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Digital-First Primary Care Consultation Response from the Digital Healthcare Council

About the Digital Healthcare Council (DHC)

1. The Digital Healthcare Council is the representative organisation for digital healthcare providers. Our members deliver care digitally both directly to patients and by working in partnership with others. We work to inform the development of policy and regulation.

2. We fully expect the provision of digital care to grow considerably over the next few years but it is important to note that digital services already reach millions of patients in England and many more across the world. So, while digital healthcare is a relatively new phenomena, it is already an established route to healthcare.

3. Our approach is informed by four core underlying principles that we need to get right if patients are to reap the full benefits of digital healthcare:

    a. Services designed around patients;

    b. Fair and appropriate market rules for providers, including regulation, procurement, and reimbursement;

    c. Access to data based on open standards subject to appropriate information governance; and

    d. An evidence-based approach that is responsive to patients' choices, outcomes, efficiency and understands that digital approaches are rapidly evolving, including through continuously learning algorithms.

General observations

Areas we welcome

4. The DHC strongly welcomes the commitment in the NHS Long Term Plan to give every patient in England access to digital GP services. This is important for several reasons, not least:

    a. Patients and the public should have the widest possible choice of ways to access healthcare which suits both their usual preferences and specific ways to discuss specific symptoms or circumstances

    b. The enthusiasm shown for digital services by patients is evidence of a strong public appetite for services that meet contemporary consumer expectations.

    c. Digital care is predicated on collecting data that supports continuous quality improvement.

    d. More effective and widespread utilisation of digital triaging represents a profound opportunity to ensure patients are channelled effectively to the most appropriate professionals to provide their care. In turn, this will reduce wasted multiple appointments which is a direct benefit to patients and creates capacity for hard-pressed health professionals and services.

    e. Digital services can offer additional benefits than more traditional approaches, e.g. the opportunity to receive a transcript or recording of the consultation

5. Further, we welcome the recognition of the importance of digital in the consultation paper. We agree that that the current contracting rules need to change to take digital-first services into account, both in terms of patient benefits and ensuring the equity of how NHS funding is used for both taxpayers and localities.

6. We strongly support the statements made in the consultation paper that emphasise the importance of patient-centred care, specifically:

    a. That money continues to follow the patient.

    b. The centrality and importance of patient choice.

7. We also agree that digital health can make a significant contribution to help with the shortage of doctors, as well as contributing to a better working experience, and health

inequalities, those noted below we have profound concerns about the proposed mechanisms suggested in the consultation.

8. We support proposals to streamline APMS contracting, though as noted below we have significant reservations about the disaggregation proposals and associated criteria. We have also highlighted areas that require further clarification

Proposals where we have concerns

9. While we agree with the intention stated aims of the consultation, we have several concerns that the detail of the proposals may undermine those objectives. Specifically:

    a. The consultation appears to focus mainly on a single model of end-to-end provision. There are many other delivery models that the consultation does not explicitly consider. Consequently, there is a significant risk that these may be ruled out in the future by default simply because they have not been considered at this stage.

    b. Digital providers are increasingly entering into a diverse range of partnership models with existing providers. There is a lack of clarity in the consultation paper about how these relationships will be affected, and again, we are concerned that these opportunities may be inadvertently restricted, in some cases before they have even been conceived.

    c. The consultation contains remarkably little focus on the role of Primary Care Networks in harmonising resources across neighbouring CCGs. Digital has real potential here to act as the enabling glue that facilitates PCN-level synergies. This seems to be have developed in isolation from the strategy for PCNs.

    d. The consultation paper repeatedly focuses on CCG-based geographies. This is fundamentally an organisational-centric approach rather than being patient-centred. Consequently:

        i. opportunities stemming from the inherently non-geographic nature of digital provision may be missed;

        ii. a patient living near the boundary of one CCG may be significantly inconvenienced by being restricted to services defined by that CCG's geography when there may be more convenient physical provision more closely located in a neighbouring CCG.

