

SCRUTINY BOARD (HEALTH & SOCIAL CARE) INQUIRY INTO LOCALISATION OF HEALTH SERVICES

Content

The attached papers provide information on the planning and decision making process for commissioning health services in Leeds. They should be read in the context of the previous paper circulated to the Scrutiny Board on factors driving localization which gave the high level background.

The papers cover the following:

1. GP Practice Based Commissioning
2. Community Needs Assessment
3. Service Development
4. Public Consultation and Engagement

Members will also have received a report from Dennis Holmes, Chief Officer Social Care Commissioning, on the social care input specifically in relation to commissioning and the community engagement elements of the Joint Strategic Needs Analysis. The commissioning approach and work programme described in the report will be reflected in the new GP commissioning consortia arrangements currently being introduced.

January 2008

GP Practice Based Commissioning in Leeds

1. Background

Practice based Commissioning (PBC) is about engaging practices and other primary care professionals in the commissioning of services. Through PBC, front line clinicians are being provided with the resources and support to become more involved in commissioning decisions. PBC should lead to high quality services for patients in local and convenient settings. GPs, nurses and other primary care professionals are in the prime position to translate patients' needs into redesigned services that best deliver what people want, and achieve better use of resources.

PBC was first mentioned as an aspiration by the incoming Labour government in the NHS Plan. It has been a central part of the government's NHS reforms since April 2005, when interested practices were first entitled to an indicative budget. PCTs were expected to achieve universal coverage of PBC by December 2006. As a minimum PCTs were required to:

- Provide practices with an indicative budget.
- Provide information on use of resources.
- Offer GPs an incentive to engage.
- Put in place governance and accountability arrangements.

PCTs are also expected to provide practices with the tools (e.g. timely, high quality information about activity and finance) and the support they need effectively to discharge their commissioning responsibilities, either directly or through agreed alternative arrangements.

2. Current Position in Leeds

Leeds PCT has encouraged practices to group together to implement PBC but has not imposed a specific locality configuration. Practices have therefore come together into groups of like minded practices. All but one practice in the city is signed up to the implementation of PBC through the consortia arrangements outlined in the table below:

Consortia	No of Practices	Population
Leodis	25	170,584
H3CG	13	137,741
West Leeds GP Collaborative	15	95,271
NE Consortium	9	85,196
Leeds Virtual Commissioning Collaborative	15	55,953
Wharfe and Aire Consortium	7	54,907
The Morley/Ardsley Consortium	4	48,316
South Leeds Consortium	8	45,342

The Wetherby & District Group	5	33,038
Church Street Group	5	13,090
Total in Consortium arrangement	106	739,438
*Unaligned practices	9	60,029

*Note: of the 9 unaligned practices, 8 are implementing PBC as an individual practice; 1 practice is not signed up to PBC.

The attached map shows the configuration of the PBC consortia compared with Local Authority Area Committee boundaries and the super output areas. One of the challenges for the PCT in respect of PBC is how the configuration of PBC consortia relates to the wider partnership agenda in the city.

PBC consortia are supported by the PCT to develop commissioning plans based on assessment of health needs, analysis of current patterns of service provision, identification of gaps and development of proposals for redesign of care pathways in partnership with secondary care clinicians, local authority and voluntary sector stakeholders. Practice based commissioners have a specific responsibility for involving patients and the public in the development of commissioning plans and redesign of care pathways.

The PBC Forum has been established to bring together clinical leaders from the PBC consortia with strategic commissioners from the PCT to enable PBC to take place in the context of the overall vision and strategic priorities for the PCT. The PBC Forum also enables sharing of commissioning plans between consortia and the identification of opportunities for collaborative working.

