Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Measuring how well Services in Sheffield are Meeting People's Needs

Governing Body meeting

5 March 2015

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Author(s)	Susan Hird, Consultant in Public Health
Sponsor	Tim Furness, Director of Business Planning and Partnerships

Is your report for Approval / Consideration / Noting

Consideration

Are there any Resource Implications (including Financial, Staffing etc)?

There will be resource implications depending on decisions made by Governing Body. These include financial implications if a decision is made to externally commission some work, or staff capacity decisions if work is carried out by existing staff.

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?

1. To improve patient experience and access to care
2. To improve the quality and equality of healthcare in Sheffield
3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? If not, why not?

No formal Equality Impact Assessment has been carried out yet. However, equality impact has been considered as part of writing this paper. Measuring how well services in Sheffield are meeting people's needs could lead to a significant positive impact on improving access to services for people with protected characteristics and other vulnerable groups.

PPE Activity

How does your paper support involving patients, carers and the public?

Patients, carers and the public will need to be involved in developing and approving how we measure how well services are meeting needs.

Recommendations
The Governing Body is asked to: • Note and approve the broad framework proposed in this paper including the need to have a line of sight between the JSNA - commissioned services – individual level need – population level outcomes. • Consider the complexity involved in developing indicators for Sheffield, alongside the benefits and the resource implications. • Decide whether or not to pursue measuring how well services are meeting needs in Sheffield.

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1. Introduction

1.1. The CCG Governing Body agreed at the November 2014 meeting to explore the feasibility of measuring "the extent to which services are meeting need in the city".

1.2. At the heart of this question lies the inverse care law – a concept suggested over 40 years ago by Julian Tudor Hart in a paper for The Lancet, to describe a perverse relationship between the need for health care and its actual utilisation. In other words, those who most need health care are least likely to receive it. Conversely, those with least need of health care tend to use health services more (and more effectively).[1] [2]

1.3. This is not the first time that the CCG (and the PCT previously) has considered this question. Some recent examples include the Musculoskeletal (MSK) commissioning for outcomes work, and the Continuing Health Care (CHC) personalised care case management approach. It is important to draw on the learning from these and previous experiences of trying to measure how well services are meeting need.

1.4. This paper discusses some of the issues involved in trying to measure how well services are meeting needs, and outlines some of the options available to the Governing Body including a consideration of the resources that might be needed to achieve it.

2. Assessing need

2.1. Measuring how well services in Sheffield meet people's needs involves considering the following:

- Is our Joint Strategic Needs Assessment (JSNA) a good enough assessment of need?
- Are we commissioning services effectively to address those needs?
- Are the commissioned services meeting need?
    - Are they meeting the needs of the individuals using the service?
    - Are they contributing to population-level outcomes identified in the JSNA?

2.2. The CCG (and Health and Wellbeing Board) therefore needs a clear line of sight that makes the connection between the JSNA - commissioned services – individual level need – population level outcomes.

2.3. Is our JSNA a good enough assessment of need?

[1] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(71)92410-X/abstract
[2] http://www.kingsfund.org.uk/publications/articles/inverse-care-law

2.3.1. Assessing whether the JSNA is a good enough assessment of need would require us to devise a mechanism for assessing the JSNA against some kind of gold standard, which is unlikely to exist. This could quickly lead to a perpetual search for a perfect JSNA which can't be achieved. The process for producing the Sheffield JSNA is robust and includes a substantial consultation process. It may not be worth putting resource into assessing if it could be better.

2.3.2. The JSNA is a strategic document, therefore can't look at health needs in the level of detail that may be needed by the CCG in order to commission health services effectively. For example, the JSNA is not the right document for a detailed assessment of need for rheumatology services in the city. This needs to be done through additional healthcare needs assessments.

2.4. Are we commissioning services that address the needs identified in the JSNA?

2.4.1. The CCG (and Health and Wellbeing Board) needs to know whether the range of services currently commissioned is addressing the full range of need identified (and in the right way, with the right volume, with ease of access, etc).

2.4.2. The methodology for doing this would need further thought, but would involve some kind of assessment of the range, depth and quality of commissioned services against the health needs identified in the JSNA. Some of this will be covered by health needs assessments exploring particular topics, or other work already underway within CCG portfolios as part of commissioning.

