those patients living in London, rather than those registered with London practices. The higher cost of running a practice in London is already reflected within the separate market forces factor for London practices.

Digital services need not be run from the location of the practice so, for these services, payments related to practice address are even less relevant.

However, where the London adjustment for out-of-area patients is fundamental to the resilience of the GP practice and its ability to support those on the practice list, any change to funding must be phased with an agreed flexibility on the services delivered.

Q4. 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?

We agree that practices should receive a lower payment for out-of-area patients where the services available to them are less i.e. home visits are not offered. Currently the NHS may pay for the same patient twice as an out-of-area patient for one CCG, but for emergency care elsewhere as their registered GP is too far away. This is not viable as a long term solution in a financially stretched system.

Again, where the payment for out-of-area patients is fundamental to the resilience of the GP practice and its ability to support those on the practice list, any change to funding must be phased with an agreed flexibility on the services delivered.

Q5. 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?

The option should remain for practices to opt-in to deliver a full range of services for out-of-area patients, thus retaining the full payment. This may be vital for practices in very rural areas or where there is a high prevalence of single handed GPs, with local agreements for alternative support to patients.

However, consideration should be given to the likelihood of those services being required, with ‘closer’ out-of-area patients being more likely to use the services than, for example, Birmingham patients registered with a London practice. The opt-in should remain, but safeguards must be put in place to avoid abuse of the system.

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

Digital-first access can not be the only primary care access model available to patients in a given area, traditional routes must remain for those unable or unwilling to access digital media for whatever reason. However, the potential for easier access to a GP or practice staff reduces the likelihood of improper use of emergency health services and also reduces disruption for employers when staff have medical appointments.

While digital-first access offers a quick access solution for ad hoc episodes of illness, patients with chronic disease may benefit from consistent care from a named clinical professional. The doctor / patient relationship is an important part of managing long term

conditions; compromising this through an over reliance on digital access may impact on secondary care services.

ii. GPs, their staff and practices

The digital-first model gives a GP practice a way to triage those who are using it, potentially leading to a more efficient use of limited practice resources. Training needs may increase in order to use the model to greatest effect and ensuring clinical safety, requiring upfront investment in both staff and the necessary technology.

There is the potential that access to digital consultations reduces the need for home visits. This may need to be considered in future iterations of the funding model, particularly when considering rurality.

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?

Answers apply to both scenarios, although the benefits may be seen in health economies remote from the practice, if it is serving a wide geographical area. Consideration needs to be given to how these benefits are fairly redistributed across the health and care economy. For example, a CCG may be paying a practice which has a high number of out-of-area patients so the reduction in A&E usage is seen at a neighbouring CCG rather than within the one which is funding the digital consultations.

• 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?

The triage potential of digital-first primary care is already being demonstrated. This could enable GP practices to review and change their skill mix, meeting the needs of their population in a more appropriate way. The way funding is distributed may need to alter to take alternative staffing models into account, where these are providing services to the population that reduces demand elsewhere.

• 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?

The provision of digital-first primary care services will require significant upfront investment in technology and staff training. There is also a need for patient engagement and communications. If, as anticipated, digital-first access encourages patients to change practice more frequently then it is vital that the systems available to GPs are compatible to allow transfer of information and avoid unnecessary conversion costs to the NHS.

Digital-first offers GPs the opportunity to carry out consultations with a greater number of people, potentially addressing some of the demand issues in primary care. However, if primary care throughput is increased, the consequential impact on secondary care could be significant, thus ‘shunting’ costs to other parts of the system.

It is likely that CCGs will see funding requirements for primary care increase as one off investments are made and as reporting requirements change. The cost impact on other parts of the health and care system must be considered, as well as the way in which funding is distributed to general practice.

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

The additional payment relating to new patients should be reconsidered in line with the rurality, London and out-of-area adjustments, recognising the fact that registrations by out-of-area patients in order to access digital services will not create the same volume of initial face to face contacts as a new, in-area, patient. However, any new registration be it digital or traditional, will require additional resources in the first instance to process, therefore a newly registered payment remains relevant but should be scaled accordingly.

CCG areas that contain GP practices with high list turnovers, due to their digital offer, may be financially penalised by payments for newly registered payments. There is potential to use the developing digital technology to enable faster patient transfer between practices, utilising the initial consultation to register at a new practice. This could mean that the newly registered payment is only valid upon first registration and subsequent registrations within, say, the first year do not attract another payment.

• 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?

As previously mentioned, GP practices need support to develop their digital offer through investment in technology and staff training. This support could also extend to patient engagement and communication. Investment in these areas should be supported through the funding model to encourage appropriate expansion of the offer for the population that they support.

Q6. 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?

The costs and uptake of the service can only be truly understood through full, probably mandated, reporting as suggested. However, the costs of providing this reporting must be minimised so as not to negate any potential cost benefits arising from the technology. Additional reporting requirements on GP practices may require system changes, staff training and therefore additional funding from CCGs. Consideration should be given to reducing current reporting requirements in order to facilitate this.

There may be scope to build data reporting requirements into the systems used to deliver digital-first access, thus reducing any reporting ‘burden’ as a consequence of this request. This will only be possible if reporting requirements are considered and communicated at an early stage so they can be included in the development of new systems.

Contact

If you would like to discuss any of our comments in more detail please contact Sarah Day, policy and research manager: sarah.day@hfma.org.uk.