3. Decision making in PBC

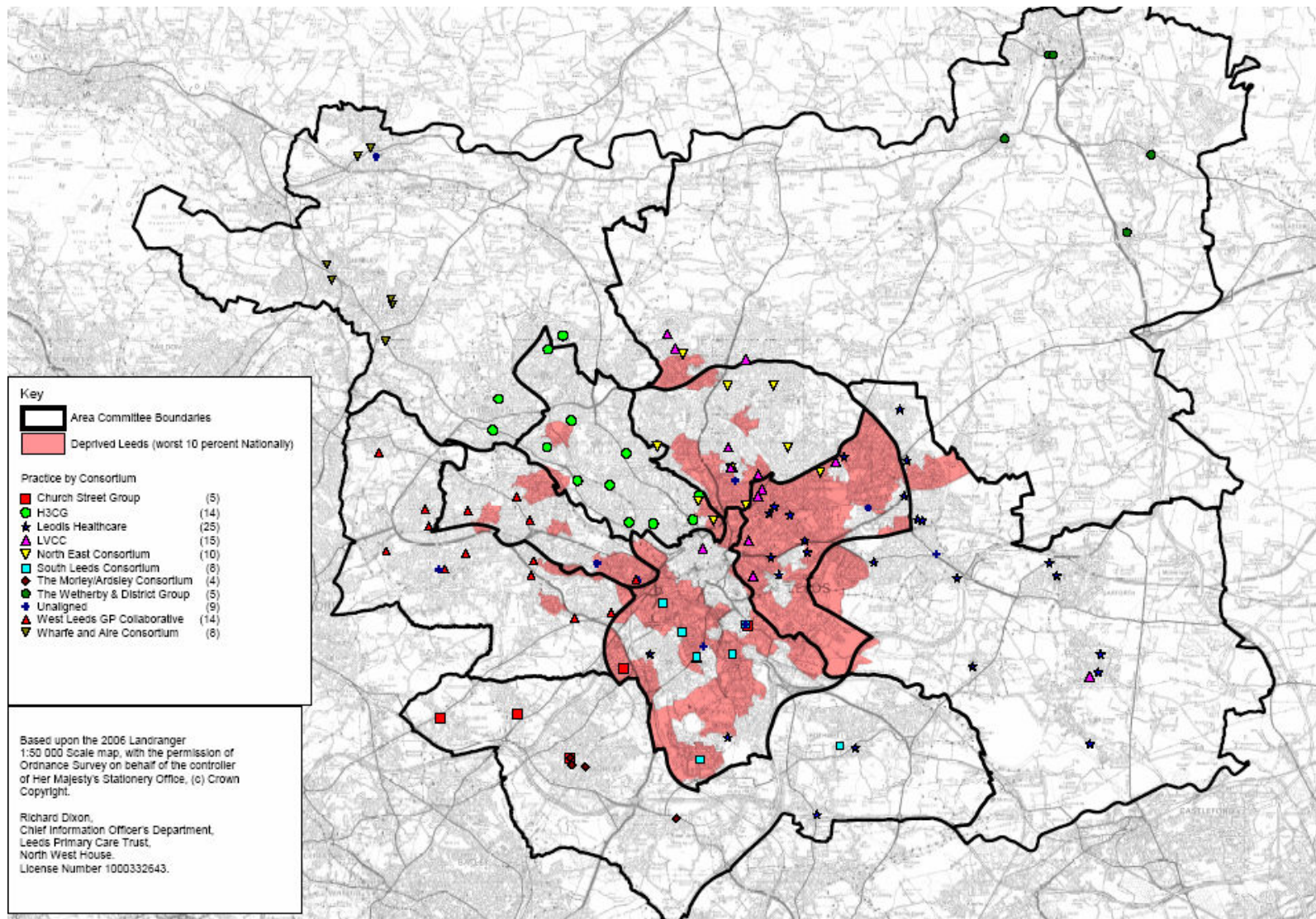
The PCT has established a sub-committee of the Board, the PBC Governance Committee, to approve PBC commissioning plans and business cases, ensuring that potential conflicts of interest in the decision making process are dealt with. The PBC Governance Committee is advised by a Clinical Reference Group, ensuring that proposals reflect evidence based quality services, and a Patient Advisory Group (PAG), ensuring that business cases are reviewed from a patient and public perspective. Questions raised by the group are fully explored by the PBC team to make certain that the proposals reflect the needs of the local population.

