SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	10R-2020210-?
Service	Deprivation and inequalities
Commissioner Lead	Steve McInnes, Primary Care Relationship Manager
Provider Lead	
Period	1 April 2020 – 31 March 2021
Date of Review	By 31/12/2020

1. Population Needs

1.1 National/local context and evidence base

People living in deprived areas suffer from health inequalities. Deprivation has been linked to a broad range long term conditions from mental ill health to ischaemic heart disease and diabetes but the burden of disease falls many years earlier than in less deprived areas. Failure to engage in prevention and screening programmes increases the risk of cancer presenting at later stages and contributes to premature death.

Deprived areas have many multi-morbid patients, who also have complex social needs. These communities have a high prevalence of mental health problems. Depression is common and funding for these patients is provided by the QOF (in addition to core funding), but other mental health disorders such as PTSD and anxiety disorder are commonplace, and do not attract funding. Personality-disorder is another diagnosis that does not attract investment, but which requires significant resource to manage at primary care level (without which there would an even greater burden on secondary care). Due to its nature, PD patients will often drift down the social strata.

The emotional well-being of deprived patients is affected disproportionately by issues such as domestic violence, substance misuse, family-breakdown, and contact with the criminal justice system. There are practices with relatively high numbers of patients from war-torn countries, or those seeking asylum, where English may not be their first language. These are extremely needy patients, requiring expertise, time and compassion –but again this is not funded work. Migrant workers at the poorer end of the social spectrum move to the area seeking work but speak very little functional English although they still require primary care.
Patients from deprived communities often have poor literacy skills, and poor educational backgrounds, they lack coping strategies and tend to be less able to self-care and remain healthy. Therefore in general they are higher users of health care, including primary care, and consultation rates are high.

Employment can also affect how patients interact with healthcare. In deprived communities there are many patients who work within the service industry, in manual jobs, or in factories. They frequently suffer from musculoskeletal problems which can affect their ability to support themselves financially.

Safeguarding issues are a large part of the workload. Children who are deemed to need a Child Protection Plan (CPP) are just the tip of the iceberg, and an enormous amount of work is involved supporting Families In Need – no specific funding is attached to this work. The Child Welfare Inequalities Project (Feb 2017) analysed data on over 35,000 children in the care system as a looked-after child or on a child protection plan. Roughly one in every 60 children in the most deprived communities was in care compared to one in every 660 in the

least deprived. Each 10% increase in deprivation rates saw a 30% rise in a child's chances of entering care.

The above aspects of work within deprived communities are largely unfunded, but are essential functions of primary care. By performing this work, primary care has less time available to offer to patients with LTCs, or who those need urgent appointments.

Practices therefore often have long waiting times, and patient satisfaction can be low, despite the generally high standard of care being offered. There can also be issues with regards recruitment of GPs and others clinical workers, as working within deprived communities can be seen as unattractive or difficult work.

In recognition of the increased workload placed on practices in deprived areas due to the burden of biopsychosocial issues in deprived populations, this locally commissioned service is intended to fund some aspects of the work required to carry out core GMS to deliver good quality access and care to these deprived populations and help address health inequalities which are linked to deprivation.

The Carr–Hill formula – used to weight funding for GP practices – has frequently been criticised for not sufficiently taking the impacts of deprivation into account[1] and the new GP contract fails to address this. As a result, the weighted component of per-capita funding for primary care is based on a formula which systematically under-funds practices in areas with the most need. A variety of mechanisms could be used to mitigate this – offering higher payments in deprived areas being one example. Policy makers must specifically consider the impact of deprivation on ability to unlock funding if there is to be equality of access to funds for those with the greatest need, let alone access in proportion to need. Outside the contract, there are potentially other sources of funding available – NHS England is clear that it expects CCGs to use some of their additional funding for inequalities to boost primary care capacity and access.

The Index of Multiple Deprivation (IMD) (2015) provides a relative ranking of areas across England according to their level of deprivation. Deprivation is experienced across a range of issues and refers to unmet need caused by a lack of resources – not just financial resources. For overall deprivation, Portsmouth is ranked 63rd of 326 local authorities where 1 is the most deprived in terms of the average score. Twenty-two per cent of all dependent children under the age of 20 years are living in poverty, which is above the England average with levels at twice the national average in some areas of the city (Charles Dickens ward). The percentage of pupils known to be eligible and claiming free school meals is higher than the national average, reflecting low incomes in the city.

Some areas of Portsmouth have more health inequalities than others. A breakdown of the IMD scores is provided at Appendix 1.

