A prospective health impact assessment of Plymouth PCT’s Strategic Service Development Plan supporting the Local Improvement Finance Trust
A prospective health impact assessment of

Plymouth PCT’s
Strategic Service Development Plan
supporting the Local Improvement Finance Trust
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- Neil Boot, Development Manager, Plymouth Health Action Zone
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Preface
The Plymouth Health Action Zone has invested in the development of health impact assessment (HIA) through the Environment and Health Programme Board and a programme of work has been developed around an HIA agenda for Plymouth.

Plymouth Primary Care Trust is embarking on a leading edge policy development through a Local Improvement Finance Trust (LIFT), with the aim of delivering lasting improvements to primary care and related facilities and services for the population of Plymouth.

This prospective HIA of the Strategic Service Development Plan (SSDP), which is in support of the LIFT, recognises the significant contribution that the SSDP has in tackling inequalities in health for Plymouth. It affords the LIFT Project Board an opportunity of enhancing the positive health impacts that are evident from the plans, but also to minimise potential negative health impacts that could arise from the implementation of the SSDP over the next twenty years.

The development of this HIA by the Public Health Development Unit, in partnership with the Plymouth HAZ HIA Project, is also seen as step towards the integration of HIA into the PCT's policy making framework thereby contributing to the PCT's role of meeting the health needs of the local population of Plymouth.
Executive Summary

This rapid prospective health impact assessment study of the proposed implementation of a Local Improvement Finance Trust, public-private partnership scheme in Plymouth, is based on the judgements of twenty-five key informants from the Social Inclusion Partnership in Plymouth and is supported by a selected review of evidence of inequalities in health from the published literature. The study identified eight major impact categories and twenty-eight derived impact categories. The impacts are of equal weight, however some major categories generated more impacts than others. Questions for policy debate (below) are suggested and relate to each major category area; responding to these policy questions will offer the LIFT Project Board an opportunity to address positive and negative impacts arising from the implementation of the PCT’s current Strategic Service Development Plan.

LOCALE: Policy Questions
- What range of health needs have been considered when deciding the location of the Local Care Centres and Primary Care Centres?
- What mechanisms have the LIFT Project Board proposed to review the SSDP against the Bradshaw range of health needs? i.e. has an equity profile been proposed?

TRANSPORT: Policy Questions
- What discussions/proposals have taken place between the LIFT Project Board and the Public Transport service providers in Plymouth re transport provision to the new LIFT centres?
- What proportion of the population, who have transport needs and are therefore potentially vulnerable, will rely on public transport to access the LIFT centres?

WORKFORCE: Policy Questions
- How far have the LIFT Project Board’s plans developed towards introducing a sophisticated and holistic approach to workforce planning to meet the staffing needs of the new LIFT centres?
- How confident is the LIFT Project Board that the new LIFT centres will be fully staffed and thereby able to offer the range of services proposed in the SSDP?

SERVICE PROVISION: Policy Questions
- What governance proposals does the LIFT Project Board have which would ensure co-ordination and new service development, e.g. outreach services, across a number of sites in Plymouth so that vulnerable members of the community are not health disadvantaged?
- What quality assurance measures will be used in establishing contracts with support services for LIFT centres, e.g. cleaning, hotel services etc?

HOLISTIC HEALTH: Policy Questions
- In what ways is the LIFT Project Board actively embracing the social model of health for its Centre’s services?
- What proposals are there via the LIFT Project Board for funding arrangements of the voluntary sectors involvement in LIFT services?

SOCIAL CAPITAL: Policy Questions
- How does the LIFT Project Board propose to encourage its Centres to identify with its local community and generate trust and acceptance of services?
- How far will local community acceptance of premises’ appearance influence the design of the new LIFT Centres?

SUSTAINABILITY: Policy Questions
- What processes does the LIFT Project Board have in place to ensure that the best prevailing value for money option re NHS asset usage has been identified and selected?
- What procedures are proposed for the design and build of LIFT premises to take account of the impact on the environment?

