Leeds Health & Well-being Board

Commissioning Primary Care Services in Leeds – 2014-2016

October 2014

Introduction

This paper sets out the commissioning approach and plans for primary care services in Leeds over the two years from 2014-2016. There are four sections based on the four contractor groups:

A. General practice
B. Dental services
C. Community pharmacy
D. Community optometry

A. General Practice

1. Approach

This paper has been produced collaboratively by the four NHS organisations with commissioning responsibilities for General Practice in Leeds: NHS England, NHS Leeds North CCG, NHS Leeds South and East CCG, and NHS Leeds West CCG. It sets out the national Strategic Ambition for general practice, the local challenges and the commissioning response for the next two years.

2. NHS England Strategic Ambition for General Practice

In summer 2013, NHS England launched a Call to Action: *Improving general practice.* The purpose of this consultation was to support action to transform services in local communities and to stimulate debate as to how we can best support the development of primary care to improve outcomes and tackle inequalities.

Out of the Call to Action, NHS England has set out an ambition for primary care:

We want to ensure that everyone in England gets access to the same high quality services.

a. **Proactive, coordinated care**: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long term condition.

b. **Holistic, person-centred care**: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.

c. **Fast, responsive access to care:** giving you confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.

d. **Health-promoting care**: keeping you healthy and ensuring timely diagnosis of illness, engaging differently with communities to improve health outcomes and reduce inequalities.

e. **Consistently high quality care**: reducing unwarranted variations in effectiveness, patient experience and safety.

In order to support delivery of our ambitions, we believe that primary and community providers will need to operate **at greater scale and in greater collaboration** with one another, and with patients, carers and local communities.

Importantly, this does not necessarily have to involve a change in organisational form, but the organisations and individuals within those organisations across primary and community care will need to organise themselves together in larger groupings, in formal ways, supported by investment and management capacity.

Our approach is that there should be **no national blueprint** for how this is done but that change should be locally led and over the next two years, NHS England will deliver a series of commissioning workstreams that enable change:

	Description	**Deliverables**
Service Models	A description of the key service components required to deliver against our five ambitions, along with the implications for providers (primary care at scale).	Practical resources to support local strategy development, including: • Service component descriptions, by ambition • An explanation of the strategic choices providers will face • Practical examples and case studies in all areas. (This will also draw on learning from the Prime Minister's Challenge Fund)
Standards for out of hospital care	National standards for any out of hospital care providers that reflect our five ambitions and can be applied to the range of potential providers of the future.	A small number of measurable national standards for out of hospital care, to be incorporated into the contracts for all primary care providers. (It is anticipated that the majority of standards and associated goals for these services would be set locally.)
Co-commissioning	The nationally agreed arrangements for enabling CCGs to drive transformation across primary and community care, and supporting tools.	The options and governance arrangements for co-commissioning of GP practice. Contract forms to support greater formal collaboration across primary, community and secondary care providers. The options and governance arrangements for pooled budgets in 2015/16.
National Contracts	Ensuring that the vision for primary care at scale is appropriately reflected in the national contracts for GPs, dentists, pharmacy and optometrists.	A single negotiating remit for all national primary contracts for 2016/17, which reflects the vision and ambitions for primary care.
Workforce	Ensuring that the future primary care workforce is designed and developed in a way that supports primary care at scale and the new models of care.	Immediate work on returners, retention, international recruitment and GP remediation to increase the number of available GPs. A review into the future primary care workforce, including options for new roles and different skill mix.

3. Local Challenges & Commissioning Plans

Alongside the national work, NHS England in West Yorkshire and the three CCGs in Leeds have continued to work on improving the standards of general practice and developing integrated models of care. There are five principle challenges facing general practice in Leeds. These are the need to:

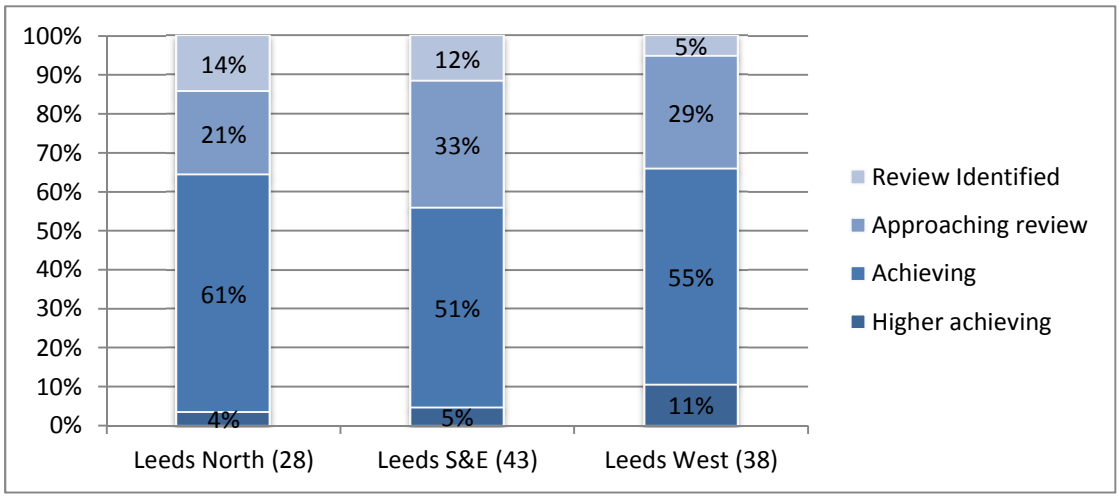
1. sustain and improve the quality of service provision for patients
2. improve patient experience, particularly in relation to access to services
3. develop and drive integrated care out of hospital
4. develop a sustainable workforce for now and the future
5. ensure value for money