Portsmouth Clinical Commissioning Group (CCG) recognises that the creative working practices required to support patients living in the most deprived areas of the city come at a cost. This scheme is designed specifically to support the **two practices** in the city that are 'red flagged' as having the most deprived population, in accordance with the IMD scores. These practices need to develop flexible approaches and different ways of working to give their patients the best chance of achieving health outcomes which are comparable to the wider population.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	√
Domain 2	Enhancing quality of life for people with LTC	√
Domain 3	Helping people to recover from episodes of ill-health or	

[1] Focus on the global sum allocation. British Medical Association (July 2015).

	following injury	
Domain 4	Ensuring people have a positive experience of care	√
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	√

2.2 Local defined outcomes

The key outcomes that the service will deliver are:

- a convenient, accessible, timely and equitable service to all patients on the practice registered list
- a safe service in safe environment close to the patient's home
- improvements in health related outcomes
- in addition, specifically those outcomes that may be listed under Schedule 4, parts A-D, of the associated NHS Standard Contract

3. Scope

3.1 Aims and objectives of service

To reduce health inequalities and improve health outcomes for people living in the most deprived areas of Portsmouth through developing and implementing innovative ways to deliver services, with a targeted approach where appropriate.

3.2 Service description/care pathway

Part A

The practice will manage child protection plans and other associated queries/concerns in a timely fashion, following relevant guidance as set out in *Protecting children and young people: the responsibilities of all doctors (GMC Guidance - Protecting children and young people 2012).* The payment recognises the volume of CP plans that practices in the most deprived areas have to manage and the time taken by both clinicians and administrators in responding to requests.

Part B

For patients whose first language is not English, the practice will utilise longer appointment times as necessary. This will be to help accommodate use of interpreter services and to ensure patients are well-informed about appropriate use of health services, vaccination programmes, health promotion initiatives and self-care options.

Part C

The practice will aim to deliver improved outcomes in the following areas for its population, using pro-active engagement with patients and new and innovative ways of working:

- 5% increase in 'patients receiving the intervention' for specific QOF measures (to be agreed between the CCG and the practices)
- 5% reduction in ED attendances
- 10% increase in number of patients entering a stop smoking programme
- 10% increase in number of patients attending for NHS health check
- Achieve and maintain all childhood imm targets (or as an absolute minimum achieve within 5% of all the targets)
- Add more here?
- Add more here?

3.3 Population covered

This scheme covers all patients on the practice's registered list, but with a focus on the cohorts relative to specific requirements outlined.

3.4 Any acceptance and exclusion criteria and thresholds

N/A

3.5 Interdependence with other services/providers

Local Safeguarding teams; Interpreter services; Child Health Information Services; Well-being services

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

N/A

4.2 Applicable standards set out in Guidance and/or issued by a competent body

N/A

4.3 Applicable local standards

N/A

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Refer to Schedule 4 of NHS Standard Contract

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

N/A

6. Location of Provider Premises

The service should be provided from the main provider site and any branch sites where applicable.

7. Prices and costs

~~**Child Protection Plans** - Child protection issues take up considerable administration and GP time. Payment for this element will be £200 per registered patient with a Child Protection Plan. Practices will not be required to provide any data as the CCG has access to numbers of Child Protection Plans by practice. Practices are expected to follow best practice in as set out in ***Protecting children and young people: the responsibilities of all doctors (****GMC Guidance - Protecting children and young people 2012).~~

~~**Extended length of appointments** - in recognition of the extended length of consultation required for patients whose first language is not English. Payment for this element will be £45 per consultation supported by interpreter service activity reports.~~

£1.50 per head of (weighted) population

App 1

GP practice and proposed PCN by population weighted Index of multiple deprivation 2015 (IMD 2015) score

Practice Code	PRACTICE_NAME	Number of Patients registered	GP practice IMD2015 score Popn weighted
J82060	SOUTHSEA MEDICAL CENTRE	7,797	39.8
J82085	LAKE ROAD PRACTICE	15,594	38.1
Y02526	GUILDHALL WALK HEALTHCARE CENTRE	8,049	34.2
J82117	THE HANWAY GROUP PRACTICE	14,241	33.5
J82177	JOHN POUNDS SURGERY	4,333	32.2
J82199	THE UNIVERSITY SURGERY	20,961	30.8
J82114	NORTH HARBOUR MEDICAL GROUP	9,409	30.1
J82155	PORTSDOWN GROUP PRACTICE	43,996	30.0
J82090	SUNNYSIDE MEDICAL CENTRE	13,628	27.2
J82149	DERBY ROAD PRACTICE	13,022	25.5
J82028	TRAFALGAR MEDICAL GROUP PRACTICE	23,232	23.0
J82055	CRANESWATER GROUP PRACTICE	11,542	22.3
J82194	EAST SHORE PARTNERSHIP	13,478	22.0
J82073	KIRKLANDS SURGERY	8,811	21.6
J82165	THE DEVONSHIRE PRACTICE	5,825	20.3
J82102	THE DRAYTON SURGERY	18,650	14.3
Grand Total		**232,568**	**28.2**

Source: Calculated from total registrations by LSOA from NHS Digital (Data is extracted as a quarterly snapshot in time from the GP Payments system maintained by NHS Digital. This release is an accurate snapshot as at 1 April 2019.)

Indices of deprivation (ID) 2019 - map of Portsmouth with the England rank of Index of Multiple Deprivation (IMD) 2019 score in deciles by Lower Super Output Areas (LSOAs) overlaid with electoral wards and GP surgeries.

Source: Ministry of Housing, Communities and Local Government, English Indices of Deprivation 2019.