3. That partners in the Health and Social Care System lobby for review of the Carr-Hill Formula funding and identify how more funding would benefit GP Surgeries within the most deprived areas of Plymouth, reporting progress to the next meeting of the Select Committee;

A number of areas of work are ongoing, not specifically triggered by the Select Committee but part of the response to the issue, focussing on different opportunities to influence.

- The Carr-Hill formula review is underway and is being led by technical experts. The timeline for reporting findings has been extended several times, with a current date of April 2018. I have explored whether we could provide information and insight to this review team, but membership of the group has not been made public. However, previous review findings agreed with the view that deprived populations are underfunded using the current formula, and this is evidenced through published research papers, and so it is reasonable to anticipate that recommendations will be in favour of increasing funding to primary care in our most deprived areas.

- Through the Primary Care Committee (which involves NEW Devon CCG, NHS England and public health), an 'Atypical practices' workstream (considering the specific factors that lead to a practice being essentially underfunded for its population) has been in place for some time. An initial review of the literature highlighted deprivation as a key factor but one that would be addressed as part of the Carr-Hill work; however, as it became clear that this was not going to result in any alteration to funding in the near future, a paper was prepared to support additional funding for deprivation. This was agreed, and in total £100k was provided to GP practices who have the highest population in the most deprived decile (10%), when compared to the average England population.

- The issue of funding has been raised with local politicians, along with updates around the position of primary care in Plymouth. There is awareness of the issues and that insufficient funding for the complex issues faced in deprived populations is almost certainly a contributory cause. This is of course in the context of inequity of funding across the NEW Devon CCG with the Western Locality area receiving a lower share of funding.

There are a number of papers that have discussed this within them. I have pulled together the issues into one short paper which is attached.

Director of Public Health

CARR-HILL FORMULA

ODPH

The current GMS global sum formula, developed with the support of a number of academic teams including Professor Roy Carr-Hill of York University, provided the basis for the distribution of global sum payments by calculating each practice's fair share of the total global sum resource. The formula did not determine the total global sum resources available nationally. The Carr-Hill formula is based on analysis of consultations in the General Practice Research Database between 1999 and 2002.

The current formula takes account of six key determinants of practice workload and circumstances:

(i) patient sex and age for frequency and length of surgery and home visit contacts

(ii) nursing and residential home status

(iii) morbidity and mortality

(iv) newly registered patients

(v) unavoidable costs of rurality

(vi) unavoidable higher costs of living through a MFF applied to the costs associated with employing practice staff. In particular, this compensates for those additional costs involved in delivering services in high cost-of living areas such as the south east of England.

The main concern with the formula is that it is based on consultation / workload data which are now more than twenty years old. The role of the GP, the services they link to and the communities around them have not remained static during this time.

There are two factors in particular of interest here; the age weighting, which is likely to shift funding away from deprived areas unfairly since the higher the deprivation, the younger the age at which ill health, frailty and death occurs; however, the factor for morbidity and mortality should account for this. It is not possible to understand this without looking afresh at new data on workload and the formula.

However, there is considerable qualitative data that suggests that this does not adequately account for the additional complexity of these patients, in terms of wider social determinants of health. This is reflected in analysis of consultation rates by Boomla et al [1] in East London which found that an individual aged 50 years in the most deprived quintile consults at the same rate as someone aged 70 years in the least deprived quintile, and in relation to the funding;

We then recalculated the age-sex workload element in Carr-Hill by weighting the population by the observed consultation rates in each deprivation quintile. For Tower Hamlets, one of the top five deprived boroughs in England, we estimated that a fair formula that allowed for the additional workload would provide 33% more funding.[1]

A review was carried out, reporting in 2007 [2]. This found that, although the use of mortality and morbidity was a proxy measure for deprivation, the use of the index of multiple deprivation (IMD) was more appropriate. The findings from this review were not implemented, and in 2015, NHS England began undertaking a new review of the Carr-Hill formula, with a focus on addressing the adjustments for deprivation in particular. The review was expected to report in late 2016, since delayed to April 2018.

[1] Boomla et al GP funding formula masks major inequalities for practices in deprived areas, BMJ 2014;349:g7648

[2]http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/GMS/GMS%20Finance/Global%20Sum/frg_report_final_cd_090207.pdf