NHS
East Lancashire
Clinical Commissioning Group

Agenda Item No: 6.4

REPORT TO:	**PRIMARY CARE COMMITTEE**	
MEETING DATE:	**12 April 2017**	
REPORT TITLE:	**Supporting the Atypical GP Practices**	
SUMMARY OF REPORT:	The majority of GP Practices have common characteristics and are funded on a consistent basis. However three important characteristics have been identified by the Department of Health as placing significant additional demands on a GP Practice that make them Atypical. These characteristics involve serving a small and isolated population or having large numbers of either university students or those that do not speak English. Through this report the CCG has interpreted this guidance and recognised the unique features of a GP Practice that serves small and isolated populations and recommends that a specific service specification is developed to ensure that any such population continues to have their primary care health needs met by their current GP Practice.	
REPORT RECOMMENDATIONS:	Asks members of the Primary Care Committee to consider the guidance offered by the Department of Health in relation to Atypical GP Practices and the CCGs interpretation of these guidelines together with the development of a specific service specification. In addition recognises the importance of primary care provision to small and isolated populations.	
FINANCIAL IMPLICATIONS:	None at this point	
REPORT CATEGORY:		**Tick**
	Formally Receipt	√
	Action the recommendations outlined in the report.	√
	Debate the content of the report	√
	Receive the report for information	
AUTHOR:	**Andy Laverty, Locality Commissioning Manager - Rossendale**	
	Report supported & approved by your Senior Lead	**Yes**
PRESENTED BY:	**Lisa Cunliffe, Primary Care Development Manager**	
OTHER COMMITTEES/ GROUPS CONSULTED:	**None**	
EQUALITY IMPACT ANALYSIS (EIA) :	Has an EIA been completed in respect of this report?	**N**
	If yes, please attach / If no, please provide reason below: Not appropriate at present	
RISKS:	Have any risks been identified / assessed? **Risk Register entry to be prepared**	**N**
CONFLICT OF INTEREST:	Is there a conflict of interest associated with this report?	**N**
CLINICAL ENGAGEMENT:	Has any clinical engagement/involvement taken place as part of the proposal being presented.	**Y**
PATIENT ENGAGEMENT:	Has there been any patient engagement associated with this report?	**N**
PRIVACY STATUS OF THE REPORT:	Can the document be shared?	**Y**

Which Strategic Objective does the report relate to		**Tick**
1	Commission the right services for patients to be seen at the right time, in the right place, by the right professional.	√
2	Optimise appropriate use of resources and remove inefficiencies.	√
3	Improve access, quality and choice of service provision within Primary Care	√
4	Work with colleagues from Secondary Care and Local Authorities to develop seamless care pathways	

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PRIMARY CARE COMMITTEE

12 April 2017

SUPPORTING THE ATYPICAL GP PRACTICE

1. Introduction

1.1 The vast majority of GP Practices serve communities that have common characteristics and work to contracts that have similar terms, conditions and funding arrangements. Whilst 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 recognized 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 as being Atypical.

1.2 General Medical Service (GMS) contracts are funded through the Carr Hill formula and represent an attempt to fund practice workload, regardless of the population that they serve. However 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.

1.3 The Department of Health have recently produced a guide for both NHS England and delegated CCG Commissioners of 3 atypical populations by detailing the particular challenges faced by providers and offering examples of either provider or commissioner reports that may help to either articulate or address these pressures. These three atypical populations are:-

a) Unavoidably small and isolated populations
b) University populations and
c) Practices with a significantly high ratio of patients who do not speak English

1.4 This guidance issued by the Department of Health does not go as far as specifying appropriate financial tariffs.

2. Purpose / Background

2.1 This report seeks to recognize GP Practices who are serving unavoidably small and isolated populations. There are no university main sites based in East Lancashire and no GP Practices with a significantly high (75% or over) ratio of patients not speaking English in East Lancashire. Although there are a lot of patients registered to East Lancashire GP Practices who do not have English as their first spoken language and the workload implications for this group of practices is being considered separately.