The Patient Advisory Group draws its membership from a range of patient groups and community and voluntary organisation in Leeds including a representative from Leeds VOICE – Health Forum, 2 representatives from Leeds Patient and Public Involvement Forum, 1 representative from Leeds Black and Minority Ethnic (BME) Network, 2 representatives from Leeds Involvement Project Locality Development Schemes, 1 representative from the Older People’s Modernisation Reference Group, 1 representative from Leeds Carers Strategy Group and 1 representative from Leeds Hospital Alert. The group is chaired by the PCT’s Patient and Public Involvement Lead for PBC and Primary Care.

4. Mechanisms for local engagement

In addition to the role of the Patient Advisory Group outlined above, all PBC consortia are required to describe processes that they have in place to involve patients and the public in the development of commissioning plans and redesign proposals. One large consortium has appointed a lay member to the Board, and the PCT has supported work to scope the patient/public involvement and partnership agenda in that consortium through the secondment of a member of the Patient and Public Involvement team. The outcome of this piece of work is now informing the development of structures in all consortia to support local engagement. This is likely to include the following approaches:

- Encouraging PBC Consortia to include patient and public representation as part of their governance arrangements.
- Conducting a baseline audit of current arrangements for PPI within PBC Consortia.
- Further development of Patient Participation Groups at practice and consortium level.
- Mapping of and engagement with key local stakeholders (local authority; third sector, etc) in each PBC Consortium area.
- Development of focus groups to inform the redesign of services and to renew new services.
- Development of a database at Consortium level to identify community and voluntary stakeholders in each area.



Community Needs Assessment

1. Introduction

The following report outlines the process to undertake a health needs assessment based on guidance produced by Public Health, Leeds PCT and describes a community health needs assessment recently undertaken for students.

2. Health Needs Assessment Process

2.1 Definition

A Community Health Needs assessment is:

- A systematic description of the needs of a community, and the resources that exist for that community
- It is carried out with the active involvement of the community itself

2.2 Purpose

- The Health Needs Assessment (HNA) process has to deliver activities which will improve health and reduce inequalities locally.
- The health concerns and inequalities tackled, must reflect Government and local priorities.

By the end of the process there should have been real steps toward fulfilling the following conditions: is the activity in response to an identified need? Were the local community involved in identifying the need? Does the health need you are responding to affect a lot of people locally? Is it reaching those people with the most to gain?

The population to be targeted needs to be defined i.e. a whole population or a sub-set in response to government/local priorities/greatest need, or a gap in provision, e.g. live in geographic area, share a characteristic e.g. age, ethnicity, gender, disability, health issue, etc.

2.3 Building a Profile of the community

Information on the community needs to be collated which will include population age and distribution, deprivation ratings, mortality and morbidity rates, behaviour related health data, the environment, housing, transport, crime, amenities, statutory and voluntary services. This will involve consultation with local providers and health specialists, as well as local people on whether they think services are adequate.

Carrying out HNA offers the opportunity for team building, partnership building and improving links with the local community, to highlight areas of need that have

previously not been recognized, and to link with other work being done. Partnerships help produce joined up services preferred by the public, and pooling of resources to maximize impact.

Inequalities can be considered across three broad areas:

- Multiple deprivation – what a person experiences in terms of the underlying causes of ill health – this includes housing, poverty, educational attainment, local levels of crime, etc. Evidence suggests that a patient with a chronic disease who experiences high levels of multiple deprivation will have poorer outcomes
- Access – patients need to have similar levels of access to services, particularly those that are known to under use services, and once patients have accessed a service there must be confidence that the provision is appropriate to different need
- Disease burden – in each disease group individuals and communities who are more likely to experience the disease can be identified.

