NHS England

# Guidance Note: GP Practices serving Atypical Populations

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| **Description** | Small numbers of GP practices provide services to a patient population which is sufficiently different ("atypical") to result in workload challenges that are not always recognised in existing contracts or funding allocations.<br>This document outlines challenges faced by providers and offers examples that may help articulate and/or address these pressures. |
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## Document Status

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# Guidance Note: GP Practices serving Atypical Populations

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# Contents

# 1 Introduction

## 1.1 Purpose of this document

The General Medical Services (GMS) funding formula (Carr-Hill formula) is an attempt to fund practice workload, regardless of the population they serve. It is applicable to the vast majority of the UK, but there are some practice populations that are so significantly atypical that using the GMS funding formula would not ensure the delivery of an adequate general practice service. This working group has looked at three such atypical populations: unavoidably small and isolated; university practices and; those with a high ratio of patients who do not speak English.

Support for practices should directly impact on patient care as well as the long term viability of practices, and therefore commissioners are encouraged to undertake a review of identified practices in their area. By reviewing the practices in your area, commissioners and providers can identify practices that require such support. Without this support many practices will be unable to maintain the service and as a result health outcomes may suffer. Where available, The Learning Environment provides examples of support that commissioners are providing to some practices serving atypical populations.

## 1.2 Background to this work

Whilst the vast majority of GP practices serve communities that have common characteristics and work to contracts that have similar terms, conditions and funding arrangements, a small cohort of practices provide services to a patient population which is sufficiently demographically different to result in particular workload challenges that are not always recognised in the practice's existing contract/s or its funding allocation. A population that triggers 'uncommon' workload challenges that are not experienced by the majority of GP practices is referred to here as 'atypical'.

This document was produced to assist NHS England and delegated Clinical Commissioning Group (CCG) commissioners of 3 such atypical 'populations' by detailing the particular challenges faced by providers and offering examples of either provider or commissioner reports that may help either articulate or address these pressures. How members of the public relate to and use GP services is influenced by the accessibility of other services including, for example, pharmacy, A & E, Walk-In Centres and voluntary agency support infrastructure.

The populations are:

- Unavoidably small and isolated
- University populations and
- Practices with a significantly high ratio of patients who do not speak English including those services designed to address the needs of migrants.[1]

[1] For the central Primary Care Commissioning Team, the project files include further background to developing this guidance'.

This document guides commissioners to the types of issues and data sources they could consider in coming to a judgement about support that is relevant to their particular circumstance, where commissioners and individual practices have a shared concern about meeting the health needs of their patients.

This document outlines the additional needs of these patient groups, the pressures that providers face and the duty on commissioners to secure quality services which may legitimately require consideration of additional funding support.

In reading this document, commissioners and providers should be aware that services should be equitable for all population groups in line with the Public Sector Equality Duty (PSED) under the Equality Act 2010 and have regard to reduce health inequalities under the Health and Social Care Act 2012.

Promoting equality and addressing health inequalities are at the heart of NHS England's 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.
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

In addition, this guidance is designed to complement but not duplicate or replace other related support initiatives. As such it does not advocate any one service model over another, specify or advocate specific funding arrangements, specify financial arrangements for managing the workload associated with Temporary Residents or describe how to distribute the national programme funds[2] supporting struggling practices to improve their sustainability and resilience over the short/medium term.

## 1.3 Call for evidence

Where available, this document also describes some examples of innovative practice to overcome challenges associated with serving the atypical populations. Hyperlinks to further information are included in this document where available. Over the coming months, where available, other examples will be posted on the free access Case Studies pin board of The Learning Environment.

If commissioners have further examples of local initiatives to address issues associated with 'atypical practices' please submit them to england.primarycareops@nhs.net with the heading 'Atypical Populations: Call for

[2] £10m Vulnerable Practice Programme (2016-17), £40m General Practice Resilience Programme (£16m 2016-17 and £8m p.a. for the following 3 years)

evidence'. Suitable case studies will be published on The Learning Environment website as a resource for commissioners and providers.

To complement these case studies NHS England will consider the viability of commissioning a more detailed investigation into these cohorts of patients to properly understand the difference in workload and related pressures not recognised in the funding formula.

