NHS
Oxfordshire
Clinical Commissioning Group

Service Specification 2017-18
Locally Commissioned Service for Deprivation and Inequalities

1. Introduction

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.

2. Local Context

Some areas of Oxfordshire have more health inequalities than others. In Oxford city, there is a difference of 8 years in mortality between males in different parts of the city. There have been significant cuts in social care funding which has led to severe strains across the system. There have been cuts in budgets for the homeless and the functioning of the new pathways for this group are untested. There are deficiencies in services around refugees and asylum seekers which are often concentrated in a few practice areas mainly in the city and larger towns of the county.

Patients need time with an appropriate team of workers including primary care, to help them understand their problems, and how to navigate their way through the increasingly complex health and social care system. It is generally accepted that primary care as individual practices and working in clusters are well placed to address this but resources are not directed to do this within Oxfordshire. 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.

3. Payment

The following areas are proposed for calculation of the payments for 2017-18:

- **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).*

- **Language Line usage,** 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 telephone interpreting based on quarterly Language Line activity reports. Practices are not required to submit any data, however it is expected that clinicians will take full advantage of longer appointment times to ensure that patients are well-informed about appropriate use of health services and have access to health promotion and disease prevention services and initiatives.

Payment for both these elements will be made at the end of the year as part of the contract reconciliation process. Practices will not be required to invoice the CCG.

4. Termination

This service will terminate on 31st March 2018 unless extended with the agreement of both practices and the CCG following review.