SECONDARY CARE: Policy Questions
- What proposals does the LIFT Project Board have in place to monitor the effect on secondary care service demands because of the new LIFT centres?
- What mechanisms are proposed by the LIFT Project Board to evaluate referral patterns from the LIFT centres to secondary care?
A prospective health impact assessment
of Plymouth PCT’s Strategic Service Development Plan
supporting the Local Improvement Finance Trust

Background

The NHS Local Improvement Finance Trust (LIFT) is a Public Private Partnership (PPP), which has been established nationally by the Government to support the modernisation agenda of the NHS Plan (DoH 1999). To implement LIFT nationally, ‘Partnerships for Health’ has been set up as a limited company with the Department of Health (and the NHS) and Partnerships UK (the private sector share-holders). Partnerships for Health will invest in local NHS LIFT Company’s, along with local stakeholders and a private sector partner to build and refurbish primary care premises, which they will own, and to rent accommodation to GPs on a lease basis (as well as other partners such as chemists, opticians, dentists etc).

The Department of Health has approved three ‘waves’ of LIFTs in England; they are intended to focus initially on improving primary care facilities in:

- deprived inner city areas
- areas that have high levels of health need
- areas that have a disproportionately high number of sub-standard premises

Plymouth is part of the second wave of nationally approved Local Improvement Finance Trusts and a LIFT Project Board has been established in Plymouth with representation from the key players in the health and social care community to collaboratively develop a Plymouth LIFT through the PCT’s Strategic Service Development Plan (Plymouth PCT 2003).

The Strategic Service Development Plan (SSDP) provides the framework for investing £40 million in Primary Care infrastructure, over a twenty-year period, through an NHS LIFT arrangement and is largely based upon existing plans and strategies that have been drawn up and agreed with the PCT’s local partners.

The SSDP will be reviewed at least annually and includes:

- a shared vision for primary and community care development based on the health needs of the local population
- delivery of the modernisation agenda for the NHS in Plymouth
- a description of primary care infrastructure investment opportunities which private investors and service providers will be invited to tender for under the LIFT procedures
Rationale for the health impact assessment

The Independent Inquiry into Inequalities in Health (Acheson 1998) recommended that

As part of health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities.

The SSDP and development of a LIFT in Plymouth is a significant primary care policy development for local health and social care services and should have an impact on health inequalities over the next twenty years in Plymouth. The rationale for the prospective health impact assessment (HIA) was four fold. Firstly, to open the Plymouth LIFT to scrutiny through an HIA process, secondly to use the HIA findings as a gauge for selecting a successful private sector partner, thirdly to develop an approach to HIA that could benefit other LIFT initiatives elsewhere, and lastly to use the experience of the HIA as a test-bed for the applicability of using HIA for other PCT policies in the future.

The definition of health and health impact assessment used

The definition of health from the World Health Organisation (1946) offers a broad concept of health and was used as the basis of understanding health in the study.

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition”.

Although this definition has been criticised for its ‘utopian’ view of health, it still forms the basis of the social model of health.

For the purposes of this HIA the ‘Gothenburg Consensus paper’, also from the World Health Organisation (WHO 1999:4), was used as the basis to understand health impact assessment and the nature of health impacts:

Health Impact(s) are the overall effects, direct or indirect, of a policy, strategy, programme or project on the health of a population. (This may include direct effects on the health of the members of the population and more indirect effects through intermediate factors that influence the determinants of health of the population. Such impacts may be felt immediately, in the short term, or after a longer period of time).

Health Impact Assessment is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.

There is no agreed methodology for undertaking an HIA, but they may be conducted retrospectively, prospectively or concurrently; this SSDP HIA was a prospective study.

The purpose of doing an HIA is to help identify negative health impacts which can then be minimised and positive health impacts which can then be maximised (Eliston and Maconachie 2002).
Methods

Research objectives
National funding for LIFT initiatives is granted to areas of deprivation in order to tackle inequalities in health. Drawing upon an inequality in health impact assessment toolkit (Bro Taf Health Authority 2000) the HIA research objectives were shaped around population groups that experience inequalities in health, i.e.,

- Families with children, pregnant women, young children and teenagers
- Vulnerable people, including those who are mentally or physically disabled, frail older people, and those with learning disability and carers
- People who may be disadvantaged by reason of their gender or sexuality
- Black and minority ethnic communities (including asylum seekers) and those who find communication in English difficult

The research objectives of the HIA (agreed in conjunction with the LIFT Project Manager), were to:

- assess potential impacts, negative and positive, on health inequalities arising from the implementation of the SSDP in Plymouth
- inform the further development of the SSDP in order to reduce negative health impacts and to enhance positive health impacts

A statement of health impact assessment intent for the contract bidders was also agreed; the statement of intent forms part of the successful bidding process for contractors to demonstrate how their proposals will reduce negative impacts on health and enhance the positive impacts that might arise from their proposed development.