2.2 GP Practice's serving small but dispersed populations have limited ways in which to influence their income or costs, yet provide a vital primary care service. Like most other GP Practices their main funding is directly linked to the size of their registered list (ie Global sum / QOF payments) which because they are small cannot easily be expanded and may compromise the ability to deliver quality care and exacerbate workload

pressures. Further characteristics of a GP practice serving a small and isolated patient list are as follows:

- Due to their location they are often serviced by small class B roads potentially making travel difficult and time consuming for both patients and service providers
- Many such communities do not have easy access to a pharmacy or an A&E Department whereby ambulance access and response times can be longer than an urban environment and community service 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.
- Inadequate broadband can add to the sense of isolation.
- Some practices with Atypical populations have been particularly badly hit by changes to both PMS and MPIG funding, with many having to close as a result of losing essential funding.

2.3 The Accountants Deloittes, reporting to NHS Employers, published a report *''Adjusting the General Medical Services Allocation Formula for the unavoidable effects of geographically dispersed populations on practice sizes and locations''* – March 2006. This report highlighted that there was clear evidence of diseconomies of scale for practices with list sizes below approximately 1,900. The report went on to establish that 1,900 is the approximate number of patients per GP across all of the practices that they sampled and consistent with their hypothesis that a single practice has largely fixed costs. At list sizes of greater than 1,900, which represents full capacity for a GP, costs cannot be spread over a larger number of patients and as a result no further economies of scale are realized. The result of diseconomies of scale for smaller practices is broadly consistent with the Carr-Hill regression analysis which was used in setting the current contract.

2.4 A further point made by the Deloittes report is that areas of low population density contain a number of instances where removing a practice would impose large additional travel costs on the patients involved. These additional travel costs in their analysis outweigh the potential economies of scale from larger practices with the likelihood that a practice is appropriately small, in that removing it would impose a large additional burden on patients depending upon the distance to the next nearest practice and the density of the population in the area being served. The report identifies practices to be classified as being appropriately small if there are no alternative GPs nearby.

3. Conclusion

3.1 The main anticipated outcome of supporting a practice that is considered small and isolated is to ensure the continued access for patients ensuring that the full range of GMS Enhanced Services, are available to the population served by a small and isolated GP Practice.

3.2 In addition that the services over and above the core GMS contract provided by these practices are also available to practice patients. This ensures that a stable environment for these patients, some of whom will be vulnerable through either age or rural isolation reasons, thus helping them to receive continuing healthcare.

3.3 This paper recognizes the following characteristics of a small and isolated practice:-

a) List size lower than 1,900 patients
b) Catchment area in excess of 100 square miles
c) Is at least 8 miles from the nearest neighbouring alternative GP Practice
d) Is over 20 miles from nearest Accident & Emergency Centre
e) Is required to provide the full list of GMS Enhanced Services
f) When required it provides services over and above core GMS
g) Is located in a geographical area classified as rural
h) Located in an area where ambulance response times are below targets
i) Travelling between the practice and next nearest practice is along B roads
j) Has limited public transport

3.4 This paper identifies a small and isolated practice to be Atypical if it:-

a) Provides the full range of Enhanced Services including – Minor surgery etc
b) Provides services over and above the core GMS contract including the treatment of minor injuries and treatment room in addition to having the capability when required to provide some community, district nurse and assessment of social care support
c) Has at least two members of staff recognised as First Responders
d) Willing to embrace telehealth as a solution for patients to seek a clinical consultation as an alternative to a patient visit
e) Has ability if required to provide GMS services to specific cohorts of vulnerable patients such as looked after children

4. Recommendations

4.1 Members of the Primary Care Committee are asked to consider:-

a) The guidance provided by the Department of Health with regard to Atypical GP Practices.
b) The importance of primary care service provision to small and isolated locations.
c) That the CCG Primary Care Team in collaboration with finance colleagues start to identify any practices deemed to be Atypical in East Lancashire as per 3.3 above and fulfilling the functions identified at 3.4 above. In turn develops a specific service specification that meets the primary care health needs of its population with the application of an appropriate tariff.

Andy Laverty
Locality Commissioning Manager - Rossendale