iii. Many would now consider CCGs archaic (although we note they still have statutory powers) with the Long-Term plan focussing on the three levels of systems (STPs), localities and neighbourhoods (PCNs).

e. The threshold-based criterion for forced disaggregation is problematic because it focuses on the number of out-of-area patients in the “original” CCG. In turn, the proposals mean that a growing provider may be faced with numerous contracts across many CCGs each with a small number of patients. Depending on the thresholds chosen, and original practice size, this would lead to 13-18 new lists of around 3,000-4,000 patients in the case of one existing practice, and potentially even more in the future. In turn, the administrative burden related to these contracts may be disproportionate both the CCGs and providers. Instead of the current organisation-centric approach, it may be wiser to pursue a more patient-centric model. For example, a disaggregation threshold based on the locations where patients live, rather than the host practice may prove viable. Alternatively, an approach that considers the STP/ICS as the core geographic unit, would bring several benefits (see section below on ‘alternative approaches’ for more detail).

f. We believe that digital can play a major role in reducing health inequalities and we strongly support the consultation’s aspirations to achieve that goal. However, the proposed mechanism for focusing on under-doctored areas defined at CCG-level, and then further restricting physical locations by areas of high deprivation, may be both counter-productive and exclude large swathes of the country[1]. This runs counter to the NHS Long Term Plan commitments to give all patients access to digital first primary care over the next five years. Moreover, the data suggest the proposal will exclude many under-doctored localities and could exacerbate the exact problem it seeks to address.

g. Similarly, the additionality requirements may restrict adoption of new provision by creating barriers between individuals working to treat NHS patients. The experience of the wave one contracts with the Independent Sector Treatment Centre programme was mixed, and it is notable that the Department of Health dropped additionality requirements in the second wave of ISTC contracts. There is a risk that these lessons have been forgotten.

h. The proposal to introduce a delay before practices qualify for the new patient premium works against patient choice. Evidence suggests that patients who are more active in their care have better outcomes and in general choose less expensive treatment options. We should therefore encourage patients to make proactive decisions about their providers, not introduce delays in payment.

[1] see note on under-doctored areas, deprivation and current data

Areas that require clarification

10. Further, there are areas where more detail is required to understand the full implications of the consultation's proposals. For example:

    a. the requirement for "evidence-based" solutions is understandable, but there is no stated definition of what qualifies as "evidence-based". We assume that NICE guidelines may fulfil a role here, but this is needs to be explicit. Further, NICE standards on the evidence base underpinning digital technology specifically avoid continuously learning algorithms. Given these are likely to be of increasing importance, this area needs significantly more clarity.

    b. The requirement for a "symptom checker" as part of the threshold of the definition of a digital first service is again open to interpretation. Symptom checkers include a broad spectrum of propositions: everything from a rudimentary form to outline symptoms, simple scoring or decision-tree tools through to a fully scoped AI / machine learning solution. This is so broad that without further definition, the requirement is of questionable value.

    c. APMS authorisation. The proposals talk about the "automatic" award of new contracts following disaggregation, but in discussions about the consultation there has been talk of NHS England signing off new contracts. This prompts several questions, for example:

        i. which organisation will hold the contract, and which organisation will sign off the contract? We assume this will be the same organisation, but it would be helpful if this could be clarified.

        ii. if sign off is required, then presumably this will be based on as-yet-unspecified criteria, so the award of new contracts will not be automatic. In turn, it would be helpful to understand that criteria.

        iii. It is not clear how the relationship with the local CCG will work if NHS England holds the contract with new types of providers.

        iv. What rules will be in place to ensure appropriate behaviour in relation to local provision in competition?

    d. Rent and rates reimbursement. The consultation lacks detail about reimbursement relating to any new premises. We are concerned this could mean the physical opening of sites may be mandated without any of the equivalent funding rights already available to existing providers. This would create a discriminatory funding model that would send a clear signal that traditional

practices are preferred over innovative, digital first providers. Given the potential of conflicts of interest within CCGs, this may provide a mechanism for existing providers to render new provision inviable even where patients clearly demand alternatives. This would be anti-competitive, potentially open to challenge and certainly not in the interests of patients. Greater clarity is needed. Either:

i. a guarantee of rent and rates reimbursement that is consistent with that available to existing practices and not subject to local commissioner discretion; or
ii. a guarantee of capitation-related payment with an equivalent cost basis.