3.1 Quality Improvement

(*Supports delivery of Leeds Health & Well-being Strategy – Outcome 3 – People will enjoy the best possible quality of life*)

In summer 2013, NHS England developed and published a Quality Assurance Framework for General Practice. This was the first time that service and outcome data on every general practice in England was brought together and published in a way that allowed commissioners, providers and the public to review and compare the performance of every practice. The Framework assesses practices against more than 30 indicators and establishes whether they are a statistical outlier against their expected performance.

For practices in the Leeds CCGs, the current (August 2014) position is:



For practices in the North and West, this compares favourably to the rest of England where, on average, 39% practices are approaching review or have a need for a review identified. For the South, the assurance framework does identify that 45% of practices are approaching review or have a need for a review identified.

Against this background, NHS England and the CCGs have put in place a number of initiatives to improve the quality of services for patients:

Organisation	Commissioning Approach for 2014-16
All	• Agreed MoU on quality improvement setting out roles and responsibilities. • Improvement plans developed with individual practices of concern.
Leeds North	• Practice level profiles developed for all practices. Profiles encompass key themes from Assurance Framework, JSNA practice profiles and other intelligence. Profiles used to support quality improvement plans for practices with "review identified" and to information action at practice, locality and CCG level. • Specific quality interventions in place across localities include diabetes care in Chapeltown, improving CVD prescribing, city-wide antibiotic / anti-microbial initiative.
Leeds South & East	• Quarterly quality visits to practices. • Specific interventions in place such as action to improve bowel screening uptake and patient safety reporting.
Leeds West	• 10 Locality development sessions per year with quality focus • Quarterly visits to practices. • Practice MOT distributed quarterly to benchmark practices across a number of local indicators and activity data. • Specific interventions in place linked to JSNA, to improve respiratory care, CVD, cancer and alcohol misuse.

3.2 Improving Patient Experience and Access

(Supports delivery of the Leeds Health & Well-being Strategy – outcome 2: people will live full and independent lives, outcome 3: people will enjoy the best quality of life, and outcome 4: people will be involved in decisions made about them)

The latest GP survey results (July 2014) show that patients in Leeds:

	Satisfaction with the quality of consultation (seven questions)			Satisfaction with overall care (two questions)			Satisfaction with access (three questions)		
	2013 - June %	2014 - July %		2013 - June %	2014 - July %		2013 - June %	2014 - July %	
NHS LEEDS NORTH	90.13	90.54	↑	86.25	85.90	↓	84.43	81.10	↓
NHS LEEDS SOUTH & EAST	89.07	89.17	↑	81.40	80.55	↓	80.20	77.57	↓
NHS LEEDS WEST	90.33	90.33	↑	84.65	83.65	↓	83.07	79.90	↓
WEST YORKS	89.63	89.74	↑	83.50	82.35	↓	82.03	77.80	↓
ENGLAND	89.76	89.96	↑	84.00	85.00	↑	83.57	82.70	↓
NORTH OF ENGLAND	90.71	90.59	↓	84.85	83.25	↓	83.83	79.10	↓

In common with patients across West Yorkshire and England, satisfaction with the quality of the actual clinical consultation remains high and is improving but the overall experience is deteriorating due, primarily, to dissatisfaction with access to services (getting through on the telephone, convenience of appointment and availability of appointments).

Against this background, NHS England and the CCGs have put in place a number of initiatives to improve patient experience and access:

Organisation	Commissioning Approach for 2014-16
All	• NHS England enhanced service for patient engagement • NHS England enhanced service for extended access • NHS England funding for system resilience in primary care. Leeds initiatives led by the CCGs include extended hours over bank holidays, additional clinics for children to avoid ED attendances, direct booking from ED to GP, and improved transport to hospital for potential GP admissions to facilitate early assessment and same day discharge. • Prime Minister's Challenge Fund – piloting new approaches to access for patients. First wave commenced July 2014. Second wave to be announced autumn 2014. • Introduction of Friends & Family Test in general practice at end 2014.
Leeds North	• Roll-out of Year of Care: to better inform and engage patients with long term conditions in their care. • Locality based approach to sharing bets practice in relation to primary care access and training with non-clinical staff to improve patient experience. • Commissioning practices to trial new approaches including pre-diabetes support group, practice champions and well-being co-ordinator posts to improve access and experience. • CCG co-ordinated Patient Reference Group bringing together representatives from across the CCG to inform commissioning.
Leeds South & East	• Roll-out of Year of Care: to better inform and engage patients with long term conditions in their care • Implementation of "yellow card" scheme to allow GPs to record soft intelligence on patient experience of services. • Practice development programme utilising service improvement and LEAN methodology to improve capacity and ways of working.
Leeds West	• Development of a Local extended access scheme (from 2014) to test out improving access across 5-days and 7-days, open to all 38 practices. Outcomes focussing on quality of consultation as well as access to appointments. • Roll-out of Year of Care: to better inform and engage patients with long term conditions in their care. • Introduction of Care Co-ordinators working between practices and community teams to pro-actively manage patients. • Roll-out of Productive General Practice programme to improve productivity and engagement with patients. • Patient comment boxes distributed to all practices to collect patient feedback throughout the year.