Health Profile
A mini-health profile of Plymouth was compiled using data and reports relevant to inequalities in health. The profile was included as part of the baseline information in the SSDP prospectus and a summarised version was included in the HIA workshop packs (Appendix 1).

Literature review

Plymouth’s Strategic Service Development Plan was also reviewed and summarised for the workshop participants and included as a separate document in the HIA workshop packs.
Key Informants
Key informants for the HIA workshops were drawn from the Social Inclusion Partnership (SIP), an independent partnership consisting of over 100 signatory organisations, including community groups, the voluntary sector and statutory service providers. One of the aims of the SIP is to tackle social exclusion and to reflect this issue to the Local Strategic Partnership (SIP 2002). A letter was sent to every contact on the SIP database inviting them to participate in a half day HIA workshop on a choice of two dates. Along with the confirmation letter of attendance a summary of the SSDP and prompt questions to identify impacts was also posted to the responders a week in advance of the workshop to enable pre-workshop preparation. Of the 103 invitees, 25 key informants attended the workshop sessions.

Workshop materials
Drawing on the Home Zone guide to doing a prospective HIA (Maconachie and Elliston 2002) a three-hour workshop was devised (repeated on the second day); it consisted of:

- A Task Book for each participant containing:
  - two group work activities (Appendix 2)
  - definitions of health, equality, equity and health impact assessment
  - Prompt questions, to generate debate regarding inequalities and adapted from the Swedish model of HIA in local government [http://www.lf.se/hkb/engelskversion/instruments.htm](http://www.lf.se/hkb/engelskversion/instruments.htm) (Appendix 3)
  - A mini health profile of Plymouth
  - Impact recording charts, which were adapted from the Home Zone HIA chart (Appendix 4)
- A presentation summarising the SSDP and LIFT proposals
- A short presentation on HIA

Key informants were divided into pre-selected groups (five groups in total over the two workshop sessions). A member of the HIA Project Team facilitated the tasks and the discussions were recorded in the facilitators Task books using the impact chart (Appendix 4). Groups first brainstormed what the impacts could be in the short-term (within five years) and as well as over the twenty-year period.

From the brainstorming session the groups were asked to select those impacts that they felt were the most significant and record them on the impact chart (Appendix 4), detailing what the impact was, if it was positive (+) or negative (0), what would cause the impact, who it would particularly affect, when it would occur, the likelihood of it occurring and how it could be measured.

Data analysis
From the Facilitators Taskbooks the impact charts were transcribed into Excel spreadsheet and combined into one chart. Where an impact was mentioned as occurring both in the short and long term, it was disaggregated into two recorded impacts. Where an impact was mentioned as being both ‘definite’ and ‘probable’ it was recorded as ‘definite’ so as not to underrate the impact, (this applied to very few impacts. The total number of disaggregated impacts recorded was 117 (62 positive, 55 negative).

Using grounded theory (Straus and Corbin 1990) as an approach to qualitative data analysis, initial categories themes and sub themes were identified and given a code. The combined chart was ‘coded’ according to the initial categories. From the initial coding, a draft ishikawa (fishbone) diagram, using SPSS Allclear4, was devised to represent initial categories. An ishikawa diagram is a useful tool for visualising cause and effect relationships (Baric and Baric 1995), therefore the SSDP/LIFT is entered at the right on the main bone and major impact categories are added to the back-bone and the smaller bones represent linked
impacts from these categories (derived impacts). Major impact categories and derived impact categories were re-classified as the data was iteratively examined and given a new coding label. Using the new coding all the categories were re-coded and re-sorted and the ishikawa diagram was updated.