e. Relationship with Primary Care Networks. More clarity is needed on the proposals in this consultation paper and the policy on Primary Care Networks. Specifically, it is unclear if how and whether new APMS providers will join and relate to existing PCNs, especially if the volumes of these new contracts tips the "obvious" PCN over the 50,000 threshold. Further, the consultation proposes that the possibility of a single provider may need to hold multiple APMS contracts in a single PCN area. In such circumstances, there is obvious scope for duplication and waste but conversely this could be an opportunity for significant savings and service improvements if structured correctly.

Opportunities and alternative approaches

24/7 provision

11. We also note that the consultation appears to focus only on core hours PMS provision. Patients want to access care at a time and place that is convenient to them. Just as digital care is not necessarily tied to specific geographies, so digital can also be a mechanism to deliver care at a time that is convenient for patients. We believe therefore that a digital first proposition should include thinking on out-of-hours provision. Again, this seems counter to the commitments in the long-term plan.

Disaggregation

12. Alternative approaches to disaggregation. As noted above, we have significant reservations about any threshold based on the number of out of area patients at a given CCG. If forced disaggregation is implemented, then it may be better adopt one, or a combination of, the approaches outlined below:

    a. use thresholds based on a minimum number of patients at locations where patients live, rather than the CCG of the practice with which they are registered, i.e. take a patient-centric approach; and/or

    b. examine ways in which CCGs can cross charge each other with agreements about how digital first primary care can provide appropriate local service delivery requirements. These arrangements may differ depending on availability of local

provision. This more flexible approach will allow arrangements to be put in place that meet local rather than a one size fits all approach. In turn, this flexibility will make it more straightforward to align with priorities and challenges facing Primary Care Networks and achieve more integrated care provision; and/or

c. use the STP/ICS as the geographic unit rather than CCGs. This would:
    i. solve the funding issues that the consultation seeks to address while maintaining choice of practice and facilitating access to digital first primary care
    ii. be consistent with the strategy outlined in the Long-Term Plan
    iii. avoid the creation of numerous small APMS lists and associated duplication of administrative cost
    iv. allow new best-in-class physical practices to be located in genuine areas of need rather than arbitrarily located to fit CCG-oriented criteria that may make little sense to patients.

13. We would welcome discussions with NHS England about practical implications of how to implement the suggestions above and finesse the details to optimise benefits to patients.

Addressing health inequalities

14. We believe that digital can play a major role in reducing health inequalities and we strongly support the consultation's aspirations to achieve that goal. However, as noted elsewhere, the data suggest that proposed mechanism will miss its target and exclude many potential beneficiaries.

15. The evidence shows clearly that there is no longer a robust correlation between under-doctored areas and deprivation. It is now far more nuanced, no doubt in part because of outputs from the Equitable Access to Primary Medical Care programme which looked to bring more capacity into "under-doctored" areas. It is important therefore to learn from those challenges including maximising the availability of GPs (and other health professionals), the availability of premises solutions and the variable costings, value for money and improvement of patient outcomes/inequalities.

16. We believe that the best way to achieve this is to avoid geographic limits based on arbitrary criteria, and instead make digital first primary care as widely available as possible. In turn, the key benefits of delivering services digitally to patients exactly when they need them, and associated triaging will enable resources to be targeted precisely at patient need.

17. Although digital first services do not target specific patient cohorts, different patient demographics have varied needs and aptitudes for technology. By enabling patients to choose digital first services regardless of where they live, the service as a whole benefits in two distinct ways:

a. Patients that want digital services benefit from the ease of access they provide and all the associated quality improvements;

b. People who are less digitally comfortable also directly benefit because GPs and other care providers have their more time available because they no longer need to provide multiple appointments the patients that would prefer to access their services digitally.