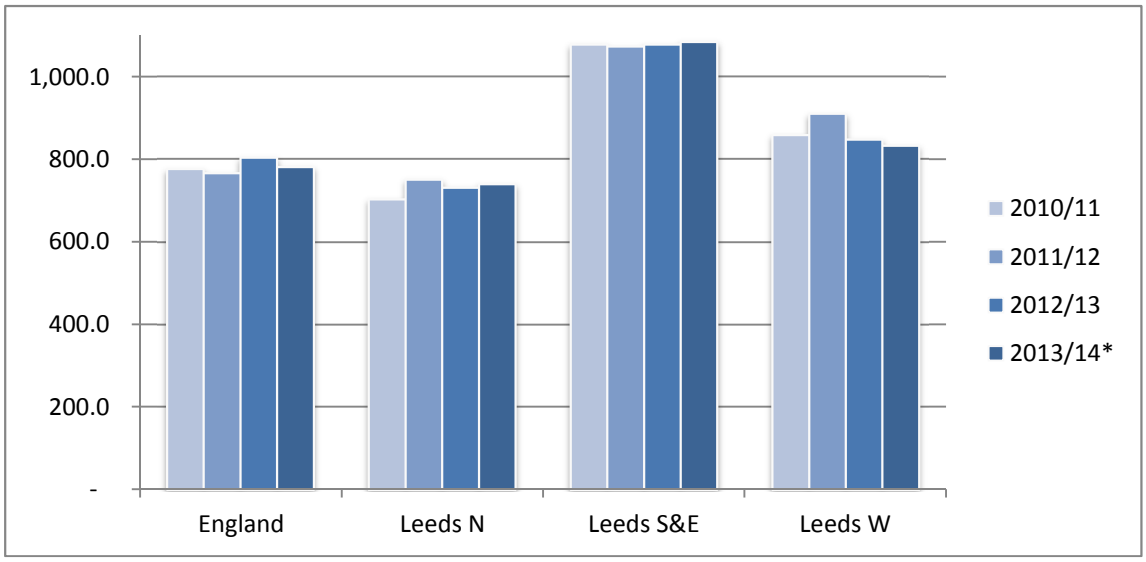
3.3 Develop and drive integrated care out of hospital

(Supports delivery of the Leeds Health & Well-being Strategy – outcome 2: people will live full and independent lives)

Benchmarking data on the three Leeds CCGs indicates that utilisation of secondary care in the north and west of the city is lower than the England average, but higher in the south and east of the city:

Per 1000 population (2013/14)	Leeds North	Leeds West	Leeds South and East	England
G&A emergency admissions	7.65	7.7	9.6	8.52
OP attendances	25.26	24.51	27.59	25.66

For conditions amenable to care outside of hospital, in 2013/14 (*provisional data), there were ca 2500 admissions to hospital where ambulatory care might have been a possible alternative:



Against this background, NHS England and the CCGs have put in place a number of initiatives to improve integrated care out of hospital (note: these initiatives focus solely on work in general practice. There is a much wider commissioning plan for integrated care involving acute, community and voluntary sector providers):

Organisation	Commissioning Approach for 2014-16
All	• NHS England enhanced service to deliver proactive care for the most vulnerable patients in each practice • NHS England enhanced services for dementia care, and alcohol related risk reduction. • Development of standards for out of hospital care to provide commissioner assurance and benchmarking of provision
Leeds North	• Clinical pharmacist working with practices and care homes to undertake medicine reviews for older people. Plan to roll out to patients with a learning disability and vulnerable patients at home. • Working with Otley and Wetherby localities to commission additional capacity to improve support for older people and those with complex

	needs. • Extension to pro-active care scheme and commissioning of additional system resilience initiatives over winter. • Locality-specific schemes relating to alcohol, diabetes and third-sector.
Leeds South & East	• Enhanced support to care home residents and providers • Extension to pro-active care scheme linked to plans for winter • Medication review scheme for most complex patients • COPD scheme to improve prevention, diagnosis, management, admissions avoidance and end of life care
Leeds West	• Year of Care scheme to improve patient engagement in planning and delivery of their care • Development of care co-ordinators to support pro-active care • Clinical pharmacists in care homes to review medications, minimise harm and reduce waste • Extending access to general practice to ensure patients have earlier access to primary care services. • Review of enhanced (medical) care to care homes.

3.4 Develop a Sustainable Workforce

(Supports delivery of the Leeds Health & Well-being Strategy – outcome 3: people will enjoy the best possible quality of life, and outcome 5: people will live in healthy and sustainable communities)

CCG Name	GP Providers	Registered population	GPs per 100,000 population
AIREDALE, WHARFEDALE AND CRAVEN	91	156,100	58
BRADFORD DISTRICTS	202	331,364	61
CALDERDALE	101	211,979	47
LEEDS NORTH	107	202,948	53
BRADFORD CITY	59	117,384	50
GREATER HUDDERSFIELD	130	239,437	54
LEEDS WEST	183	356,860	51
LEEDS SOUTH AND EAST	146	261,359	56
NORTH KIRKLEES	90	186,075	48
WAKEFIELD	201	355,373	56
AREA TOTAL	**1307**	**2,418,879**	**54**
REGIONAL TOTAL	**7,258**	**15,718,338**	**46**
NATIONAL TOTAL	**24,083**	**55,704,177**	**43**

Benchmarking data shows that the number of GPs per 100,000 population in Leeds is well above the figures for the north of England and England overall.