From the draft ishikawa diagram, abstract impact categories (holistic health, social capital, sustainability and secondary care) and literal impact categories (locale, transport, workforce, service provision) were identified. The ishikawa diagram was revised to represent the new ordering, with 'literal' impact categories running along the top of the diagram and the more 'abstract' impact categories running along the bottom of the diagram. (Figure 1)

The narrative of the impact assessments can be found in the Findings section of this report, the spread of the impacts across the eight major categories can be seen in Figure 2.

![Ishikawa Diagram](image.png)

**Figure 1:** The ‘Ishikawa Diagram’ showing the Major Impact Categories and the Derived Impact Categories
Issues around ‘Service Provision’, ‘Holistic Health’, ‘Sustainability’ and ‘Transport’ generated the most impacts, however each major impact category is of equal weight in terms of its importance to the next.

Figure 2: Spread of Impacts diagram
THE HEALTH IMPACTS

LOCALE

Definition:  
*The geographical catchment area served by LIFT Local Care Centres and Primary Care Centres, as well as their physical siting.*

<table>
<thead>
<tr>
<th>Major Impact Category</th>
<th>Derived Impacts</th>
<th>Impact certainty</th>
<th>Total Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOCALE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location based on need</td>
<td>Location based on need</td>
<td>D (2)</td>
<td></td>
</tr>
<tr>
<td>Location competition</td>
<td>Location competition</td>
<td>D (1) P (1)</td>
<td>4</td>
</tr>
</tbody>
</table>

LOCALE: Key informants identified four health impacts
- two relate to the location of services on the basis of identified need
- two relate to geographical location creating competition for services.

**Location based on need**

5 Year impacts
*A definite positive impact* of having the ‘Local Improvement Finance Trust’ (LIFT) in Plymouth was that it had been granted to Plymouth because of identified health need. This would be beneficial to all the population of Plymouth and could be measured through patient surveys and uptake of services.

20 Year impacts
*A definite negative impact* of the current SSDP was that it did not appear to re-dress an historical imbalance of where primary health care services are geographically located in Plymouth and therefore how accessible the centres would really be, for example to residents living in deprived areas. This could be assessed through an ‘equity profile’ of primary health service provision against identified health need.

**Location competition**

5 Year impacts
*A definite negative impact* would occur if the siting of LIFT services were not carefully assessed in relation to non-LIFT services in neighbouring areas. This would affect all people living in Plymouth, particularly those in adjacent non-LIFT areas. It could be measured through patient surveys and patient attendance rates.

20 Year impacts
*A probable negative impact* would see the displacement and decline in city centre-based services, particularly voluntary services, if the city were divided into zones where the new LIFT services situated. This would affect people who do not have transport to the new non-city centre based services, as well as the voluntary sector providers. It could be assessed by records held by the Guild of Voluntary Service in Plymouth and a loss in diversity of city centre voluntary sector service provision.
**TRANSPORT**

**Definition:**
The accessibility, availability and affordability of public transport services and wider transport policies in Plymouth

<table>
<thead>
<tr>
<th>Major Impact Category</th>
<th>Derived Impacts</th>
<th>Impact certainty</th>
<th>Total Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSPORT</td>
<td>Accessibility</td>
<td>D (2) P (2) S (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Availability</td>
<td>D (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Affordability</td>
<td>D (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy</td>
<td>S (4)</td>
<td>13</td>
</tr>
</tbody>
</table>

**TRANSPORT:** Key informants identified 13 health impacts
- five relate to transport accessibility
- two relate to availability of transport
- three relate to affordability of transport
- four relate to wider transport policy in Plymouth

**Accessibility**

5 Year impacts
*A definite positive impact* is dependent on having accessible transport services to provide easy access to LIFT centres. *A probable positive impact* would be fewer journeys to Derriford hospital. Accessibility to the LIFT centres affects all of the population in Plymouth, and could be measured by traffic surveys and, more anecdotally, by letters to the Evening Herald.