Intellectual property

18. The consultation paper does not consider emerging issues such as the ownership of intellectual property. Given digital partnerships make likelihood of rapid improvements and innovations more likely, this area needs careful consideration.

Notes on under-doctored areas, deprivation and current data

20. The consultation paper states:

    "It [digital first primary care] could also help address the inverse care law in general practice. We could allow new digital-first practices into our most under-doctored geographies – for example, CCGs in the bottom 10% or 20%. And require these practices to meet key criteria: (i) demonstrate that the GPs they will be bringing into the local community are additional; (ii) ensure that the physical part of their service also includes the most deprived areas of the CCG; and (iii) actively promote their service to the most deprived communities, so that their lists properly reflect the make-up of the local population. In this way, the NHS could harness the potential of digital-first providers to reduce health inequalities."

21. We recognise the clear link between deprivation and health outcomes which shows, for example, considerably shorter life expectancy in high deprivation areas compared to now deprivation geographies[i]. However, this is not necessarily the same as a link between under-doctored CCGs and areas of high deprivation.

22. To understand this in more detail, we explored the data, specifically we combined data covering:

    a. GP practices, GPs[ii] and list sizes[iii]
    b. Population data at LSOA level[iv]
    c. IMD by LSOA[v]

23. We used ONSPD data[vi] to link LSOAs, CCGs and practices to:

    a. estimate the number of GPs per head of population for each CCG
    b. correlate this with average IMD across CCGs

24. The visualisation below shows the relationship between IMD and GPs per head of population for each CCG. Each dot is a CCG. The orange coloured dots are CCGs with the highest head of population to GP, i.e. the most under doctored areas.

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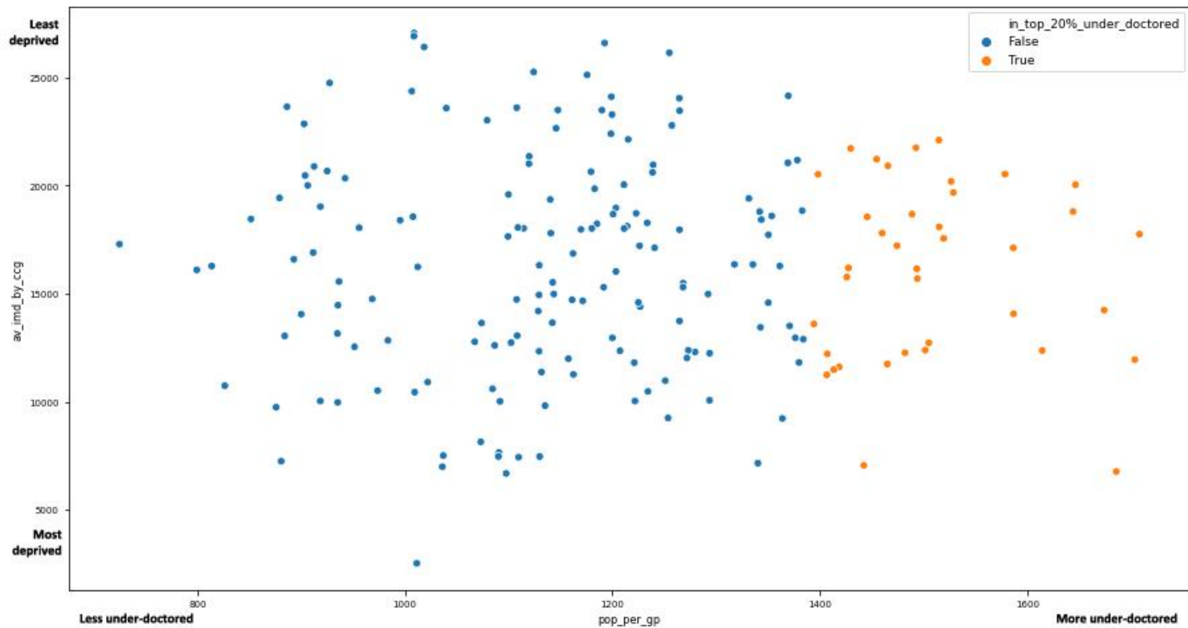

Fig 1

25. If there was a correlation between deprivation and most under-doctored areas we would expect to see a clustering along a line from the top left to the bottom right in Fig 1 above. It is hard to see any such correlation.