# 2 Context: General Medical Services (GMS) Funding Formula Review

## 2.1 Commitments to reviewing primary care funding

NHS England has committed to reviewing the GMS funding formula which underpins the capitation payments made to GP practices under the General Medical Services (GMS) contract. This commitment was confirmed in the General Practice Forward View. We are working with the BMA's General Practitioners Committee, NHS Employers, the Department of Health and academic partners on the review to develop a formula that better reflects the factors that drive workload, such as age or deprivation.

## 2.2 Existing GMS funding formula (introduced in 2004)

The intention of the formula was to weight remuneration to reflect the comparative practice workload, complexity and the relative costs of service delivery based on the demographics of the patient list. As such the formula has two parts:

a. A workload part that provides an estimate of the workload for each GP practice based on its list size and various patient and practice characteristics; and
b. A cost part that adjusts the payment for workload for variation in costs experienced by practices in different places.

The workload part is also used to inform the primary medical services component of the primary care allocation formula. It is recognised that due to the wide diversity of populations serviced by GP practices, a national formula will never be able to accommodate the workload needs of all practices, hence the need for guidance on atypical practices.

## 2.3 What does the GMS funding formula not achieve?

It has been suggested that the GMS funding formula could be improved upon in a number of ways:

- The data that make up the formula requires updating (some of the data are more than ten years out-of-date)

- Factors currently included do not adequately reflect the workload associated with older people who may not be living in nursing or residential care and have a range of complex co-morbidities
- The impact of deprivation has been questioned and all the weightings will need to be reviewed.

It is acknowledged that no formula will address the particular characteristics of 'atypical' populations hence this guidance.

# 3 Background to developing this document

A joint workshop between NHS England, the British Medical Association's (BMA) GPs' committee, Local Medical Committee (LMC) representatives and NHS Employers was convened in September 2015 to:

- Provide a list of propositions on atypical practices and views on whether these could or could not be reflected in a formula
- Identify those characteristics that will never be fully met by a formula, and
- Aid a description about the characteristics of a practice where it is likely that some additional support is required due to the practice characteristics not being fully recognised by any formula approach.

The information used at that workshop has been used as the basis for this paper focusing on 3 specific cohorts, agreed with the BMA's GPs' committee:

- Unavoidably small and isolated (from other practices and other NHS services) with static populations
- University practices
- Practices with a significantly high ratio of patients who do not speak English including those designed to address the needs of migrants (Asylum seekers are excluded from the scope of this work as it is recognised this group requires a more specialised service).

These populations were chosen as priority areas because:

- Small and isolated practices have particular challenges when meeting demand from dispersed rural communities. Opportunities to develop primary care working 'at scale' are more limited and population growth is slower, impacting on the available primary care budget
- Anecdotal evidence tells us that university practices (in particular campus-based services) have a population that consults general practice more than expected for their age and health (e.g. in terms of mental health and sexual health issues)
- Practices supporting a significant number of patients that do not speak English have operational complications associated with communication problems (this also links to a separate NHS England work stream on translation and interpreting).

A working group was convened in Spring 2016, comprising NHS England and Clinical Commissioning Group (CCG) commissioners, LMC representatives, a BMA

representative and a Royal College of General Practitioners (RCGP) representative. The working group was chaired and administered by NHS England.

# 4 Identifying ‘Atypical’ populations locally

Because of the degree of variation nationally in terms of health and social care economies and patient expectation, demand and behaviour, there is no one method of identifying which populations could be considered as atypical. There are however a number of examples of how commissioners have scoped the issues and what data sources they have used (an example from Devon can be found on The Learning Environment’s case studies pin board).

# 5 Unavoidably small and isolated

## 5.1 Description of the Issues

- Practices serving small but dispersed populations have limited ways in which to influence their income or costs yet provide a vital primary care service
- Their funding is governed by their registered list (global sum / QOF payments) which, by the nature of their geography, cannot be expanded and may compromise the ability to deliver quality care and exacerbate workload pressures
- Because of their location they are often serviced by small B class roads, potentially making travel difficult and time consuming for patients and service providers
- Many such communities do not have easy access to a pharmacy or an A&E Department, ambulance access and response times can be longer than in an urban environment and community services are diluted
- Public transport makes it difficult for patients to attend outpatient departments and other health facilities. As a result, some patients tend to rely on practices to provide a wider range of services than is normally regarded as ‘core’ general practice and staff require regular training to maintain their skills for providing first response in the absence of A&E. It may be hard to measure this effect but it can be summarised as a greater independence by patients from hospital care and a higher level of intervention and support from the practice
- Engagement of GP locums or recruitment of successors to a contract can be problematic because of geographic isolation, income and potential workload pressures. It is recognised that country or island life is not everyone’s preference
- Housing costs associated with ‘desirable’ or expensive country or island locations can also negatively impact on recruitment of practice administrative staff
- Some rural locations attract itinerant workers who may not speak English, have no accessible medical record and consultations take longer.