However, we know that more and more GPs are choosing to work part-time and that there are a significant number of GPs approaching retirement. In 2014/15, insufficient GP trainees were recruited to Yorkshire & Humber due to lack of interest from newly-qualified doctors.

In addition, there are pressures in practice nursing arising from an ageing workforce profile and difficulties with recruitment, and a need to consider the workforce requirements for new “at scale” / integrated care models.

Against this background, NHS England and the CCGs have put in place a number of initiatives to understand and improve the workforce position in general practice:

Organisation	Commissioning Approach for 2014-16
All	• Work with Health Education England to complete GP Workforce survey for 2014. • West Yorkshire Quality Improvement Network focus on workforce • Clinical fellowship posts to work alongside clinical leaders • TARGET programme of clinical training in practice • Development of city-wide Practice Nurse Conference and local practice nurse forums.
Leeds North	• Nurse leadership programme commenced in 2014 • Practice manager action learning sets, practice manager forum and training needs analysis supported by CCG. • GP Portfolio Leads development programme.
Leeds South & East	• Action Learning Sets for practice managers • Vocational training scheme for newly-qualified nurses (or nurses moving from secondary care) • Mentorship scheme for practice nurses • E-learning package for clinical skills
Leeds West	• Practice manager development programme • Undergraduate and post-graduate nursing scheme started in 2014 • Leadership course for nurse members – a bespoke leadership opportunity led by a performance coach. • Development of HCA apprenticeships. • Skills audit undertaken to inform future training provision.

3.5 Ensure value for money

There are two city-wide initiatives which will help drive value for money in the commissioning and contracting of GP services:

(i) Equitable funding review

General practice is predominantly funded through one of two national contracts: GMS and PMS. In common with practices across West Yorkshire, PMS practices in Leeds receive more funding than GMS practices. In some cases, this is due to the delivery of additional services but in other cases there is less clarity about what the additional funding delivers.

NHS England has commenced a funding review of PMS practices with the aim of ensuring that by 2018 there is an equitable approach to their core funding when compared to GMS practices.

	Funding per head 2014/15 (national value for GMS and mean value per CCG for PMS)	Range of funding per head in PMS practices
Core GMS Funding	£73.56	
Leeds North (12 PMS practices)	£73.69	£72.56 - £90.70

Leeds South & East (21 PMS practices)	£76.84	£68.16 - £114.67
Leeds West (24 PMS practices	£75.40	£70.32 - £101.04

This may result in core funding to individual practices being increased or decreased (depending on whether they are above or below the national level of core funding for GMS practices). In the circumstance where income is decreased then the practice will receive three years' of transitional relief.

Any funding released from this funding review will be reinvested in general practice in the CCG of origin.

(ii) Co-commissioning

In June 2014, NHS England announced that interested CCGs could choose to participate in the co-commissioning of general practice. The aim is to more closely align the commissioning of the national contract (NHS England's responsibility) with the CCGs' existing responsibility for quality of care and their local plans for integrated out of hospital care.

The three CCGs in Leeds have expressed an interest in co-commissioning from April 2015 and are exploring the opportunity of working together in one city-wide approach with NHS England.

The guidance from NHS England will be published in November 2014 with a view to having joint commissioning arrangements in place from April 2015. The legal framework to support formal joint commissioning arrangements between CCGs and with NHS England was published on 1 October 2014.

The ambition is that there will be opportunities to devolve and pool budgets for primary care to drive integration of general medical services with wider community care.

Alison Knowles – Commissioning Director, NHS England (West Yorkshire)

Gina Davey – Head of Primary Care – Leeds North CCG

Debbie McCartney – Senior Locality Manager – Leeds South & East CCG

Kirsty Turner – Head of Primary Care Transformation – Leeds West CCG.

Section B - Commissioning NHS Dental Services

1. Commissioning Responsibilities

Since the Health & Social Care Act 2013, there has been a tri-partite arrangement for oral health and dental services: Public Health England are responsible for oral health needs assessment, local

councils are responsible for oral health improvement for their residents and NHS England is responsible for commissioning NHS dental services (primary care, community and hospital).

