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 November 2015

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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 are likely to be resource implications in the form of staff training, and putting staff resource into developing and implementing a programme of work. There may be financial resource required to support this.

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. Measuring how well services in Sheffield are meeting people's needs could have a significant positive impact on improving access to services for people with protected characteristics and other vulnerable groups. EIAs will be done at appropriate points if Governing Body gives approval for this work to begin.

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 the programme of work and the solutions. This aspect of the programme is still to be developed.

Recommendations

The Governing Body is asked to discuss the paper and consider the following suggested actions:

- As system leader, the CCG should work to establish a city-wide consensus and commitment to ensuring services are meeting people's needs as this will reduce health inequalities and improve health. This needs to be at the level of Chief Executive.
- Identify lead(s) to develop the framework and associated actions discussed in this paper. Ideally these leads would come from commissioning and provider organisations (including the VCF sector) so the work can be developed jointly. This should be a high profile, visible programme of work that includes patient and public participation. It needs to be explicitly integrated into relevant work that's already happening eg the Integrated Commissioning Programme, Prime Minister's Challenge Fund, the Health and Wellbeing Strategy action on 'improving access to services', etc.
- Identify a CCG lead to ensure the framework and relevant actions are incorporated into CCG commissioning, so that it becomes 'just how we do business'.
- Develop monitoring and evaluation as part of the programme so we can measure impact.
- The CCG may need to consider discussions with regulators as there is likely to be tension between meeting national targets and meeting local needs.

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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". A short paper came to Governing Body in March 2015, outlining some of the ways in which need could be defined and measured and making a number of recommendations, including getting agreement on the definition of need.

1.2. Governing Body agreed to pursue the recommendations in the paper. Consequently all interested Governing Body and CET members attended a workshop on 21 May 2015, in order to establish an agreed definition of need and to explore ways of measuring this.

1.3. This Governing Body paper has drawn heavily from papers written by Professor Sarah Salway (University of Sheffield) as part of the Evidence and Ethnicity in Commissioning Group.[1] Professor Salway has given permission for the work to be used in this way.

1.4. Measuring how well services are meeting people's needs is an inequalities and an equalities issue. It is also a quality and efficiency issue. It needs to be incorporated into the ongoing CCG and city-wide work on these agendas rather than be seen as something separate.

1.5. This paper:

- summarises the discussion at the workshop in May 2015;
- proposes a framework for improving how well we measure whether services are meeting needs; and
- makes recommendations to Governing Body about next steps.

2. Summary of workshop discussions from 21 May 2015

2.1. The workshop took the format of a brief presentation and facilitated discussion. The group discussed the following:

- Measuring how well services are meeting needs is a key way in which the CCG can contribute to reducing inequalities as well as meeting statutory equalities duties.
- Need can be defined in different ways, but for our purposes we agreed to define it as 'ability to benefit' (from an intervention, treatment, service, etc).
- People's experience of using a service is very important, but this is not what we are trying to measure here. There are other and better ways of measuring

[1] [1] http://ethnicitycommissioning.group.shef.ac.uk/about.html

experience and satisfaction with services, some of which the CCG is already doing.

- In essence we want to measure unmet need, best thought of as 'who's not using a healthcare service who should be'. Some services already have a clear idea of this and are interested in trying to address it.
- As a commissioner of healthcare services and as a membership organisation the CCG has the potential to ensure that services are meeting people's needs, thereby improving quality and efficiency and reducing inequalities. To date we have failed to maximise this potential because we have not considered health inequalities as part of the quality and efficiency agendas thereby making this a mainstream part of commissioning.
- Improving how well services are meeting need requires leadership and ownership across Sheffield. For example, action is needed at the city-wide system level, at different levels within organisations, via the CCG's commissioning and contracting levers, as well as by individual services and health professionals.
- There may be conflict between meeting national targets (for example 4 hour A&E waits) and meeting local needs. We may need to have discussions with regulators about this.
- It is not possible to have an overview indicator/basket of indicators that measures the totality of unmet need in Sheffield in a way that is meaningful.
- If we are successful in identifying and addressing levels of unmet need, this might have resource implications for services. We need to be aware of this and respond appropriately through commissioning. For example, if more underserved populations start using a service through the changes we make, services will be busier. However there will be efficiency gains (fewer DNAs/wasted appointments). Plus it is crucial to remember that these people needed the service (they had the capacity to benefit) therefore are simply accessing help at an earlier stage, which could help reduce unnecessary emergency admissions. Services will need to flex and perhaps be commissioned differently to accommodate this.
- The VCF sector are generally more adept than the statutory sector at reaching out to/finding people who would benefit from their service – statutory sector commissioner and providers could learn from this.