2.4.3. Assessing the scale of unwarranted variation in access to health care across the city is an aspect of this. The materials produced by the Health Inequalities National Support Team to assist with this are still relevant. This would be a large piece of work therefore we would have to identify which areas to investigate first. Obvious priority areas would be cardiovascular disease, cancer, and mental health.

2.5. Are commissioned services meeting need?

2.5.1. Are services meeting the needs of individuals using the service?

2.5.1.1. The concept of 'need' is one of the most widely used terms in health and social care. It is also one of the most slippery to define. Need is a multi-faceted concept with no single universal definition or agreement on how it can be measured. It is understood differently in health compared to social care.[3] Table 1 sets out Bradshaw's taxonomy of need, which is commonly used when discussing need.[4]

2.5.1.2. There is a difference between the need for health, and the need for healthcare. The need for health is broader and can include problems for which there is no known treatment. The NHS tends to define need as

[3] Exploring unmet need. Joseph Rowntree Foundation. 2000
[4] Bradshaw J. (1972) A taxonomy of social need. In McLachlan G (ed.) Problems and progress in medical care. Seventh series NPHT/Open University Press.

'capacity to benefit' from an intervention or service.[5] Using this definition, a need would only be defined as such (whether felt, expressed, normative or comparative) if there was the capacity to benefit from the intervention or service. 'Need' is not synonymous with 'want', 'demand' or 'expectation' for a particular treatment or service.

Table 1: Bradshaw's taxonomy of need

Type of need	Explanation
Felt	Felt need is what people say they want or feel they need. When determining felt needs, there are three things to note: people have a tendency to express needs in terms of a solution (for example more nursing home beds); people may be representing others as well as themselves; and the level of expectation in relation to services may influence felt need. Felt need does not take into account an individual's capacity to benefit from a service or intervention.
Expressed	Expressed need refers to what can be inferred about the health need of a community by observation of the community's use of services. However a need may exist but because there is no service in place to meet it, the expressed need may not be identified.
Normative	Normative need refers to what expert opinion based on research defines as need. For example, all children aged 12 - 15 months should be vaccinated against measles. This indicates a health need, if data indicate that many children are not immunised.
Comparative	Comparative need is derived from examining the services provided in one area to one population and using this information as the basis to determine the sort of services required in another area with a similar population. When assessing comparative need the level of service provision in the reference area must be appropriate in the first place. Data collected may in fact be due to over-servicing or under-servicing by service providers rather than an indication of true need for the service by health consumers.

2.5.1.3. Broadly therefore, we have two main categories we could measure (appendix 1):

- how well services are meeting people's perceived needs; and
- how well services are meeting people's capacity to benefit from a (clinically effective) intervention.

2.5.1.4. Measuring how well services meet someone's needs could be done by simply asking service users for their opinion on how well the service met or meets their needs. This already happens with regards to asking people about their experience of using services – for example through routine patient feedback in hospital clinics, patient participation groups in GP surgeries, or the friends and family test.

2.5.1.5. However there are some difficulties with this approach when looking at need rather than patient experience. For example, if someone states a service hasn't met their needs, is this because the service has failed to do so, or the person didn't have the capacity to benefit from what the service offered, or because the person had wants or expectations that the service could never reasonably be expected to meet?

[5] Asari-Ladi et al. *Need for redefining* needs. Health and Quality of Life Outcomes 2003, 1:34

2.5.1.6. Moreover, this approach will only give us information about the people who use the service (expressed need). It will tell us nothing about the group of people who might have a need and capacity to benefit from the service, but don't access it for whatever reason.

2.5.1.7. This is what we need to measure in the second category – how well services are meeting people's needs in terms of their capacity to benefit from a service. This includes, for example, people who have a particular disease or condition but for whatever reason aren't receiving appropriate clinically effective treatment – this could be because they've not approached a doctor to discuss their symptoms and get a diagnosis, or because they're not receiving maximum possible treatment, or because they're receiving a clinically ineffective treatment.

2.5.1.8. We therefore need a systematic and appropriate approach to getting assurance that commissioned services are meeting need at the individual level, taking account of these issues.