2. Adult Oral Health in Leeds

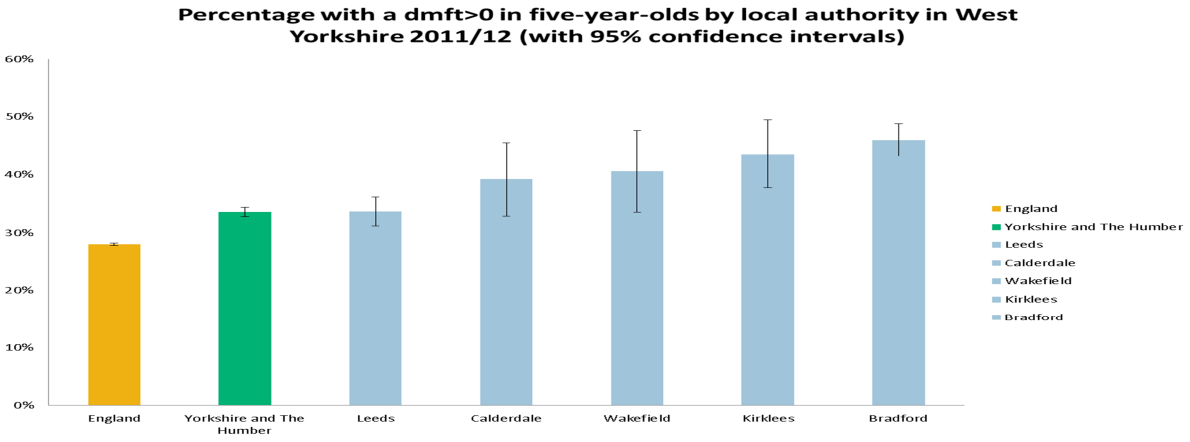
The most recent data available on adults is from the National Adult Dental Survey 2009 which provides analysis at a Yorkshire and Humber level and a postal questionnaire of Yorkshire and Humber adults in 2008 which provides Leeds level data.

The national data (2009) shows that the oral health of adults has been improving and the adult postal questionnaire (2008) shows that adults in Leeds report oral health on a par with people across Yorkshire and Humber:

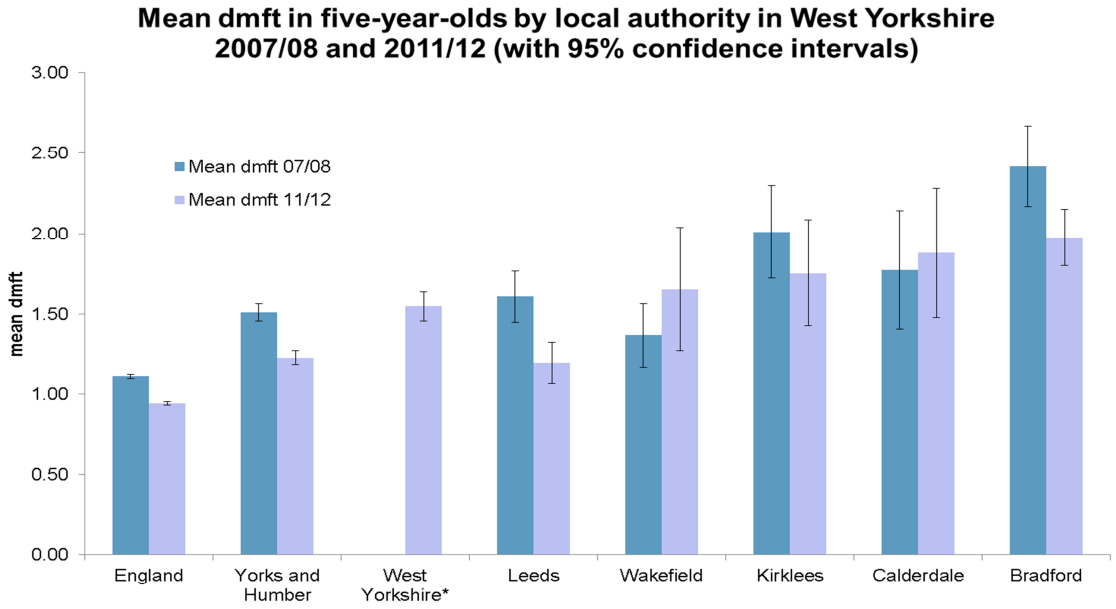
	Leeds	Yorks & Humber
If you went to the dentist tomorrow would you need treatment?	25.6%	25.4%
How would you rate your oral health? (% poor)	24.2%	25.3%

3. Children's Oral Health in Leeds

34% of 5-year old children in Leeds have a dmft score >0 (number of teeth decayed, missing or filled) which is the lowest in Yorkshire and Humber but still higher than the proportion in England overall which is 28%:



In the four years between 2007/2008 and 2011/12, the mean dmft score for 5 year old children in Leeds improved significantly. It is significantly better than the score for children living in other local authorities in West Yorkshire but still above the England score:



Source: PHE National Dental Epidemiology Programme for England.
Chart produced by PHE Knowledge and Intelligence Team Northern and Yorkshire