20 Year impacts
Longer term *definite and probable positive impacts* of accessible transport mirror those within five years. *A speculative negative impact* of having fewer but larger primary care centres would mean further distances to travel for some residents. Distance to travel particularly affects elderly, disabled, parents with young children residents in Plymouth. It also affects staff. This could be measured by the uptake of services.

**Availability & Affordability**

5 Year impacts
*Definite negative impacts* will occur if public transport to LIFT centres is not frequent and subsidised and if there are car-parking charges at LIFT centres. This will particularly affect elderly, disabled, parents with young children, as well as any other patient or service user with out a car. Car parking charges will affect private transport users.

20 Year impacts
*Definite positive impacts* of having a frequent and subsidised public transport service would benefit the elderly, disabled, and parents with young children over the longer-term. The short term and longer-term impacts of available transport could be measured through the uptake of LIFT services of different patient groups, monitoring letters of complaint to Plymouth City Council re transport provision and public letters to the Evening Herald.
**Transport Policy**

5 Year impacts
Speculative negative impacts include more congestion and pollution and less access to services because of road congestion and failure to link into a citywide transport strategy. This will affect all road users, people on low incomes and residents in the area of LIFT centres.

20 Year impacts
Speculative negative impacts would be felt over the longer term by providing car parking at LIFT centres instead of encouraging cheap buses. This would affect all patients and road users; short and long-term impacts could be measured by public transport surveys.

**WORKFORCE**

Definition:
Professionally qualified, including clinical and non-clinical staff, support and ancillary staff, unpaid staff, e.g. hospital visitors and volunteers

<table>
<thead>
<tr>
<th>Major Category</th>
<th>Derived Impact</th>
<th>Impact Certainty</th>
<th>Total Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>WORKFORCE</td>
<td>Employment opportunities</td>
<td>S (4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational health</td>
<td>S (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff retention</td>
<td>P (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shortages</td>
<td>D (1) S (2)</td>
<td>11</td>
</tr>
</tbody>
</table>

WORKFORCE: Key informants identified 11 health impacts
- five relate to employment opportunities
- two relate to occupational health
- two relate to staff retention
- three relate to staff shortages

**Employment opportunities**

5 Year impacts
Speculative negative impacts were predicted from having new employment opportunities at new LIFT centres which would draw staff away from the acute care provider in Plymouth.

20 Year impacts
A speculative positive impact of the SSDP is that it will provide a good setting for employment and could make existing staff more available, providing flexibility in employment opportunities. However, as in the short term above, a speculative negative impact is that staff will be drawn from Derriford hospital to staff the new LIFT centres. In the short and long term, this could affect staff recruitment and retention rates at the Derriford Hospital site. The impacts could be measured through staff turnover and recruitment at Derriford.
**Occupational health & staff retention**

**5 Year impacts**
A probable positive impact is predicted for improved staff recruitment and retention at the LIFT centres, and speculatively there will be less staff illness due to a good environment and having less staff working from one site.

**20 Year impacts**
Longer-term positive impacts reflect those in the short term. All staff employed in the new LIFT centres will be affected; the impacts could be monitored by occupational health and staff sickness rates.

**Staff shortages**

**5 Year impacts**
A definite negative impact will arise from a national shortage of skilled staff to fill vacancies at the LIFT centres, and speculatively Plymouth may increase a demand for skilled staff that cannot be met.

**20 Year impacts**
The speculative negative impact of lack of skilled staff in the labour market will continue with supply not meeting local demands. The short and long term impacts will affect all LIFT centres; measurement could be through staff vacancies unfilled and agency staff use levels.
SERVICE PROVISION

Definition:
The governance and range of primary health care and local care centre services provision in Plymouth, including supportive services, e.g. hotel services etc

<table>
<thead>
<tr>
<th>Category</th>
<th>Impact</th>
<th>Impact certainty</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE PROVISION</td>
<td>Integration</td>
<td>S (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fragmentation</td>
<td>S (6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accessibility</td>
<td>D (4) P (8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outreach</td>
<td>D (4) P (4) S (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flexibility</td>
<td>D (1) P (2) S (5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support services</td>
<td>S (3)</td>
<td>40</td>
</tr>
</tbody>
</table>

SERVICE PROVISION: Key informants identified 40 health impacts
- one relates to service integration
- six relate to service fragmentation
- 12 relate to accessibility of services
- 10 relate to outreach services for vulnerable groups
- eight relate to flexibility of service provision
- three relate to supporting services

Service integration

20 Year impacts
The integration of mental health services into primary health care was predicted to be a speculative positive impact and could result in less stigma attached to mental health issues. It would affect people with mental health problems and could be measured through social services statistics and users surveys.