26. Fig 2 below represent the same data as Fig 1, except that the CCGs are coloured to show the highest and lowest deciles of GP provision and deprivation.

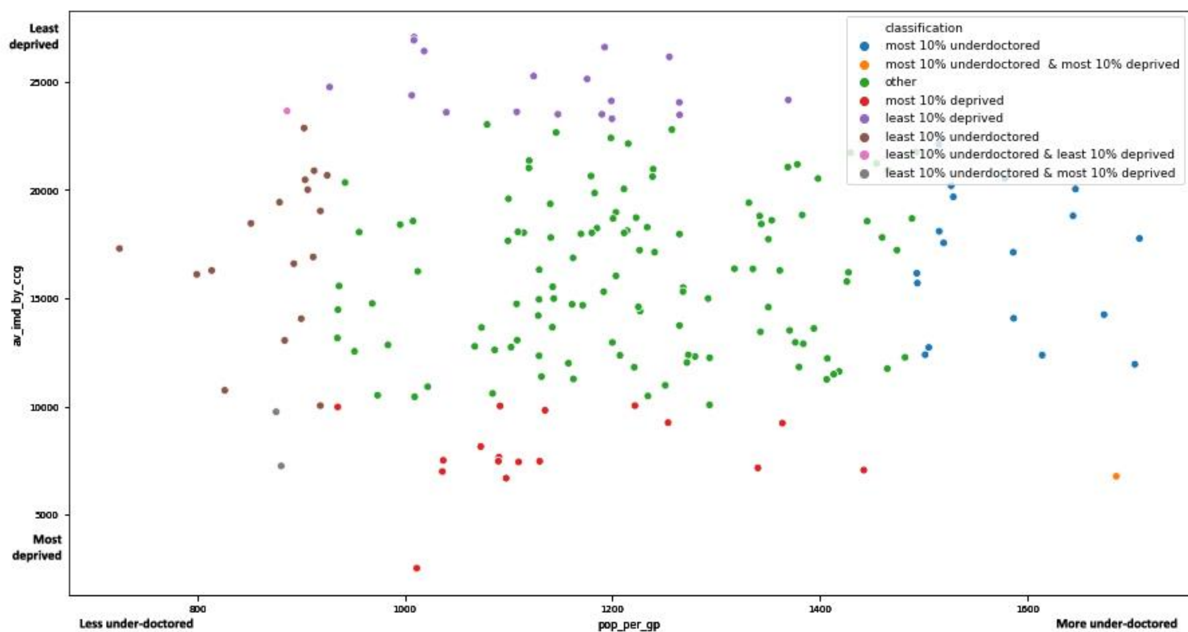

Fig 2

27. Fig 2 shows clearly that just one CCG is in the worst decile for both deprivation and most under doctored. It also shows that the other 18 CCGs in the most deprived decile by average IMD would be excluded from provision. This is entirely inconsistent with a policy where the stated aim is to target areas of deprivation.
28. Figure 3 below highlights the highest and lowest quintiles.