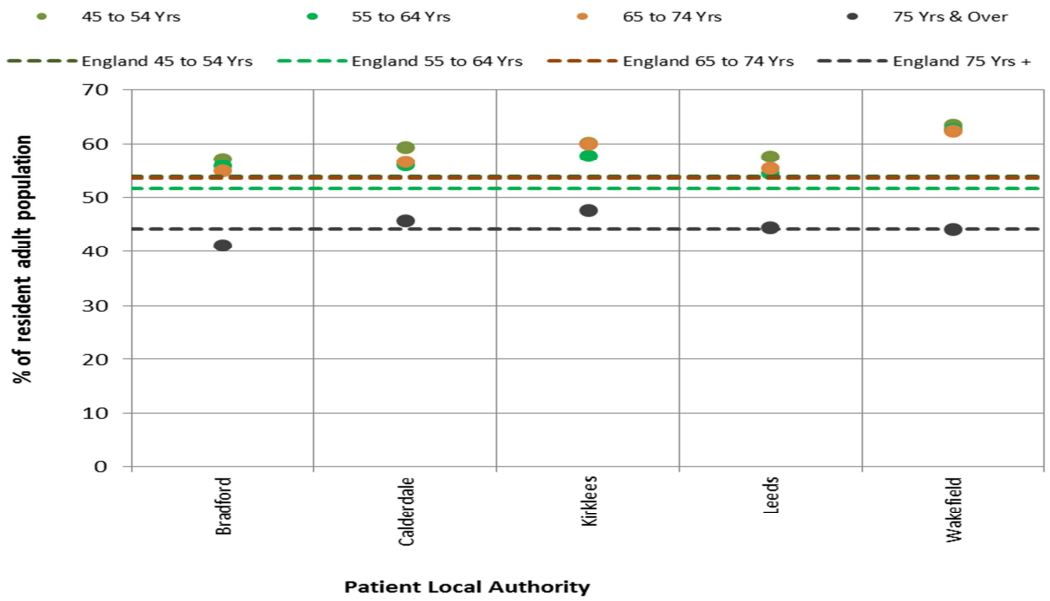
4. Service Structure in Leeds

The NHS spends £45.9 million on dental services in Leeds. The majority of patients attending LTHT are from the Leeds area but the more specialised services area also accessed by patients from across West and North Yorkshire.

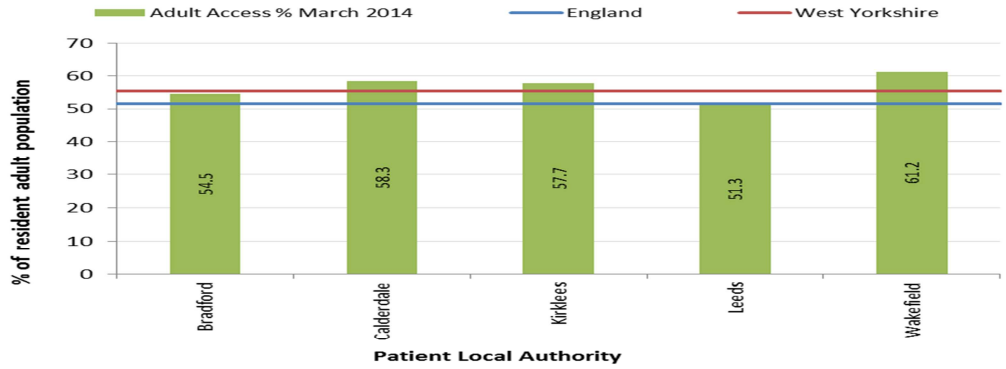
Sector	Provider	Scope	Value
Hospital	LTHT	Secondary care dental, oral surgery and maxillo-facial surgery	£8.2million
Community	LCH	Dental care for children and adults with special needs, and sedation service (including general anaesthetic)	£2.6million
Primary care	101 practices	1.27million UDAs to provide assessment and treatment.	£34.3million
Urgent care service	LCH	Urgent care, 365 days / year	£0.8million
Total Spend			£45.9million

5. Access to Primary Care Dental Services

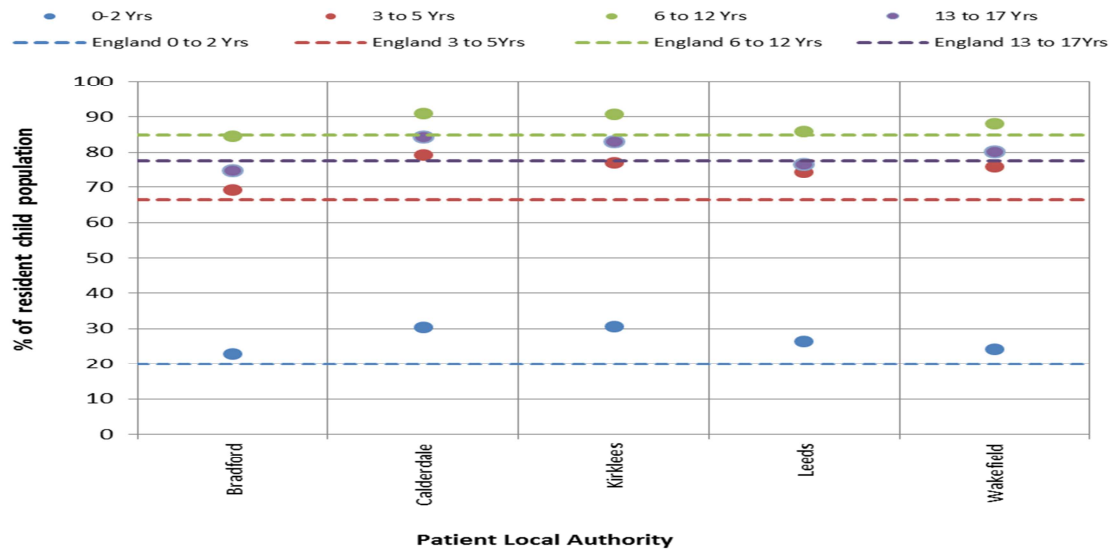
For adults, the access rates in Leeds are at or above the average for England in all age bands:



