Written evidence submitted by 18 September 2020

This submission to the Race Equality Commission is made by the team at Page Hall Medical Centre, Sheffield, to raise concerns about inequitable funding for core primary care services locally and nationally.

Summary

- Effective communication with our patients is core to our everyday work.
- Funding to run core primary care services is adjusted nationally to account for additional patient need and practice workload.
- Simple patient demographics are included, but ethnicity and language needs are not.
- We believe this is inherently racist and impacts significantly on the services our patient population can access.
- We have developed a simple system of recording when an interpreter is used, which could inform an enhanced funding model to address this gap.
- Some of our staff have shared their patient stories at the end of this submission.

As GP practices we are funded in the main through a capitation fee, known as the Global Sum, based on our list size. This sum is then adjusted using the Carr-Hill formula, to compensate for differences in local populations which create more or less work for the practice.

Factors included in the Carr-Hill formula:

- patient age and gender (used to reflect frequency of home and surgery visits)
- additional needs: Standardised Mortality Ratio and Standardised Long-Standing Illness for patients under the age of 65 years
- number of newly registered patients (generate 40% of work in 1st year)
- rurality
- costs of living in some area (ie South East - ? higher staff costs)
- patient age/gender for nursing/residential consultations (1)

Interestingly the weighting associated with the demographic data is based on the length of time of a consultation with people of different sex and ages.

However, there is no consideration or adjustment based on ethnicity or language needs.

At our practice, 30-50% of consultations require the support of an interpreter. Many of our neighbouring practices, as well as others across the city, face similar issues. These consultations clearly take at least twice as long, and often longer, but this is not accounted for in our core funding.

Prior to 2015, practices on a PMS contract were able to apply for enhanced funding to deal with local needs which compensated for the increased workload of caring for a multi-ethic (BAME)population many of whom require an interpreter, and have very different expectations of what the NHS can offer(2). Our practice was awarded increased funding to offer bilingual reception staff, who also acted as interpreters and patient advocates, as well as extra clinical staff, to compensate for the extended length of consultations.

In 2015 NHS England undertook an equalisation process to bring all practices in line with a national capitation fee (2). This was intended to iron out unfair differences in funding, but did not plan for situations where practices were dependent on extra income to offer the support their patients needed. The intention was to review the adjustment formula and include details about ethnicity and language need, but this proved too complicated and it never happened.

In 2016 NHS England identified that some practice populations did require extra financial support and classed them as those with Atypical Populations (3). The responsibility to address these additional needs was placed on local CCGs. However, CCG budgets are based on the weighted population, so they were not receiving the income they needed to support BAME populations.

In 2015 Sheffield CCG did agree to ring-fence £300 K for practices experiencing Significant Additional Patient Pressure (SAPP fund), which is shared out between practices who apply for it. This has up to now always been a temporary offer, and each year the amount is different, depending on who else has applied for it. It does not offer sustained financial support to allow us to offer an equitable core service to our population.

NHS England did a 'deep-dive' assessment of the impact on workload and services available for a population like ours, but conclusions were difficult to draw and measuring this is really challenging.

We have been working hard to find a solution and have developed a simple method of data collection which accurately evidences the number of interpreted consultations which take place on a daily basis, and which could inform a national 'enhanced service' whereby funds could be allocated on a practice-by-practice basis, much like several other income streams. This would then remove the pressure to fund interpreted consultations locally, and could be applied across the country, in line with the Carr-Hill formula. This would fit with one of the recommendations made by PHE in their summary document about the impact of Covid-19 on the BAME community (4).

Sussex CCG have recently commissioned a service in primary care targeting the specific issue of Covid-19 in the BAME community (5).

Without sustained additional funds, we cannot hope to offer an equitable service to our practice population -a model which is mainly based on individual conversations between us and our patients– be that written or verbal.

We ask that our idea for funding based on interpreter use is considered at a strategic level, and if felt to be unworkable, to identify an appropriate alternative to secure funding based on need for primary care in Sheffield.

We believe that to continue to ignore this issue highlights the institutional racism which has been exposed by the impact of the Covid-19 pandemic on BAME communities in the UK (6).

