Creating a healthier Hull

NHS Hull Clinical Commissioning Group

Item: 8.1

Report to:	Primary Care Commissioning Committee
Date of Meeting:	22nd April 2022
Title of Report:	Recognising Deprivation in Hull – Proposal for a Local Scheme
Presented by:	Phil Davis, Strategic Lead - Primary Care, NHS Hull CCG
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STATUS OF THE REPORT:

To approve	x	To endorse	
To ratify		To discuss	
To consider	x	For information	
To note			

PURPOSE OF REPORT:

The purpose of this paper is to outline an approach for a local scheme developed in recognition of the level of deprivation within Hull and the impact of additional workload for primary care.

RECOMMENDATIONS:

It is recommended that the Primary Care Commissioning Committee:

1. consider the proposal and two options to utilise resources to support a local scheme which recognises the impact of deprivation on the workload for and delivery of primary medical care services;
2. approve the utilisation of resources in 2022/23 to support a scheme for PCNs to deliver improvements in outcomes to be agreed with each PCN.

REPORT EXEMPT FROM PUBLIC DISCLOSURE No [x] Yes [ ]

If yes, detail grounds for exemption

CCG STRATEGIC OBJECTIVE *(See guidance notes on page 4)*

Integrated Delivery

The updates contained within this report support the CCG objective of Integrated Delivery through the development of PCNs

IMPLICATIONS: (*summary of key implications, including risks, associated with the paper*),

Finance	Financial implications where relevant are covered within the report.
HR	None specific to this report
Quality	Quality implications where relevant are covered within the report
Safety	None specific to this report

ENGAGEMENT: (*Explain what engagement has taken place e.g. Partners, patients and the public prior to presenting the paper and the outcome of this*)

Engagement has been undertaken with the Primary Care Networks through Clinical Directors and with the LMC.

LEGAL ISSUES: (*Summarise key legal issues / legislation relevant to the report*)

None at this stage.

EQUALITY AND DIVERSITY ISSUES: (*summary of impact, if any, of CCG's duty to promote equality and diversity based on Equality Impact Analysis (EIA).* ***All*** *reports relating to new services, changes to existing services or CCG strategies / policies* ***must*** *have a valid EIA and will not be received by the Committee if this is not appended to the report*)

	Tick relevant box
An Equality Impact Analysis/Assessment is not required for this report.	√
An Equality Impact Analysis/Assessment has been completed and approved by the lead Director for Equality and Diversity. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.	
An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.	

THE NHS CONSTITUTION: (*How the report supports the NHS Constitution*)

The report supports the delivery of the NHS Constitution as the commissioning of primary care services will aid in the delivery of the following principles, rights and NHS pledges:

1) The NHS aspires to the highest standards of excellence and professionalism
2) NHS works across organisational boundaries and in partnership with other organisations in the interests of patients
3) Quality of care
4) You have the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide.

RECOGNISING DEPRIVATION IN HULL – PROPOSAL FOR A LOCAL SCHEME

1 INTRODUCTION

The purpose of this paper is to outline an approach for a local enhanced scheme developed in recognition of the level of deprivation within Hull and the impact of additional workload for primary care.

2 BACKGROUND

The paper is written on the premise that General Practice can do more to reduce health inequalities, and that areas with the highest socioeconomic need will require the most support.

The local scheme will use c £300,000 PMS Premium monies currently not committed in 2022/23.

The scheme will supplement the Health Inequalities component of the 2022/23 PCN Network DES.

3 INFORMATION

It is well recognised that all practices in Hull serve deprived communities, with Hull being the 4th most deprived area in the country based on the Index of Multiple Deprivation (IMD) - the official measure of relative deprivation in England

Within Hull there is still a range of deprivation, and funding will be calculated based on deprivation of individual practices but allocated at PCN level. The intent is to make a small start to tackling the inverse care law and to work with practices to pilot how additional resources might try to offset this in some way.

Two options are explored within this paper in terms of how this funding allocation could be calculated.