2.5.1.9. One option is to try to reduce levels of unwarranted variation as described in 2.4.1.2. Another is to conduct audits of levels of non-attendance at services, assessing the extent to which there is social, ethnic, gender, or age patterning of non-attendance and investigating (probably using qualitative methods) reasons for these. Service providers could be asked to complete these audits then act on the findings. This could include general practice as well as secondary care.

2.5.1.10. We could also conduct audits of services to establish how much work people have to do to access them – for example transport, workplace and childcare arrangements and arrangements for accompaniment or language. Healthwatch and the VCF sector could lead on this work, using volunteers to do the audits. This could include general practice as well as secondary care.

2.5.1.11. Conducting these audits are a recommendation included in the Sheffield Health Inequalities Plan under action 3.4 'Improving access to services'. The recommendation was approved by the council's Health and Wellbeing Strategic Outcomes Board on 28 January 2015, and by CET on 10 February 2015. We may have to prioritise particular services to look at in the first instance, as it will not be feasible to include everything. Criteria for supporting prioritisation could include the service's potential impact on premature mortality, disability free life expectancy, prevention etc.

2.5.1.12. Related to this, the CCG could, through contracts, ask providers to do more in terms of data collection and implementing changes as a consequence. This has the advantage of engaging providers in being part of the solution.

2.5.2. Are services contributing to population-level outcomes identified in the JSNA?

2.5.2.1. If the JSNA is a good identifier of need, and appropriate services are commissioned and provided in ways that meet these needs, then we

should see an impact on some population health outcomes in the NHS, Public Health and Adult Social Care Outcomes Frameworks. We will need to identify which are the most relevant.

2.5.2.2. However we must remember that access to services only plays a small part in population health – estimates suggest only about 20%, with the remaining 80% attributable to the wider determinants of health such as education, employment, poverty and housing.[6] Therefore we'd have to be cautious about attributing any lack of progress.

3. Summary

3.1. In summary, setting up a process to measure how well services are meeting needs in Sheffield is not a straightforward task. We need to assess what the benefits are from doing this and whether the investment (time/people/money) is worth the return.

3.2. The benefits of doing this work could include:

3.2.1. Services having a better understanding of what makes them inaccessible to different groups of people, and what changes need to be made to make them more accessible.

3.2.2. Earlier diagnosis and intervention for previously underserved groups – this may increase elective care but decrease urgent and unscheduled care, and is likely to have a net financial benefit.

3.2.3. Greater involvement of the public in shaping how services are delivered.

3.2.4. Reduction in provision of clinically ineffective interventions, possibly resulting in savings to the CCG and wider system.

3.2.5. The overall aim would be improved population health outcomes with a reduction in health inequalities.

3.3. There are resource implications associated with doing this work, in particular if the Governing Body decide to develop a collection of indicators as this will require resource (staff time). If this is seen as 'part of the CCG's job' then it will be about redirecting resource to achieve it, rather than seeing it as an extra.

3.4. Regardless, it will need involvement from CCG staff and the council (through the public health core offer). From the council perspective, this is likely to require staff involvement beyond current capacity. This might mean replacing some of the current public health core offer workplan with this work, requiring discussions within CCG portfolios to agree what public health input can be temporarily halted.

3.5. Another option would be to externally commission the work. The cost of this would depend on what was being commissioned. For example there would be a one-off cost associated with commissioning the development of an indicator set, versus year on year costs if this also included monitoring and analysing the data.

[6] King's Fund Broader determinants of health http://www.kingsfund.org.uk/time-to-think-differently/trends/broader-determinants-health#messages

3.6. On top of this, there may be additional costs if more public engagement or involvement is needed as part of data collection, but this could bring additional benefits to the CCG.