1. https://gpnotebook.com/simplepage.cfm?ID=x20090615140948602623
2. https://www.england.nhs.uk/wp-content/uploads/2014/02/rev-pms-cont.pdf
3. https://www.england.nhs.uk/wp-content/uploads/2016/12/atypical-commissioning-guid.pdf
4. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf
5. https://www.seshealthandcare.org.uk/2020/08/sussex-ccgs-first-to-launch-locally-commissioned-service-for-the-bame-community/
6. https://discoversociety.org/2020/04/17/racism-is-the-root-cause-of-ethnic-inequities-in-covid19/

Patient stories told by practice staff:

Blerta Ilazi (Advanced Nurse Practitioner): A day in Page Hall

I have now worked for 2 years in PHMC and I am proud to work alongside the most caring MDT nurses, doctors and other staff that are determined to make positive differences on our patient's lives. After working for many years in emergency care and then walk-in-centre, I decided to move to Primary Care.

Our practice is very diverse GP surgery in an area with high levels of deprivation where patients often have multiple and complex needs with a range of clinical and social challenges.

Our patients often report experience of racial/ethnic discrimination and social exclusion from both public services and society which then manifests in anxiety and stress. Most of our consultation include helping their social challenges as well as clinical problems they present with which increases our workload. I will describe three of my consultation where majority of the appointment was spend helping patient with their difficulties of every day life.

First family I saw was recently arrived migrant family to Sheffield claiming asylum after leaving Iraq due to war. After hearing about their extremely difficult journey to UK, I decided to bring the family to be seen face to face instead of remote consultation. They had complicated health needs which took me 2 additional hours of my clinical time trying to get the health record from previous surgery in another city they lived prior to arriving in Sheffield, referring to social prescribing to get help with basic needs including food, clothes, referring three members of the family to secondary care including 10 years old boy who needed urgent referral to Children hospital. For each consultation, double time was needed due to family only speaking certain dialect of Kurdish language which was difficult to find telephone interpreter with Language line and I had to wait long time to get an interpreter.

Second case is another family that interpreter is needed , a young girl from Slovakia with ongoing health problem which we had already referred her to secondary care, however due to Covid all her

hospital appointment were converted to remote telephone consultation. Parents reported that they had not received any phone call from the hospital and were concerned because her problem was worsened. It took me another additional hour of my consulting time to contact the consultant secretary three time to chase up the appointment whilst patient was present.

Another case where most of my consultation time was helping a single mum manage her anxiety and trying to help her to get a house in a more safer part of Sheffield. I spent another additional hour writing supporting letter to our local MP, housing officer at the local council.

Linda Smithson (secretary):

As a secretary within a multi-cultural medical centre it can be quite challenging chasing up appointments particularly for patients for whom English is not their first language. One example from last week is chasing an appointment for an Arabic lady. I rang the hospital outpatient clerk who informed me that the lady was on the waiting list. I asked how soon she would be offered an appointment and the clerk said that if she rang them they would offer her an appointment. As her main language is Arabic she probably would not ring herself to make the appointment, not only because her first language isn't English, but also because she lacks the confidence to try and utilise a service which is not geared up to a multi-cultural population. This would then result in her being discharged and having to be re-referred. I asked if I could make the appointment for this lady, yes, so the appointment was made, I then asked the reception team if they could ask our in house Arabic interpreter to ring our patient to let her know and confirm that she could attend. It would be much easier and less costly, if resources were in place in the first place for a multi-cultural population who would feel more confident using a service which was user friendly for all.

Trish Evans (GP):

Yesterday I telephone triaged a 45 year old Roma Slovak lady with tummy pain using a telephone interpreter. Her last two periods had been very light. Her pain was not severe and could have been managed over the phone however I needed to make sure she did not have an ectopic pregnancy (very dangerous early pregnancy where the foetus begins to develop in the tubes rather than the womb). She had no idea of how to obtain or indeed to do an over the counter pregnancy test and explaining this over the phone would have taken a very long time and I still would not have been confident she had understood or indeed had enough money to purchase one.