Service fragmentation

5 Year impacts
If services are dispersed across Plymouth e.g. language translators, a speculative negative impact might occur for service delivery. It would affect users of specialist services, e.g. black and minority ethnic groups and refugees.

20 Year impacts
Speculative negative impacts in the longer term included concern over the dispersal of specialist services across Plymouth, but also referred to limited resources for social services staffing across a range of new sites and a concern that services, unless well co-ordinated, services might become fragmented. This would affect users of specialist services and social care services, e.g. people on low incomes, families with children etc. These impacts could be measured through surveys of referrals to services.
Service accessibility

5 Year impacts
Definite positive impacts included having easier access to primary health services due to longer and more flexible opening hours in the new LIFT centres. This would benefit all users and could be measured by service uptake rates. Probable positive impacts included easier access to services for minor operations and emergency care due to the modern care systems put in place. These impacts would benefit patients in need of minor surgery, for example, and could be measured by patient activity data. A probable negative impact might be reduced access to services as practices go through closure and then re-open in new centres.

20 Year impacts
The positive impacts of easier access to primary health care and minor surgery facilities would continue in the longer term (discussed above), benefiting all users of the services. The impacts could be measured through GP activity rates and social services data.

Outreach services

5 Year impacts
A definite positive impact would be achieved with the opportunity for a fresh start for primary health care services to have equality of access for black and minority ethnic groups to improve their health care experience. This would be caused by centres that were purpose built and based on good practice and could be measured by users surveys.

Probable positive impacts included improving access for people who have been previously excluded from services, and the opportunity to establish well-sited specialist services for young people, e.g. sexual health advice services. These impacts could affect homeless people in Plymouth; young adolescents and would be caused developing new services, e.g. drop services.

Barriers to service uptake however may result in a speculative negative impact if specialist services are not provided in the appropriate areas, e.g. for black and minority ethnic people. This might be caused by lack of specialist services, for example translators and could be measured by surveys.

20 Year impacts
The definite and probable impacts of new outreach services (discussed above) would continue over the longer term, benefiting groups previously excluded from health care services such as homeless people and travellers.

Outreach services that ensured equity of service uptake by black and minority ethnic groups however would require a culture shift in Plymouth, without which a definite negative impact would occur for their health care experience. This impact affects all users, including staff of primary care and could be measured through surveys.

A speculative negative impact might arise if services are not developed to promote men’s uptake of primary health care. This impact could be measured through surveys and patient activity data.
**Service flexibility**

5  
**Year impacts**  
A *definite positive impact* will occur if larger primary care centres under LIFT employed more female clinicians than at present. This would affect female patients in particular who may prefer to consult a female clinician, the impact could be measured by monitoring the gender mix of clinicians employed at the LIFT centres.

A *definite negative impact* will occur if LIFT centres offer drop-in facilities. It will affect non-drop in GP practices who could lose patients from their lists, the impact could be measured by comparing patient activity rates across practices.

*Speculative negative impacts* included a conflict of users interests at primary care centres, for example the needs of older people verses setting up a youth club from the centre. Also *speculatively*, black and minority ethnic groups’ needs might be unmet through the lack of specialist translation services.

20  
**Year impacts**  
*Probable positive impacts* included longer opening hours offering service flexibility and primary care centres adapting themselves to the specific needs of their local community. This would affect asylum seekers, black and minority ethnic groups, and other members of the local community and could be measured through service surveys.

Longer-term *speculative negative impacts* reflected those in the short term (discussed above).

**Support services**

5  
**Year impacts**  
A *speculative negative impact* was predicted from using different private contractors employing low paid staff for support services, e.g. cleaning contractors and the complex accountabilities that might arise for premises cleanliness. This impact could be assessed from management reports and staff and patient surveys.