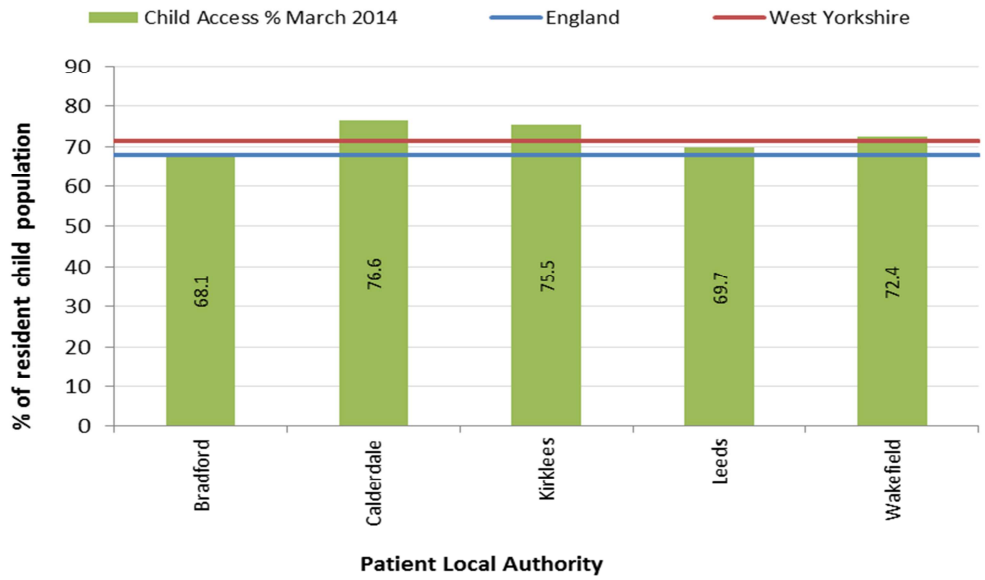
And 51.3% of adults have accessed a dentist within the last two years. This is the lowest access rate in West Yorkshire:



For children, access rates by age are good with particularly high rates in the under 5 age groups:



And 69.7% of children have seen a NHS dentist in the last two years, in line with the rate across England:



For urgent care, very few patients in Leeds attend A&E with dental needs but about 1 in 7 calls to 111 relate to dental health. This is consistent across Yorkshire & Humber.

11% of the commissioned activity in primary care is used to deliver urgent access for local patients but if a primary care dentist is not available to the patient then they are able to access the dedicated urgent care dental service provided through LCD and LCH. LCD provide a triage service supporting 111 and are able to book direct into slots at the LCH dental access centres.

6. **Quality of Primary Care**

NHS England introduced a Quality Assurance Framework for primary dental services in summer 2013. This is the first time that the quality of primary care dental services has been assessed consistently on a quarterly basis.

The quarterly results are reviewed by the Dental Commissioning Team working with clinical dental advisors. Concerns are either addressed through a quality visit to an individual practice or through contractual improvement notices, if warranted.

There are no significant concerns with dental practices in the Leeds area. The high level results from the Assurance Framework are:

Quality indicators	Leeds N	Leeds S & E	Leeds W	Leeds	W Yorks	England	
Radiograph Rate per 100FP17s	19	15.5	17.7	17.3	19.4	20.1	A low rate could indicate non-compliance with FGDP (UK) Good Practice Guidelines – "Selection Criteria for Dental Radiography".

Endodontic Treatment per 100FP17s	1.8	1	1.2	1.3	1.3	1.5	Low levels of endodontic treatment could indicate a number of factors but possibly a greater preference to extract rather than root fill or a high level of root treatments being provided under private contract.
Fluoride Varnish Rate per 100FP17s	34.2	41.7	38.1	38.3	42.9	30.6	A low level of fluoride varnish applications would suggest that treatment is not being offered according to "Delivering Better Oral Health"
Children Re-attending within 3 Months	8	7.4	7.7	7.7	8.5	7.9	In general, a patient who has completed a course of treatment that renders him or her "dentally fit" should not need to see a dentist again within the next three months. A high rate would indicate that further treatment has been provided outside the recall interval but could include urgent treatment etc.
Adults Re-attending within 3 Months	17.4	15.3	17.3	16.6	16	15.7	

7. Patient Satisfaction

There are no current measures of patient satisfaction in primary care dental services. NHS England is introducing the Friends & Family Test to primary care dentistry from April 2015.

Dental patient views on access are measured twice-yearly via the national GP Satisfaction Survey conducted by IPSOS Mori. Response rates to the dental questions in the survey are poor but for this area, the last survey showed satisfaction with access:

Tried to get appointment	**Number who reported trying**	**% successful**
In last 3 months	5216	92.9%
In last 6 months	8487	93.7%
In last 12 months	10802	92.7%
In last 2 years	12082	90.5%

These overall figures do mask differences in different populations and there is evidence that some groups of patients are disadvantaged by current access arrangements.