Instead I arranged to bring her down to surgery and see her face to face, I did a pregnancy test which was negative and examined her tummy which was fine.

She had not been using any contraception and I suggested we could look at this however she told me she would be very pleased to be pregnant. She had no idea there were any greater risks of being pregnant when you were older, did not think she was overweight (she was) and had no idea it’s important to optimise your weight before pregnancy or that it was important to take supplements such as folic acid or vitamin D.

She was incredibly grateful for my time and this information however this all took time – probably 40 minutes in all including the initial telephone consultation. Had she been English speaking with good health literacy and able to navigate online resources I could have managed this situation safely and competently in 10.

Health inequality (and institutional racism) perpetuates in situations like this, if we cannot optimise a baby's start in life we have already lost half of the battle.

Shameem Khaliq (Health care Assistant) – speaks Urdu / Punjabi:

Having worked here over 17 years, dealing with cultural needs & helping patients to understand, I often find young girls and women are suffering from depression or anxiety as they are finding it hard to express themselves to someone new each time they come, which can often lead to self-harm, homelessness or serious mental health condition. I have recently seen a young mother, with one child, every 2 weeks as she needed help and support to build enough trust to explain her situation. She had been through domestic abuse and rape in the past, and was not able to express her issues fully due to worries about the reaction of her local community. I managed to stop her from over dosing and sign posted her to a job etc, built her confidence and helped her to rebuild her life. She is now working and needing very little support but is still dealing with the court case etc. My input has been 2-weekly check-ins and helping her to understand her culture and rights as well as building her self-esteem .

Neelam Parveen (HCA) – speaks Urdu: This Is my personal story – Covid-19 at Page Hall

To support our patient we organised a system where we could help the patients get a covid-19 test safely (with the support of PHE etc).

Despite having Covid swabbing centres around areas in Sheffield, our large ethnic community often did not have the resources to attend them, and lacked the education and health literacy to understand what this was all about. Who is at risk? What can we do if we get the virus? How do we get the covid-19 swab? How does swabbing work? Many patients refused to get tested as they believed that people from the BAME community were deliberately being killed if they were admitted to hospital. Several parents refused to vaccinate their children due to fact that we may deliberately inject them with Covid-19 virus.

We created our own swabbing packs with leaflets in different languages showing diagrams on how swabbing is done in an easy simple way, we also created a YouTube video in different languages (https://www.youtube.com/watch?v=oavhg21nBMg)

Going out to swab the patients unfortunately wasn't as simple as we had planned; many of them lack education and have poor health literacy. This made it extremely difficult for us, but we never gave up and kept doing our best to help our local community.

Lizzie Mussell (Nurse Practitioner):

I spoke with the father of a 9 year old child with suspected asthma last week.
This was the 7th phone consultation between April and September 2020 regarding the child's ongoing cough symptom which a GP had initially passed to me to manage and monitor a trial of treatment for suspected asthma.
One of the phone consultations had also involved several attempts at video consultation which we finally managed. Difficulties were associated with poor internet connection and language/literacy problems. Mum's first language is recorded as English. She is from an

African country. However communication is difficult possibly in part due to very unfamiliar accent and limited educational opportunity.
The trial of treatment was difficult and needed several phone consultations due to misunderstandings re how to take the inhaler, when and why it was necessary to continue treatment. The father in particular was unhappy with the idea of a trial of treatment and suspected diagnosis without the child being examined. Communication problems hampered this and we failed to get adequate concordance.
Dad expressed anger and frustration on 7th September by which time he had decided that his child could not be suffering from asthma and, as he himself had been badly affected by Covid 19, was of the opinion that his child was suffering the same.
The child had a face to face consultation with the GP on 15th September, where the provisional diagnosis of 'likely asthma 'was confirmed. However an x ray was also ordered in order to further allay any concerns re an alternative diagnosis.
All in all, I firmly believe that this case would have taken less than half the time/resources/ intervention had the family been a British English-speaker.

The biggest scandal is the lack of a DESMOND course (recommended group education programme for people newly diagnosed with diabetes) or appropriate equivalent for our BAME communities.
It's a total scandal and stinks of institutionalised racism.

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