PCNs will not be required to undertake significant additional reporting but will be asked to identify two or more outcomes that link to their health inequalities plan. PCNs will be able to use the funding in a flexible way but will be asked to ensure a focus on those practices in more deprived areas and with higher IMD scores.

The outcomes identified by PCNs will be measured over time using the RAIDR and other routinely available data collection systems. The aim will be to measure the impact of local schemes and is anticipated over time to demonstrate a link between additional funding and impact on outcomes.

In time is hoped that a wider system discussion can place at HCV level having made the case that linking funding more closely to need is a more efficient use of resource.

4 THE CASE FOR HULL

Reducing Health Inequalities in Hull is a key aim in Hull's Joint Health and Wellbeing Strategy. Hull's poor health outcomes are well documented in its strategy with the rate of preventable premature death (under 75yrs) being two-thirds higher than England and rates differing markedly across the City. The five most common causes of death are CHD, dementia, lung cancer, COPD and stroke, accounting for around 45% of all deaths.

In addition Hull's deprivation is also well acknowledged. Hull as a whole, based on IMD score, is ranked the fourth most deprived local authority in the country.

Overall, 45 per cent of Hull neighbourhoods are in most deprived 10 per cent in the country, meaning people are much more likely to live in areas that are among the most deprived in England.

5 THE CASE FOR PRIMARY CARE

Primary Care is funded via a global sum payment for each practice which is based on a sum for the weighted patient list size of the practice. The Carr-Hill formula is used to apply these weightings. It is this funding formula that has frequently been criticised for not sufficiently taking the impacts for primary care of deprivation into account.

A study (1) from 2018 found that levels of morbidity varied within and between regions, with several clusters of very high morbidity identified. At the regional level, morbidity was modestly associated with practice funding, with the North East and North West appearing underfunded.The study concluded that Primary care funding in England does not adequately reflect the contemporary morbidity burden.

(1) Kontopantelis E, Mamas MA, van Marwijk H, Ryan AM, Bower P, Guthrie B and Doran T (2018). 'Chronic morbidity, deprivation and primary medical care spending in England in 2015-16: a cross-sectional spatial analysis'. BMC medicine 16(1), p19.

Some other sources of income for primary care networks (an annual uplift of £1.50 per patient from clinical commissioning groups (CCGs), and funding for extended hours and extended access) are also not weighted potentially further widening the gap in funding levels.

The Health Foundation is also clear in its view around this funding formula: https://www.health.org.uk/publications/long-reads/levelling-up-general-practice-in-england

- GP practices serving more socioeconomically deprived patient populations receive similar funding per registered patient to those serving less deprived patient populations. Once these populations are adjusted to account for increased workload associated with greater health needs in poorer areas, **practices serving more deprived populations receive around 7% less funding per** need adjusted* registered patient than those serving less deprived populations.

- There are fewer GPs per head of need adjusted population in deprived areas than in affluent areas, but more practice nurses. **This suggests a lower supply of doctors in deprived areas** and a possible substitution of nurses for doctors in these areas. After accounting for different levels of need, a GP working in a practice serving the most deprived patients will on average be responsible for the care of almost 10% more patients than a GP serving patients in more affluent areas.

- GP practices serving patients who live in more deprived areas tend to be smaller (have fewer GPs) than those serving patients living in less deprived areas – **with single-handed practices** particularly over-represented among practices **serving patients living in the most deprived fifth of neighbourhoods.**

- Regardless of the level of deprivation in their area, patients have a similar probability of having an appointment at their GP practice. Patients attending practices serving more deprived populations are **less likely to have an appointment with a GP** and more likely to have an appointment with a nurse than those visiting practices serving less deprived populations. Practices serving more deprived populations also deliver fewer telephone appointments than those serving less deprived populations.