3. Framework for measuring and improving how well services meet need

3.1. Measuring and improving how well services are meeting needs is not a new concept. For years we have been trying to understand how we can improve access to services for underserved groups in order to address the inverse care law, first described in the 1970s.

3.2. The focus has frequently been on changing how individuals behave. For example, improving health literacy so that people recognise they need healthcare, can seek it appropriately, and articulate their issues during a consultation; and training health care professionals in cultural awareness and equality and diversity issues. These are still important aspects of improving how well services are meeting needs.

3.3. In 2013 the Evidence and Ethnicity in Commissioning group[2] (a multidisciplinary team of researchers and healthcare managers working to improve the commissioning and delivery of health services for multi-ethnic populations in England) published two papers on how to improve healthcare commissioning to ensure that services meet the needs of ethnic minorities. Although these papers were specifically focused on ethnic minorities, the same principles apply to all groups with protected characteristics or other vulnerable people.

3.4. The papers propose a framework which has three components:

- Establish an enabling environment at the strategic level
- Enhance enabling factors at the operational level
- Support evidence-informed commissioning

3.5. This can be done by:

- Creating a commissioning environment in the city whereby commissioners routinely include the need to measure how well services are meeting the needs of different population groups into service specifications and contracts. This includes supporting commissioning staff to develop skills in addressing these issues through commissioning levers. It needs to become part of the quality and efficiency agendas, rather being seen as something separate and distinct.
- Creating/supporting the development of a provider environment whereby providers see improving population health (by improving how well services are meeting needs) as a fundamental part of their job. This includes requiring providers to collect, share and act on relevant data about uptake of services by different population groups.
- Ensuring that the key strategic Boards and programmes in the city (eg Health and Wellbeing Board, Better Care Fund/Integrated Commissioning Programme, Prime Minister's Challenge Fund, Vanguards etc) support and help further this agenda – it needs involvement of commissioners, providers and the VCF sector. This agenda needs to become an integral part of these programmes.
- Supporting the join up of work across the city – sharing good practice, showcasing good examples, helping develop the evidence base and using the expertise contained in providers, the VCF sector, and universities.

3.6. Table 1 contains a detailed list of actions that the CCG could take within this three part framework, either as a healthcare commissioner, a system leader, or a membership organisation, to improve how well services are meeting people's needs. It will be useful to focus on some quick wins and showcase current work, but not at the expense of a bigger programme of work.

3.7. Providers, the VCF sector, and communities/service users all have expertise and insight and their full involvement will be critical for success. We should be pushing more for mainstreaming and generic service competence, therefore need to be wary of too many focused areas of work being 'special' services (though equally we need to recognise when a special/separate service is needed).

[2] http://ethnicitycommissioning.group.shef.ac.uk/about.html

4. Possible actions for the CCG to take

- As system leader, the CCG should work to establish a city-wide consensus and commitment to ensuring services are meeting people's needs as this will reduce health inequalities and improve health. This needs to be at the level of Chief Executive.

4.1. Identify lead(s) to develop the framework and associated actions. Ideally these leads would come from commissioning and provider organisations (including the VCF sector) so the work can be developed jointly. This should be a high profile, visible programme of work that includes patient and public participation. It needs to be explicitly integrated into relevant work that's already happening eg the Integrated Commissioning Programme, Prime Minister's Challenge Fund, the Health and Wellbeing Strategy action on 'improving access to services', etc.

4.2. Identify a CCG lead to ensure the framework and relevant actions are incorporated into CCG commissioning, so that it becomes 'just how we do business'.

4.3. Develop monitoring and evaluation as part of the programme so we can measure impact.

4.4. The CCG may need to consider discussions with regulators as there is likely to be tension between meeting national targets and meeting local needs.