## 5.2 Information / data considerations

Here are some data sources or information that you may wish to consider when trying to define if a population is atypical:

- The average population density and average distance from patient residences are both available for individual practices and, when considered in conjunction, may produce some useful insights. It should be noted that population density is measured in persons per hectare (calculated from the population density of the relevant electoral ward) and distance to main surgery is measured in 100 metre units (as the average distance from patient's home to main surgery location). It may be useful to consider practices that rank in the top percentiles for both indicators, to help in reaching a judgement about relative rurality and isolation. These data are available as an extract from the Exeter system
- Ambulance response times (available from the local Ambulance Trust on request by the lead commissioning CCG in your area)
- Current Service profile: does the practice provide additional or extra services that are not commonly available in other practices and not additionally funded. Could these be captured in a bespoke enhanced service, set of KPIs or added formally into a PMS agreement? Examples may relate to the absence of locally accessible health and social care services
- Does the total practice income adequately cover the cost of providing services? Data sources that you could use to compare practices in your area include:
    - General Practice Expenses, GMS and PMS Contracts in England 2013/14 (NHS Digital, published July 2016)[3]
    - Adjusting the General Medical Services Allocation Formula for the unavoidable effects of geographically-dispersed populations on practice sizes and locations (Deloitte, published 2006) [4]
    - NHS Payments to General Practice, England, 2015/16 (NHS Digital, published July 2016).

## 5.3 Case studies

The case studies listed below are not an exhaustive list. Commissioners and providers can review these case studies, tailor them to their local area as required, and / or decide on other support arrangements that might be appropriate:

- Contract for primary care support to secondary care (e.g. pre-operative assessments, post-operative wound checks and suture removal)

[3] The report finds that there is no reduction in expenses per patient as practices grow. The data are basic and commissioners may want to consider the point below which a list size is too small for a WTE GP.

[4] This document's value might be limited as it is 10 years' old and the data cannot be refreshed as the datasets are not available.

- The 'My Life A Full Life' programme is a collaboration between NHS Isle of Wight Clinical Commissioning Group, Isle of Wight NHS Trust, Isle of Wight Council, Community Action Isle of Wight and other local voluntary sector organisations. Its aim is to change the face of social and health care on the Island, helping people live life to the full. Objectives are to achieve a more co-ordinated approach to the delivery of health and social care services for older people, and people with long term conditions
- First Responders such as Rural Responders in Suffolk supporting East of England Ambulance NHS Trust and Community First Responders supporting South Western Ambulance Service
- Dorset Community Action's Navigator Pilot was a collaboration with Dorset CCG as part of the Better Together programme. The pilot aimed to improve integration of care to provide more efficient use of resources and improve patient experience by supporting practitioners to refer patients to support services . Its key aims were to:
    - Manage long term conditions, especially those amongst the increasingly large cohort of older people living in, and migrating to, Dorset
    - Reducing the demand (need) for high cost care (acute hospital interventions, and long term residential and nursing care)
    - Enabling much more care to be delivered locally and enabling people to live independently for as long as possible
- Village Agent schemes or Link schemes:
    - Somerset: Work with all ages. A number of clients are elderly and involve social care issues. Village Agents also have the role of helping to shape services by feeding back to the appropriate body information about gaps in service e.g. transport provision. They can also motivate and support a community to respond to a local need by working together to address issues e.g. by helping them to set up a coffee morning for a group of lonely people or start a volunteer car scheme. A Village Agents pilot project is using the social prescribing model, taking referrals from GPs and assisting with care planning for patients. A second pilot is taking referrals from social workers at the area's Adult Social Care Hubs
    - Bedfordshire: Supported 950 clients over the financial year (with an average three visits per client) delivering a range of outcomes that included accessing health and housing services, getting home adaptations, obtaining mobility aids, take-up of benefits and tackling isolation through transport
    - Gloucestershire: The Village Agents support older people living in the area. Reports on their projects are here and case studies can be found here. Polish speaking agents are employed to support the local Polish community
    - Wiltshire: The Link Schemes are community-based initiatives that aim to improve the quality of life for disadvantaged, elderly or infirm people by providing a structured good neighbour service delivered by volunteers from within the local community. The range of Link Scheme services varies from providing volunteer drivers to take someone to a medical appointment, taking them shopping or to visit an old friend, or

simply providing good neighbour care. They aim to complement the provision of other services, whether statutory or voluntary.