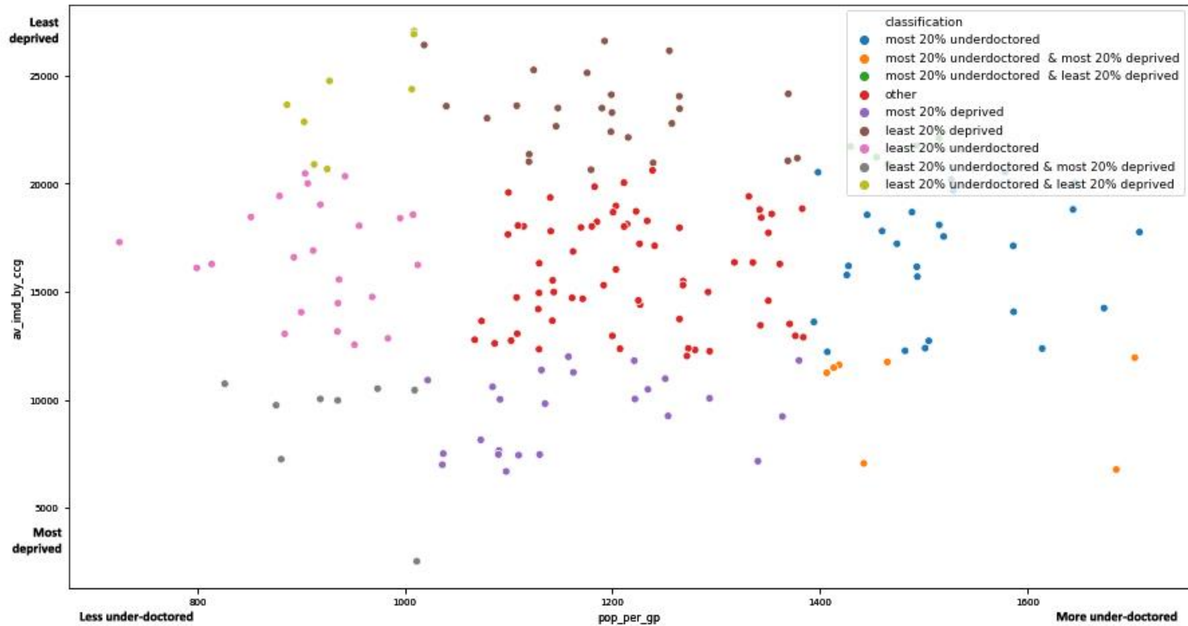

Fig 3

29. Even considering the lowest and highest 20%, we would miss most of the target areas for this policy, with just seven CCGs that are both the most 20% under doctored and most 20% deprived.

Classification	Number of CCGs
least 20% deprived	25
least 20% under-doctored	23
least 20% under-doctored & least 20% deprived	8
least 20% under-doctored & most 20% deprived	8
most 20% deprived	24
most 20% under-doctored	26
most 20% under-doctored & least 20% deprived	5
most 20% under-doctored & most 20% deprived	7
other	65

30. In conclusion, it is hard to find evidence from the data that supports a policy that filters by under-doctored CCGs as a mechanism to address health inequalities.

Tintagel House, 92 Albert Embankment, London, SE1 7TY
020 7018 1124

Responses to specific consultation questions

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?

We recognise the importance of connecting with local primary care networks and health and care services, but the proposal to set criteria focusing on the number of out of area patients in a host CCG is an inappropriate metric.

It risks large numbers of contracts with small numbers of patients while focusing on organisational based geographies, principally CCGs, rather than proposing a mechanism that is more patient-focused. We have suggested alternatives to disaggregation in our wider reflections above.

Q1b. Are there any factors which you think should be taken into account if this option were to be implemented?

The impact of potentially large number of contracts with small patients could pose difficulties for providers and PCNs.

Q1c. Please provide any views you may have about the proposed threshold of 1,000-2,000 patients for the triggering of this localisation.

We believe that setting a threshold based on the CCG of practice registration is an organisation-centric approach. Rather, if a threshold is to be adopted, it would be better to create a threshold based on the localities where patients live. Further, while CCG boundaries make sense to NHS organisations, they have little, if any, relevance to patients' lives. Specifically, a patient living or working near a boundary of one CCG would think nothing of crossing that boundary to access a nearby provider. However, they would be surprised and perplexed about a requirement to travel often quite large distances to a location that happens to be within the same CCG area but that is inconveniently located for their day-to-day life.

One of the many advantages offered by digital is that patients who wish to escape these geographic constraints have opportunities to choose alternatives, while recognising that physical services will always be an element of care provision.

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?

We agree with this element of the proposal.

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?

We strongly support the principle that resources should follow patients in a timely way. This is fundamental to developing a patient-centred model of provision.