20  
**Year impacts**  
A *speculative positive impact* however suggested that there might be improved cleanliness in the new LIFT centres, compared to large hospitals. This would affect all staff and users and could be assessed through setting up a research project.

The *speculative negative impact* of using a variety of different private contractors for support services (discussed above) was reflected again as a concern in the longer-term.
HOLISTIC HEALTH

Definition:
*Health is more than illness; it is a broad concept and includes well-being and quality of life*

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**Holistic Health:** Key informants identified 22 health impacts
- 13 impacts relate to the social model of health in services and facilities
- six impacts relate to funding issues for the voluntary sector
- three impacts relate to the involvement of the voluntary sector

**Social model of health**

**5 Year impacts**
*Positive impacts* (definite, probable and speculative) were identified from providing traditional health services (medical model of health) along with other services such as welfare benefits advice, libraries, credit unions, swimming pools (social model of health) etc in LIFT centres. People who would particularly benefit would be those on low incomes, and people who needed access to fitness centres to improve their health. These impacts could be measured by user surveys and attendance statistics and by adopting the healthy living centre concept as part of LIFT.

**20 Year impacts**
*Definite positive impacts* were predicted in the longer term of LIFT contributing to healthy public policy development for all of Plymouth by increasing the opportunities for health promotion.

*Probable positive impacts* included having the healthy living centre model adopted, e.g. counsellors could increase the uptake of benefits if they are placed in the LIFT centres, and there would be easier access to physical activity and leisure services.

*Speculative positive impacts* predicted that broad models of health could influence the planning of health services and that primary care would be less GP focused and involve more community initiatives such as benefits advice.

People particularly affected by these impacts would be people on low incomes, and those without access to transport, the impacts could be measured by self-reported health statistics, and referral rates to different services.
Voluntary sector funding & involvement

5 Year impacts
A definite negative impact was predicted in relation to tackling inequalities in health if funding is not secured for voluntary sector provision e.g. welfare benefits advice as part of LIFT services.

Speculative negative impacts included concern over potentially complicated service level agreements from LIFTco with the voluntary sector with less funding available. There was also concern that ‘hospital volunteers’ would be stretched to meet the needs of dispersed LIFT services and that the SSDP did not appear to have built in voluntary and community sector involvement in its plans.

These impacts would particularly affect voluntary sector providers in the city, including volunteers, as well as the poorer members in the community. Impacts could be assessed by evidence of benefits uptake and surveys.

20 Year impacts
The definite negative impact of not identifying funding for voluntary sector provision as part of LIFT was re-iterated with a long-term impact on poorer members of the community.

Speculative negative impacts in the long-term raised concern that a private sector company’s interests my be at variance to public sector interests; concern was also re-iterated over complex funding agreements and potentially decreasing ‘small grants’ provision for the community and voluntary sector. These impacts would particularly affect all users of the voluntary sector. Impacts could be assessed by evidence of benefits uptake and funding allocated to voluntary services.
SOCIAL CAPITAL

Definition:
The extent to which primary care services contribute a community identity and the relationship services have to individuals in the community

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<td>Community ownership</td>
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SOCIAL CAPITAL: Key informants identified 10 health impacts
• two relate to community cohesion
• four relate to primary care relationships with the community
• four relate to community ownership of primary care services

Community cohesion & community relationships

5 Year impacts
A probable positive impact was predicted through the LIFT centres providing new resources in the community such as parent support groups, health education, AA groups, mums and toddlers groups etc. This would affect young families for example, vulnerable adults and could be measured through GP surveys and activity levels.

However, large and impersonal LIFT primary care centres were thought to have speculative negative impact to community uptake of services. This impact could affect all users and could be assessed by activity rates.

20 Year impacts
A definite positive impact of improved community relationships was predicted from larger primary care centres offering more choice in whether to see a male or female clinician.
Probable positive impacts in the longer term included improved community relationships with GP services because of new decentralised services to primary care.

These positive impacts would particularly affect women as well as the immediate community in which the services are located and could be assessed through GP surveys and monitoring the gender mix of clinical appointments in LIFT centres.