<u>% of patients successful in getting appointment</u>:

White	91.9%
Other ethnicity	83.8%

Working	91.0%
Retired	94.7%
Other	86.3%

Having seen the dentist before (ie existing patient)	95.4%
Having not seen the dentist before (ie new patient)	62.0%

The national access survey results are based on patients who report having tried to see a dentist recently. The survey also establishes the reasons why patients report not trying to see an NHS dentist are complex and include preferring to access private care and not requiring treatment which together account for ca 30% of patients:

Reason	**% of patients who did not try to get an appointment (n = 5284)**
Did not need to see a dentist	19.8%
No natural teeth	10.9%
Don't like going to the dentist	5.9%
On waiting list	1.6%
See a private dentist	34.3%
Didn't think they could get a NHS dentist	14.0%
Too expensive	3.5%
Other	10.1%

8. **Two Year Plan for Dental Services in West Yorkshire**

NHS England (West Yorkshire) has established a clinical network to steer the planning and commissioning of dental services across the area. The Local Dental Network is chaired by a primary care practitioner from Leeds and has representation from hospital services, community services, Public Health England and the Local Dental Committees. Healthwatch have opted to participate in individual pieces of work rather than have a place on the over-arching network.

In April 2014, the LDN working with NHS England established two-year plan for dental services in West Yorkshire. This sets out six priorities:

1. Moving to increasingly planned care with a reduction in the need for urgent care and a focus on continuity of care;
2. Reducing inequity in access;
3. Improving patient and public access to information about dental services and oral health;
4. Building capacity in primary and community-based services to ensure care is delivered at an appropriate level for every patient;
5. Commissioning care using the national pathways and based on consistent outcomes, quality standards and price irrespective of the place of delivery;
6. Working with Health Education England to ensure the support and development of a workforce which is able to deliver the new model of care.

The financial position within the NHS means that there will not be additional investment in dental services in the two year period. As such we need to ensure that we drive value for money in all sectors of the service.

In the first year, progress has been made on:

(i) Completing an oral health needs assessment for Yorkshire & Humber. This will be published in October 2015.

(ii) Establishing a clinical review of the model for urgent dental care services to reduce reliance on stand-alone provision and set the foundations for the new primary care dental contract which will re-establish a registered list for dental patients in primary care. The review will report in early 2015;

(iii) Reinvesting the funding released from annual primary care contract reviews (July 2014) into the areas of highest need as identified by Public Health England. This funding will be reinvested from October 2014;

(iv) Working with existing providers to review the service specification for community dental services for 2015/16 to establish a core and consistent service across the five providers and to release resources for improved access for frail elderly and bariatric patients;

(v) Introducing a new approach to coding and counting secondary care dental activity to standardise the approach across providers and release funding for investment in primary care.

(vi) Commissioning a dental advice line for West Yorkshire to improve public information about NHS dental services.

(vii) Planning for a central booking service for all secondary care activity. As a first step in 2014/15, all NHS dentists in West Yorkshire have been linked to NHSNet to facilitate electronic transfer of patient and diagnostic data.

Section C - Community Pharmacy Services

As at September 2014, there are 191 pharmacies across the Leeds area, with a good spread across the district and at least 1 pharmacy in every postcode region.

There are also 6 GP practices which are authorised to dispense prescription items directly to patients in rural areas: this covers places such as Bramham, Scholes and Collingham to ensure that patients living in rural areas also have access to services.

Across West Yorkshire during 2013/14 there was a total spend on pharmaceutical services commissioned by NHS England of £80million of which £27 million is spent in the Leeds area alone. This funds core services such as dispensing of prescriptions and disposal of patient waste/returned medications, as well as additional activities such as Medicines Use Reviews to enhance the use of medications.

In addition, the local authority commissions public health services from pharmacies and the CCGs commission some enhanced pharmacy services (such as minor ailment service) across Leeds.

NHS England (West Yorkshire) has established a Local Pharmacy Network to provide clinical input into the planning and commissioning of pharmacy services. The Network is chaired by a local

community pharmacist from the Leeds area and has representatives from across primary, community and secondary care in West Yorkshire. The LPN has established the following priorities:

1. Urgent & emergency care – promotion of Pharmacy First scheme to support general practice out of hours. Learning from Prime Minister's Challenge Fund pilot in Wakefield to establish opportunity for direct booking into pharmacy as an alternative to GP appointment.
2. Integrated care – rolling out Summary Care Record to community pharmacies to promote pro-active care of patients with long term conditions. West Yorkshire is one of three national pilot areas for this.
3. Patient Safety – building on medicine optimisation programme to increase effectiveness of prescribing and reduce medicine wastage.
4. Workforce – identifying opportunities for pharmacists to work in wider primary care settings – given the excess numbers of students that are currently being trained.

Section D - Community Optometry Services

As at September 2014, there are 91 shop based contracts across the Leeds area, with a further 67 contracts to allow sight tests in eligible patient's homes.

Across West Yorkshire during 2013/14, the total spend on core NHS optometry services (excluding community and secondary care which are commissioned by the CCGs) was £24.8million of which £8.2million was spend in the Leeds area.

The NHS-funded service is governed by nationally set eligibility criteria and covers sight tests and vouchers issued against glasses for children, those over 60 and also a range of people who may be on low incomes or receive specific benefits.

NHS England does not have the responsibility to commission enhanced optometry services and this function now sits with the local Clinical Commissioning Groups. A Local Eye Health Network has been established by NHS England to bring together Eye Health specialists and commissioners from across West Yorkshire. This met for the first time in early September 2014.

Alison Knowles
Commissioning Director
NHS England (West Yorkshire)
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