5. Recommendations for Governing Body

5.1. Governing Body is asked to discuss the paper and consider the actions suggested in section 4.

Paper prepared by Susan Hird, Consultant in Public Health

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

23 October 2015

Table 1: actions for improving how well services are meeting the needs of different population groups[3]

Area	Issue	Action
Establishing an enabling environment at strategic level	Lack of legitimacy and marginalisation of this agenda	Convince key actors that this agenda is compatible with quality and efficiency agendas
		Take steps to pull these agendas together, including resources
		Ensure all staff are aware of legal duties as well as other arguments for mainstreaming this work into commissioning
		Establish a small number of meaningful local targets
	Addressing (in)equalities is seen as difficult, extra, costly, different	Clearly set out the remit of healthcare commissioning in relation to improving how well services are meeting needs, in order to address health inequalities and equalities
		Encourage more creativity in thinking about how healthcare commissioners can be effective (both directly and indirectly) in making progress
		Ensure 'mainstream' healthcare services provide equitable access, experience and outcomes for all Procure additional services where evidence shows there is a clear case for higher quality and efficiency via enhanced offers/specialist services
		Identify both quick wins and longer term goals. Seek to empower and encourage, as well as to challenge
Enhancing enabling factors at operational level	Low levels of organisational skills in this area	Provide comfortable learning spaces for people to increase confidence and competence
		Expect all staff to have a certain level of competence. Appraise this aspect of competence
		Showcase existing practice, drawing out things that didn't work as well as those that did; draw out broader lessons and 'read across' to other areas. Document.
		Reward sharing; discourage silo working. Draw on local, regional and national resources
	Poor use of existing levers/tools in	Ensure that services already commissioned are challenged and supported to improve how well that service meets the needs of all population groups, using the

[3] Adapted from Salway 2012: Some thoughts on making progress on equalities and inequalities work through Sheffield CCG

	commissioning cycle	range of levers/tools available
		Identify existing contracts/service specifications where commissioning managers have included attention to improving this eg via KPIs or service detail – are these being used? Can they be replicated?
		Identify key aspects of service provision that are known to improve experiences/outcomes for particular groups that are not happening routinely enough
		Prioritise action on key areas that are failing (with support from Trust E&D staff)
		Ensure monitoring of some simple, key measures eg DNA rates
	EIAs are tick box exercises	Build in systems to ensure that new redesign work (including decommissioning) takes measuring how well services are meeting needs on board as integral part of process. Support people to do this well (develop appropriate process). Increase confidence and commitment to this aspect of working.
		Draw on key stakeholders/resources to do this – commissioners don't have to have all the answers but they do need to be asking the right questions
	Some issues are long-standing and commissioners cannot make progress alone	Identify areas of persistent inequality in terms of services failing to meet people's needs; develop criteria for prioritising action on a small number of these (need buy-in from providers and strong community/patient input);develop a project delivery approach for these projects
	Lack of join up and learning	Take stock of what's going on, key partners engaged, what's worked well in Sheffield; build on city wide equalities groups so that provider-led equalities initiatives are learned from and supported
		Improve links with the VCF sector and learn from their knowledge and expertise
		Showcase and share learning
Supporting evidence-informed commissioning for improving how well services are meeting needs	Needs assessments including the JSNA are inadequate with respect to measuring how well services are meeting needs	Indicate clearly what sorts of data need to be available
		Challenge and support those who produce key documents to pay consistent and comprehensive attention
		Identify examples from elsewhere that can act as models for good practice
		Draw on other stakeholders to provide complementary information where NHS/LA data are missing/inadequate
		Encourage continuous improvement – where data are missing flag this up; put in place programme for future improvement
	Routine service level	Work to improve collection and reporting of services use/access data in primary care

	data collection is poor – commissioners need to push for improved data from providers; what is there needs to be used	Take stock of which commissioning managers are routinely requesting and receiving service use/access data from providers. Identify how this is happening, lessons to be learned
		Identify a small number of other priority areas to push for regular breakdowns (get buy-in from people on provider side to see value). Must link to clear plans for analyses, taking equity audit approach. For example, looking at DNA rates by ethnicity and postcode and understand reasons for low attendance
		Identify sources of data collected by providers for their own purposes by never/infrequently requested by commissioners
	Evidence on what works/what works at low cost is limited	Draw on support from universities, CLAHRC. Establish systems for systematically accessing and appraising evidence from different sources
		Ensure that new projects are well documented and evaluated. Share widely