2.4 Feeding back the evidence

The involvement of the community and other key players, should result in identifying the conditions and factors that are impacting on the health of the profiled population. This will be the base-line against which will be measured the outcomes of the actions for change. The main findings should include:

- a baseline profile of the population affected by the proposal
- summary of local circumstances relevant to the proposal
- evidence from the published literature
- information from health impact assessment/s that have been conducted on similar proposals and/or on the same community.

2.5 Health Impact Assessment

The health impact assessment will focus on the programmes, policies or projects, and examines what impact, positive or negative they will have on population health. In identifying which changes would have the most impact on the target population, actions should be examined in respect of the three levels of prevention: 1) primary prevention – preventing the problem occurring at all; 2) secondary prevention – preventing progression or recurrence of the problem; 3) tertiary prevention – preventing the consequences of the problem.

Evidence of effectiveness and pursuing 'best practice' has to be incorporated into any programme of action. However it is also important to ensure that the proposed changes are acceptable to the target population, the service providers, the managers, and commissioners.

3. Leeds Student Health Needs Assessment

3.1 Summary

The following report is drawn from a Health Needs Assessment undertaken during 2006 led by the former Leeds North West PCT (NW PCT). It describes the process undertaken to assess the particular health needs of students and the recommendations. Copies of the full Health Needs Assessment can be requested from the PCT.

3.2 Background

The former Leeds North West PCT had a sizeable student population with the three main higher education institutions (HEIs) being located in the NW PCT. The focus on the particular health needs of students in order to identify key priorities was agreed with the HEIs. A multi-agency group with representatives from the HEIs (University of Leeds, Leeds Metropolitan University and Trinity & All Saints College), Students Union, the NW PCT and the voluntary and community sector was brought together to guide the work.

The aim of the Health Needs Assessment is to improve the health and wellbeing of university and college students living in Leeds. The objectives are:

- to identify priority areas to support universities and colleges to be healthy settings
- to identify priority areas to promote positive relationships between students and the local community.

The approach to the collection of data included target (student) population perceptions, stakeholder perceptions and a literature review. The resulting identification of the priority needs of students can be captured in the following themes.

3.3 Health Services

Access to health services is a key issue for students. The seasonal nature of the academic calendar creates pressure on a range of services at certain times of the year (particularly the start of term and during exam periods). The fact that students may not be resident in Leeds for 12 months of the year can also impact upon their ability to access services that operate waiting lists. The recommendations included: that all students are registered with a Leeds GP; to promote the Dental Advice Line; and to improve the co-ordination and planning of health related activities at the start of the academic year.

3.4 Health Issues

A range of specific health issues were identified including mental health, sexual health, smoking, alcohol and drugs, physical activity and nutrition. Mental health was identified as a key issue for students and a multi-agency group was established to carry out detailed work, the recommendations from which included to prevent and reduce the number of students experiencing mental health

difficulties and to improve the access to timely and appropriate mental health services.

Recommendations for other health issues included: to reduce the incidence and prevalence of Sexually Transmitted Infections in the student population; to expand students access to Leeds Stop Smoking Service; to reduce alcohol and drug related harm in the student population; and to promote healthy eating messages, cooking and budgeting skills within the student population.

3.5 Healthy Community

The universities and their students form part of the fabric and identity of many of the neighbourhoods in the North West and increasingly in other areas of Leeds. There are a number of established initiatives that seek to address the challenges of a high concentration of students, foster positive community relationships and contribute to the development of a Healthy Community. The recommendations for further action included: developing and promoting a Community Guide to provide advice and guidance to students about living in the community; and encouraging all stakeholders to play an active role in sharing, communicating and co-ordinating their approach to students living in the community.

Other themes to emerge included healthy universities and colleges and international students.