4. Recommendations

4.1. The Governing Body is asked to:

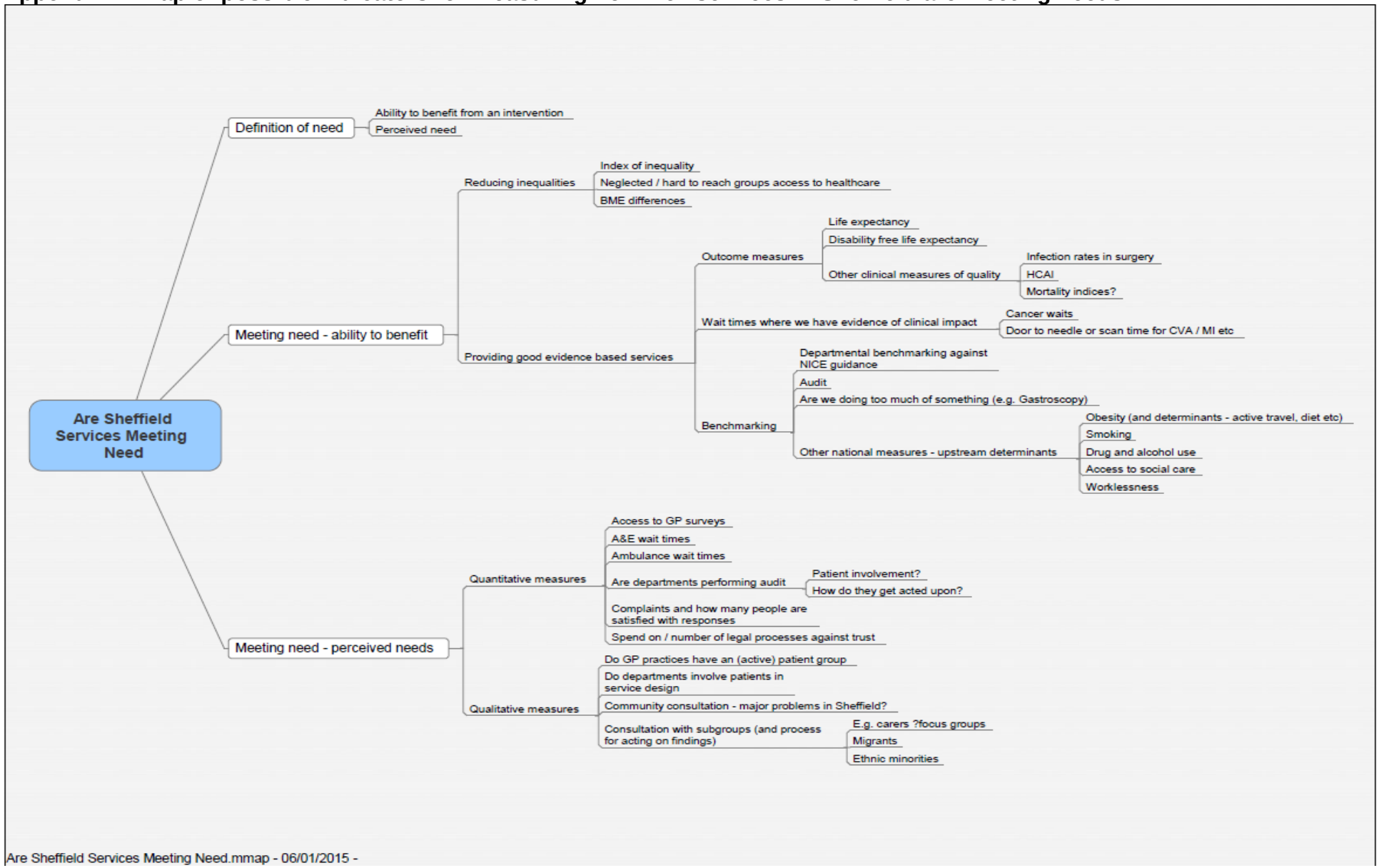
4.1.1. Note and approve the broad framework proposed in this paper including the need to have a line of sight between the JSNA - commissioned services – individual level need – population level outcomes.

4.1.2. Consider the complexity involved in developing indicators for Sheffield, alongside the benefits and the resource implications.

4.1.3. Decide whether or not to pursue measuring how well services are meeting needs in Sheffield.

Paper prepared by Susan Hird, Consultant in Public Health (with input from Professor Jeremy Wight, Sheffield Director of Public Health, Jason Horsley, Public Health, and Louise Brewins, Public Health)

On behalf of Tim Furness, Director of Business Planning and Partnerships

5 March 2015

Appendix 1: map of possible indicators for measuring how well services in Sheffield are meeting needs