Further, while digital providers do not target the recruitment of specific patient demographics, unsurprisingly digitally literate individuals tend to prefer digital services. Because current payment mechanisms are weighted to reflect demographics that have greater health needs, any self-selection by “healthier” patient groups for digital services means that payment received by digital providers are correspondingly reduced. In turn, this provides a cost-effective mechanism to treat patients with lower health needs in ways that meet their expectations, while freeing up resources to treat patients with higher health needs with more traditional services. The benefits of digital care therefore flow to patients beyond those treated directly by digital providers.

Q3b. For these purposes, how do you think “significant” movements in registered patients should be defined?

We strongly believe that care services should be designed around patient needs and financial incentives should support that objective. In turn, it follows that funding should always follow patients and reflect their choices. These principles should not be subject to thresholds. Given we have systems in place that can accurately account for patients in real time (and if we do not then that poses serious safety risks as well as questions about financial management) there are few, if any, good reasons for setting thresholds below which this principle should not apply.

Q3c. What threshold, if any, do you think should be applied to the flow of out-of- area patients to a CCG before this adjustment is applied?

The most straightforward way to reflect patient choices would be for funding always to follow the patient regardless of any threshold. Although banding could be applied, any form of tiering or thresholds will effectively risk creating perverse incentives and distract from patient-oriented care.

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

We recognise that there may be a case to help CCGs manage sizeable transitions in year, but any policy should be careful never to limit patient choice.

Q4. Do you agree that a capitation-based approach is the best way to determine the size of the adjustment required per patient or do you have other proposals?

We believe that a capitation-based approach is the most patient centric mechanism to adjust payments.

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?

Ultimately, this is about putting patients at the centre of care. There is no clearer, more powerful way for a patient to express their preferences than to choose a new primary care provider.

We therefore do not agree with the proposal. The costs associated with registering new patients exist regardless of how long they remain with a provider, so while we caution against introducing rules that may introduce perverse incentives and/or create arbitrary distinctions between different models of care.

Patients may have good reasons to choose care from one provider for a limited period, and we argue strongly that it is a good thing if patients consider options available to them. Exercising choices and actively choosing to explore different provision options should be

encouraged – patient activation is after all associated with better outcomes and lower overall costs. We should avoid creating system rules that argue patients should be more involved in their care, but then work against providers that facilitate active patient choice.

Q5b. What do you consider to be the right period of time for a patient to be registered with a practice for the practice to be paid the new patient registration premium? Six months, nine months, twelve months or other?

For the reasons outlined in response to question 5a, we believe:

- Funding should always follow patients: there should be no time lag associated with this principle
- Patient choice should be encouraged
- Practices should receive the new registration premium immediately to compensate for costs associated with facilitating patient choice.

We disagree with any delay, but if it is to be introduced, it should be kept to an absolute minimum: i.e. weeks, not months.

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?

We disagree. 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.

If patients, and the wider health system, is to benefit from digital first services, we should not arbitrarily limit the location of those services.

Instead, we strongly argue that providers should be able to treat patients wherever patients wish to receive care.

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?

We believe that digital can certainly contribute to tackling the inverse care law bringing care to those who most need it and by freeing up staff and resources to focus on what makes most difference to those patients.

However, it is hard to find support in the data for the hypothesis outlined in the consultation paper that there is a strong link between under-doctored CCGs and deprivation (see discussion above). Consequently, the proposals as articulated risk arbitrarily distorting the location of care provision and unnecessarily restricting its benefits to an unduly narrow proportion of patients.

There are patients across the country in every CCG who struggle to access primary care services that could benefit from digital provision. Moreover, there are areas of high deprivation in every CCG. To limit provision to 1/5 or even just 1/10 of the population by geography is both inappropriate and unlikely to achieve its stated aims.

Q7b. What methodology could we apply to identify these areas, specifically those that are under-doctored?

Patient choice is by far and away the best mechanism to identify patients who currently struggle with access to primary care. We should not try to limit the choices available to patients and manage this in a top-down fashion. Providers should be encouraged to innovate and bring services to patients.