Service Development

1. Summary

An overarching aim of Making Leeds Better is to improve primary and community services particularly for patients with long term conditions. This will mean providing more and better services closer to people's homes so that we can diagnose and treat people sooner, help them manage their conditions more effectively, avoid admission to hospital, and provide rehabilitation and other services needed for swifter discharge from hospital. To deliver this we are improving care out of hospital by developing systematic care pathways based on National Service Framework standards. The following report describes a re-design pathway using Chronic Pulmonary Disease (COPD) as an example.

2. Introduction/Background

The 'Making Leeds Better' re-design pathway for COPD consists of rolling out the following services across the city based on need:

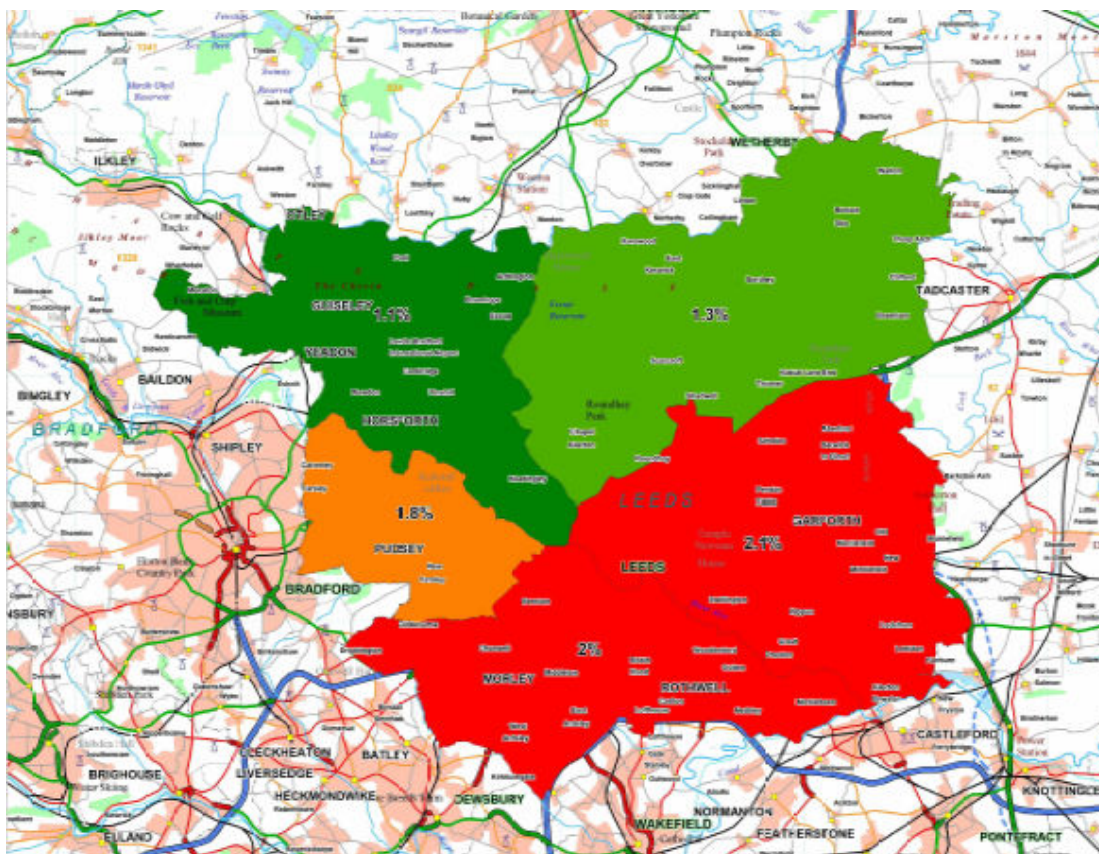
- Diagnosis of COPD using spirometry in primary care
- Early discharge scheme
- Pulmonary rehabilitation
- Chronic disease management

COPD guidelines were developed in 2005 which included patient involvement and identified the GP as the main referrer to the service. The community based service is focused on keeping patients well and delivering care closer to home. The service model comprises of COPD teams of nurses and physiotherapists providing support to GP practices, for all the above elements of the service. The above elements of the service are now provided in the community. Pulmonary rehabilitation capacity has been increased from approximately 60 places in 02/03 delivered in a hospital setting to approximately 650 places in 07/08 delivered in a community setting.