### 5.4 Patient Group Observations

Support services provided by volunteers and community groups act as a link between statutory services and the local community (some examples are listed in the Case Studies section above). They are well-placed to work across various isolated groups and share good practice as needed. Services such as those in Dorset (Dorset Community Action's Navigator pilot as part of the Better Together programme) and the Isle of Wight (My Life A Full Life)) operate at a strategic level to bring providers and commissioners together to address issues and find solutions. The key challenge is that all these services need support by commissioners and funding in some way, so that there is a whole system approach. This support is not free, but can be tailored to meet the needs of statutory providers and help to fill gaps and is cost effective, flexible and resourceful in its approach.

*Provided by Paul Dixon, Action with Communities in Rural England*

## 6 University populations

### 6.1 Description of the Issues

- Some practices serving university populations are not able to earn as much QOF funding due to the low prevalence of disease. There is an assumption by some that service provision is less onerous due to low disease prevalence.
- Anecdotally, it is believed that:
    - Since many students are living independently for the first time, this can be a time when they experiment by engaging in behaviours that affect their health and need for service interventions e.g. around alcohol and drug use and sexual activity, leading to a higher than average demand for services related to these. In addition, for students who do not have access to immediate family support, there can consequently be a greater need for primary care services especially in respect of mental health support
    - Students can present with minor ailments or with seemingly unfounded worries about their wellbeing. For those who have moved away from home and are living independently for the first time it is important that they are provided with information about the range of primary care services available including pharmacy as well as online sources of support (i.e. supported to develop "health literacy")
    - A significant number of students with long term and complex health needs attend university (e.g. CF, transplants, MS, asthma, diabetes) and transition to new primary care and secondary care arrangements, if they are leaving home, is important as is support for transition to adult services which can take place during the university years.
    - For foreign students, a lack of familiarity with the country and how health services work can create additional demand for GP practices to

signpost patients to more appropriate services or lead foreign students to go directly to A&E which leads to additional demand on CCG resources
    - In addition some foreign students may have greater health risks/needs (e.g. TB, hepatitis)
- Additional administrative effort required to register large numbers of new patients in September / October and de-register in the summer.

## 6.2 Information/Data considerations

Here are some data sources or information that you may wish to consider when trying to define if a population is atypical:

- Comparative consultation rates (if local data available)
- Prevalence of disease not covered by QOF, particularly mental health
- Per-patient weighted funding level provided by global sum
- Registration data in September – October to identify student registrations and de-registrations over the summer.

## 6.3 Support Initiatives

The case studies listed below are not an exhaustive list. Commissioners and providers can review these case studies, tailor them to their local area as required, and / or decided on other support arrangements that might be appropriate.

- GP Champions for youth health project - funded by the Department of Health
- Promotion of online support tools for young people e.g. NHS Go app
- Using technology to reduce administration e.g. text message results service, online administration e.g. updating address (University Health Centre, Sheffield)
- Local QOF or Local Enhanced Service for specific needs of the population
- Skype consultations e.g. Newham's young people with diabetes project
- Shared care between 'home' and university-based health care services can help support adherence of and management of long term conditions for young people.

## 6.4 Patient Group Observations

- There is a risk that primary care practitioners expect young people to behave in a particular way. It is important that assumptions aren't made about young people based on their age or that all university students behave the same way
- The issue that a young person may present with may not be the real reason they have attended. Young people need to feel confident to trust a clinician. Clinicians need to be skilled in recognising where there may be an underlying issue and give the young person the confidence to reveal it during a consultation

- Young people are undergoing a significant transition when they start university and having a trusted primary care practitioner to talk to can be extremely significant. They need to have information about the range of health services which exist so that they can be confident to seek help from primary care, pharmacy, A&E etc.
- Young people may wish to attend services with their peers. Practice staff should not be surprised if students attend in a group to support each other using health services, in the same way that younger children attend with a parent or carer. If a peer wishes to sit in on a consultation clinicians should ensure that part of the consultation is with the patient alone – this would also be recommended for young people attending consultations with parents or carers
- There is a unique opportunity to increase university students' awareness of how to use health services appropriately which has long term benefits for the health service
- Young people with long term conditions need to access repeat prescriptions quickly when they move to university to avoid gaps in medication. Foreign students don't always recognise drug brand names and often do not understand how to access medication.