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

Yes, though we do not agree with excluding 80-90% of the population from exercising choice in the first place.

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

No. The data does not support the hypothesis that there is a clear and consistent link between under doctored areas and deprivation. There is, however, evidence to support a link between deprivation and poor health outcomes, though it is not limited to 10% or 20% of CCGs.

We believe that physical provision should be available to patients across the country at convenient locations. This is especially important for testing and emergency provision. There are numerous ways to achieve this both through new practices and in partnership with other providers.

There are some areas in the country where deprived communities have significant need for new services. It makes sense to target those areas. Conversely, there are numerous deprived areas which already have above average levels of general practice services – in many cases as a result of considerable investment and effort over the past few years. It would be bizarre to create further physical services in these areas while leaving under-doctored areas without provision.

Therefore, we believe the proposal for a blanket requirement to establish physical premises in deprived areas is highly unlikely to achieve its stated aims of addressing either under-doctored areas or health inequalities. Rather, as discussed above, by taking a different approach to disaggregation, more responsive best-of-class physical provision could be achieved in locations that meet patient needs.

Q7e. If we require new contract holders to establish physical premises in deprived areas of a CCG, what methodology could we apply to identify such areas?

Given the lack of supporting evidence for this hypothesis, is hard to make the case for any specific methodology.

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?

This is a problematic proposal:

First, while new providers will bring additional head count in many cases, it is a mistake to think purely in terms of individual GPs. Additional capability can be achieved by providing services differently such as more effective triaging and better targeted interventions. These improvements do not necessarily require additional personnel. Rather, they require smarter ways of working: exactly the sort of improvements that digital technology supported and informed by powerful analytics can provide.

Second, we know from the experience of independent sector treatment centres where there were specific requirements for additionality, that this led to difficulties integrating local professional communities. In turn, the contractual requirements relating to additionality were dropped in the second wave of ISTC contracts. Given that digital offers a significant opportunity for synergies to be leveraged across Primary Care Networks, we should learn from the experience of the ISTCs and avoid well-intentioned, but ultimately counter-productive, policies that proved problematic in the past.

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?

We believe that patients should choose their service providers because patients are best placed to make decisions about their own individual circumstances and preferences. In turn, the cohort of patients choosing new providers may on occasions differ from the local geography. Given that remuneration reflects case-mix complexity, this will either free-up finances for providers with cohorts that have more challenging health needs, or conversely, we may find that those individuals who have struggled to access old models of care, become able to access provision that suits their lifestyle and needs.

Top-down requirements to engineer patient choices are unlikely to be successful and could lead to the creation of perverse incentives that do little to improve patient care.

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

We agree with streamlining the approach to awarding contracts according to national criteria, though clearly it becomes even more important to get those criteria right.

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?

We agree that PCNs offer great potential to generate synergies at scale and thereby may well become the default means to maintain primary care provision. However, it is important that they should not become a mechanism to exclude new providers as that would represent a profound lost opportunity. While new APMS contracts may become less common the need for them may well continue.

In general, our experience of working in partnership with local CCGs and practices is that most embrace the opportunities offered by digital first primary care and are keen to evolve their services to ensure patients benefit through improvements in safety, effectiveness and convenience.

Further information

For further information about the DHC and the comments in this response, please contact the DHC's Director, Graham Kendall, on 07957 390223 / graham.kendall@zpb-associates.com / digitalhealth@zpb-associates.com

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[i] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2015to2017#life-expectancy-and-healthy-life-expectancy-in-england-by-the-index-of-multiple-deprivation-2015-imd15-2015-to-2017

[ii] GP practice data from the ODS data set, specifically epraccur.csv and links between specific GPs and their practices from egpcur.csv (https://digital.nhs.uk/services/organisation-data-service/data-downloads/gp-and-gp-practice-related-data)

[iii] https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/august-2019 (gp-reg-pat-prac-all.csv)

[iv] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates

[v] https://geoportal.statistics.gov.uk/datasets/ons-postcode-directory-may-2019 (IMD lookup EN as at 12_15.csv)

[vi] ibid