3. COPD Needs Assessment for Community Based Services

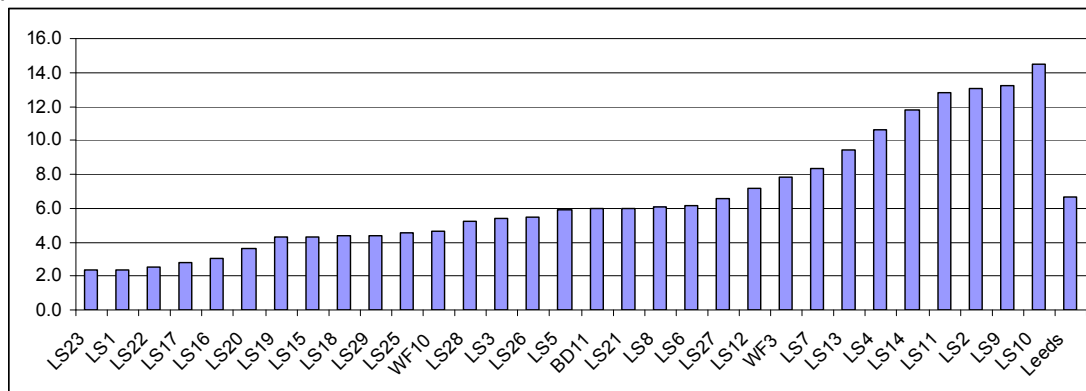
A needs assessment was carried out in 2002/03 for the former East Leeds PCT based on the prevalence and hospital activity data which concluded that there are major health and efficiency gains to be achieved by implementing the above four pathways for COPD patients. More recent data in 2006 on the crude prevalence of COPD by locality (figure 1) and hospital admission rates by postcode based on 2003/06 activity (figure 2), highlights the significant variation in COPD across the city.

Crude prevalence percentage by PCT: source QMAS 2006



Locality	Total number of COPD patients	Crude prevalence in % (95% confidence intervals)
Leeds	12617	1.60 (1.58-1.63)
Headingley / Woodhouse / Burley Total	806	0.79 (0.73-0.84)
Chapeltown Total	521	0.99 (0.91-1.08)
Moortown/Roundhay Total	1,065	1.36 (1.28-1.45)
Cookridge Total	662	1.42 (1.31-1.53)
Otley / Guiseley Total	773	1.42 (1.33-1.52)
Rothwell Total	414	1.48 (1.34-1.62)
Wetherby Total	493	1.51 (1.38-1.64)
Garforth / Kippax Total	668	1.62 (1.50-1.74)
Morley Total	976	1.71 (1.60-1.82)
Wortley / Bramley / Armley Total	1116	1.84 (1.73-1.94)
Pudsey Total	958	1.86 (1.74-1.97)
Seacroft Total	1147	1.97 (1.85-2.08)
Beeston Total	822	2.11 (1.97-2.25)
Harehills Total	1414	2.66 (2.53-2.08)
Middleton\Hunslet Total	827	2.66 (2.48-2.84)

Age standardised admission rates for COPD per year per 1000 population 40-99 for each Leeds postcode.



The assessment clearly highlights that the admission rates and prevalence is at least double in South and East areas of the city compared to other areas and therefore has a greater need for COPD services. Similarly at the locality level, Seacroft and Harehills localities; Middleton/Hunslet and Beeston localities; and Wortley/Bramley/Armley and Pudsey are in the greatest need of COPD services.