- **GP practices serving more deprived patient populations on average earn fewer quality and outcomes framework** (QOF) points, have worse Care Quality Commission (CQC) ratings and lower patient satisfaction scores than practices serving less deprived populations. These measures of assessing quality may themselves be affected by deprivation. Further research is needed across other aspects of quality to explore whether patients living in more deprived areas receive a systematically lower quality of care

6 PROPOSAL

6.1 Allocation of funding

The Indices of multiple deprivation (IMD) are widely-used datasets within the UK to classify the relative deprivation (essentially a measure of poverty) of small areas. Multiple components of deprivation are weighted with different strengths and compiled into a single score of deprivation. Seven domains of deprivation are considered and weighted as follows,

- Income. (22.5%)
- Employment. (22.5%)
- Education. (13.5%)
- Health. (13.5%)
- Crime. (9.3%)
- Barriers to Housing and Services. (9.3%)
- Living Environment. (9.3%

As reported above Hull (based on IMD scores) is the 4th most deprived area in the UK, all practices within Hull work with deprived communities. However, within Hull there is still a range of deprivation, ranging from 53.99 - 20.20. Funding will be calculated based on deprivation of individual practices but allocated at PCN level.

The intent is to make a small start to tackling the inverse care law and to work with practices to pilot how additional resources might try to offset this in some way.

There are two options that have been considered for allocation of funding:

Option 1

Grouping Method

This method of funding distribution involves placing GP Practices into four separate groups based on their IMD scores. The total funding available is then split down into four separate allocations for each group, the group with the largest IMD score will receive the highest proportion of funding and the group with the smallest IMD score will receive the lowest proportion.

The grouping thresholds and ratio of funding received are as follows:

- IMD Score <50 – 7/16ths of funding (44%)
- IMD Score 40 – 49 – 5/16ths of funding (31%)
- IMD Score 30 – 39 – 3/16ths of funding (19%)
- IMD Score 20 – 29 – 1/16ths of funding (6%)

The allocation for each group is then split out based on patient list size.

Option 2

Hull CCG Practice IMD Average Method

This method of funding distribution initially splits the total funding available out based on patient list size. The amount due to each practice is then adjusted based on the practices IMD score when compared the Hull average score. Therefore a practice with a higher score than the Hull average will have its allocation increased and a practice with a lower score will have its allocation reduced.

To note the adjustment made is scaled, therefore the closer to the average score the smaller the increase/reduction.

6.2 Link to PCN Network Contract DES

PCNs are responsible for designing and delivering the intervention described in the Network Contract DES. This includes:

- identifying and selecting the population experiencing inequality, working collaboratively across systems and localities
- engaging with the community experiencing health inequalities
- developing a PCN health inequalities plan
- identifying what outcome this intervention is expected to achieve and how that outcome will be measured. This measurement should support quality improvement activities within, and between, PCNs

The deprivation funding will be allocated at PCN level to support and enhance the actions described in the PCN Health inequalities Plans.

There will be no additional reporting requirements for practices but Clinical Directors will be asked to feed back to the CCG / ICS how they have allocated the funding and which outcomes they are going to focus on. Clinical Directors will also be required to ensure that there is a focus on the practices in the PCN serving the most deprived patients.

Some outcome measures that PCNs may wish to focus on might be:

- Increased uptake of childhood immunisation and vaccination programmes
- Increased uptake of other immunisation and vaccination programmes
- Increase in numbers of patients entering a stop smoking programme
- Increase in numbers of patients participating in a weight management programme
- Increased uptake of Cancer smears and screening programmes

Those outcomes agreed as a focus at PCN level will be monitored by the primary care team centrally using RADIR and other routinely available data collection systems.

6.3 Longer term

The funding is to be made available for 2022/23. This will be an opportunity to 'level up' marginally within Hull in order to make the case at a Humber and North Yorkshire level about the opportunities around levelling up on a wider and longer term scale. The hypothesis being that allocating resources to need makes more efficient use of those resources.

7 RECOMMENDATIONS:

It is recommended that the Primary Care Commissioning Committee:

1. consider the proposal and two options to utilise resources to support a local scheme which recognises the impact of deprivation on the workload for and delivery of primary medical care services;

2. approve the utilisation of resources in 2022/23 to support a scheme for PCNs to deliver improvements in outcomes to be agreed with each PCN.