*Provided by Emma Rigby, Association for Young People's Health*

# 7 Practices with a high number of patients who do not speak English

Some practices have a high ratio of patients who do not speak English, including practices designed to address the needs of migrants.

Asylum Seekers: The working group had initially intended to include asylum seekers as part of the non-English speaking atypical group. However it became clear that the needs of asylum seekers may go beyond "ordinary" primary care. There are often significant levels of Post-Traumatic Stress Disorder (a result of trafficking, torture, violence, rape (for women, children and men) and illness (e.g. HIV, Hepatitis B / C, TB)).

Note: A separate work stream to this Atypical Population work stream is ongoing in NHS England's Primary Care Commissioning Team on translation and interpreting services. Further information can be found here. Another separate work stream to the Primary Care Team's translation and interpreting project is ongoing between the Race Equality Foundation and NHS England's Equalities Team to scope the viability of a community languages information standard.

## 7.1 Description of the Issues

- The need for an interpreter means that all conversations take longer and increases the cost of each patient contact (in relation to time taken and the cost of interpreting)

- If interpreting is not available, miscommunication increases the risk of patients not attending follow up appointments and delayed access to care
- Surrounding support services (e.g. IAPT, obesity management) and literature are usually in English, thus necessitating the development of additional in-house support
- Lack of literacy, both in English and for some groups their native language, removes the value of written material normally used to reinforce appropriate access (e.g. appointments) and health advice
- In addition the lack of cultural understanding of the NHS requires extra support, signposting and often the recalibration of patient expectations
- Some patients have a basic lack of health education - for instance no knowledge of terms that describes cholesterol or calories, or the importance of taking medication correctly.

## 7.2 Information/Data considerations

Here are some data sources or information that you may wish to consider when trying to define if a population is atypical:

- Evidence of languages spoken and percentage of list
- Percentage of patients requiring an interpreter (recognising that the level of support may decrease over time for some patients as they learn English)
- Consultation rates compared to the average and whether different language groups consult more, and what the reasons may be for this
- Reported average length of consultation
- Demand for interpreting (spoken word) and translation (written word) support services and growth in demand over time.

## 7.3 Examples of support

The examples cited below are not an exhaustive list. Commissioners and providers can consider these, tailor them to their local area as required and / or decide on other support arrangements that might be appropriate. Where available, documents have been added to The Learning Environment Case Studies pin board.

- Funding that recognises increased consultation times / access
- Education materials available in community languages
- Acknowledgement of costs associated with interpreting, either in contractual payments or a provided service (Local Enhanced Service)
- Public Health support for staff to help manage different needs of patients (e.g. hepatitis B vaccinations)
- Additional training for staff in public heath messaging / realistic health interventions e.g. patient issues surrounding diet, behaviours and expectations of services
- Screening for patients new to the UK for communicable diseases

- Staff training on the use of interpreters particularly recognising where a patient is uncomfortable with the interpreter and knowing what action to take if staff question the quality of the interpreting service
- Bilingual receptionist or in-house interpreting.

### 7.4 Patient Group Observations

Professional interpreters are the preferred means of communication and may also have knowledge of medical language. In addition, family interpreting may not be appropriate where the procedures or consultations are of a sensitive or intimate subject. Family interpreters may have no, or limited, medical knowledge.

*Provided by Samir Jeraj, Race Equality Foundation*

## 8 Conclusion

We hope that this document will enable local commissioners to identify and support the practices that serve these populations in order that patients will continue to receive effective primary care. Further examples of case studies can be submitted to the Primary Care Commissioning Team by e-mail to be shared with colleagues across the country via The Learning Environment.

## 9 Notes for NHS England commissioners

When discussing this topic locally, please be aware that you may need to review equalities and health inequalities and the 13Q duty to consult. Copies of supporting documents completed for this project are available in the project files. Please contact the Primary Care Commissioning Team for more details by e-mailing england.primarycareops@nhs.net or calling 0113 825 1244 (PCC Team use: the files are kept here on the shared drive).

## 10 Scheduled update

This document is not scheduled to be updated. Further examples of local initiatives or case studies will be added to The Learning Environment website as they become available.