There is further local evidence for full implementation of the pathway, with a 29% reduction in admission rates for COPD in the former East Leeds PCT (2003/04) and a downward shift in COPD admissions of 26% (2006/07) in the former Leeds North West PCT.

4. Equity of access

Historically the service has been rolled out across the city on a differential basis, whereby the East PCT were the first to achieve full implementation. Immediately prior to the creation of the LEEDS PCT there was full implementation in four out of the five PCTs, with South PCT having only limited implementation. This meant that the provision of community based services for patients with COPD was inequitable as those patients with the greatest need living in the south and to a lesser extent the west of Leeds, did not have the same access to services compared with other areas of the city. To address this inequity the PCT has adjusted the distribution of resources in order that the priority elements of early discharge and pulmonary rehabilitation are provided across the city, and resources are concentrated in the areas of greatest need.

Furthermore an equity audit in East Leeds has identified that the local population is not accessing these services according to the level of their needs. The reasons for this include that the service is still new and that possibly the data system is not being used to collect all activity.

Future work on the strategic development of services for patients with COPD is planned over the next two years which will use prevalence data, admissions data and mortality rates to determine the capacity and geographical location of future services.

Public Consultation and Engagement

1. Background/Context

The NHS Plan and Our health, Our care, Our say puts patients at the centre of everything the NHS does and plans to do. Section 242 of the NHS Act 2006 which replaces Section 11 of the Health and Social Care Act 2001, requires that services for which the PCT is responsible, involve service users in:

- a) the planning of the provision of those services
- b) the development and consideration of proposals for changes in the way those services are provided, and
- c) decisions to be made by that body affecting the operation of those services.

The changes to commissioning and the introduction of Practice Based Commissioning which will need to reflect the needs, priorities and aspirations of the local population, means that commissioners will engage with the public and actively seek the views of patients, carers and the wider community.

2. Mechanisms for consulting with local people

There are a variety of mechanisms we use to consult with local people during the planning and decision-making process. These are a mixture of formal and informal, established groups and approaches, depending on the nature of the change being proposed.

The mechanisms currently being used include:

- The Patient and Public Forum (PPI) which will be replaced with Local Involvement Networks (LINks) from April 2008.
- National patient surveys which are adapted locally on choice and access
- Patient Advice and Liaison Service (PALS) which focuses on improving the service to NHS patients
- Complaints – these are analysed and used to inform service changes. (review services and create opportunities to make improvements)
- Community Groups – the PCT involves community groups as appropriate
- Voluntary sector – the PCT has a Service Level Agreement with Leeds Involvement Project to ensure dialogue with the voluntary sector
- Health Forum – a group of voluntary organizations with a health focus
- Practice Based Commissioning Patient Advisory Group to ensure that proposals reflect the needs of the local population
- Formal public consultation which is held when substantial or significant service change is planned (formerly Section 11)
- Involvement – where discussions take place with a range of stakeholders to look at ways to continually improve and develop services or respond to the need to change

- Information giving – providing people with information on local services
- Focus groups, questionnaires and patient diaries are used as appropriate

3. Urgent Care Engagement and Consultation

A recent example of engagement and consultation is the development of the Leeds and West Yorkshire Urgent Care Commissioning Programme. The key points from the work undertaken and the outcome, include:

- responding to a report from the PPI Forum about urgent care and GP Out of Hours Services formed part of the original case for change
- the engagement phase and the feedback from this has been fed into the development of a specification which will be the basis of an invitation to tender from providers
- there have been PPI representatives involved in the short-listing panels and this involvement will continue throughout the procurement process
- patient and public engagement will be on-going throughout the process with a service user reference group being established, which will review consultation methods and materials and commenting on contractor's outline solutions.
- formal 12 week consultation with information available through a website, GP practices, health centres, hospitals, libraries, community groups and centres, media work, events, public meetings, etc.