Probable negative impacts of having large LIFT centres and impersonal relationships with the local community were also raised over the long term.
Community ownership

5 Year impacts
A probable positive impact of an increased sense of community ownership was predicted from having LIFT centres accessible to the community, however there could be a probable negative impact of disenfranchising marginalised groups from the new LIFT services, e.g. homeless people, because services were being provided with an ‘establishment image’.

20 Year impacts
The positive and negative impacts in the longer term mirrored those in the short term and would particularly affect marginalised groups, young men and black and minority groups. The impacts could be assessed by monitoring the uptake by different socio-economic groups and patient activity rates in the centres.

SUSTAINABILITY

Definition:
The influence that NHS asset-use has on local economic, social and ecological sustainability

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SUSTAINABILITY: Key informants identified 14 health impacts
- five relate to the use of NHS assets
- two relate to the impact on the local economy
- two relate to regeneration and neighbourhood renewal
- five relate to local ecological issues

NHS Assets

5 Year impacts
A speculative negative impact was predicted from the public perceiving LIFT as the privatisation of the NHS, it could be assessed by user satisfaction surveys.

20 Year impacts
If NHS land was not sold off in-order to build LIFT centres, a definite positive impact was predicted, however a definite negative impact as also predicted if NHS was sold off to private companies on which to build the LIFT centres. Financial loss was also predicted as a speculative negative impact if inappropriate services were located in areas of deprivation, which required fees for access or use, e.g. swimming pools. These impacts could be assessed by comparing land on the NHS asset register now and again in twenty years time and through financial accounting processes. It was felt that these NHS asset and financial issues would affect the whole community of Plymouth.
Local economy & regeneration

5 Year impacts
The local economy would probably benefit from the commitment of LIFT if it encouraged local sourcing of employment and materials. This was viewed as a positive impact and would affect local businesses and employees.

20 Year impacts
The positive probable impacts of LIFT using local materials and workforce to develop LIFT would continue over the longer term, but also could include positive impacts of integrating the SSDP plans with regeneration and neighbourhood renewal initiatives. These impacts would benefit people living in disadvantaged area of Plymouth.

Local ecology

5 Year impacts
Speculative negative impacts were predicted in the short-term if LIFT new-build threatened exiting green spaces available at Mount Gould, also if the whole LIFT process is not linked into sustainable transport plans.

20 Year impacts
Definite positive impacts of reduced local pollution and lowered running costs were predicted if LIFT buildings built in efficiency and low environmental impact measures into their design. Speculative negative impacts reflected those discussed above.
SECONDARY CARE

Definition:
Service demands on secondary care arising from the implementation of the LIFT

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SERVICE DEMANDS: Key informants identified three health impacts
- one relates to an increase demand for secondary care services
- two relate a decrease in secondary care service demand

Service demands

5 Year impacts
It was predicted that a probable positive impact would be less demand on secondary care services, this would be caused by the introduction of new local services in primary care, longer opening hours, greater flexibility in local service provision etc.

20 Year impacts
Positive impacts reflected those in the short term, however a speculative negative impact might be increased demands on secondary care services through the extra availability of primary care services, which then referred onto secondary care.

These short and long-term impacts would affect all users of primary and secondary care and could be measured through hospital and primary care activity data and user surveys.
DISCUSSION & POLICY REVIEW QUESTIONS

This section of the report brings together the judgements of the key informants in the study as well as evidence from the published literature. One of the values of HIA is to improve public health, normalised through policy development (Elliot 2001). It is from this perspective of normalising health improvement through policy development that two policy questions are posed for the eight major impact category areas. It is hoped that the LIFT Project Board will reflect and respond to these questions in order to enhance positive health impacts and minimise negative health impacts raised in this study. Five key health impact assessment questions for bidders are also raised in Appendix 5.

Geography, health need and equity
The geographical catchment areas that are served by LIFT Local Care Centres and Primary Care Centres, as well as their physical siting will have important consequences for meeting health needs in Plymouth. Key informants welcomed the investment in primary care for Plymouth brought about by the national LIFT initiative, however the notion that the location of services described in the SSDP had been based on identified need was questioned. The SSDP states that it sets out a strategic framework for investment in primary care infrastructure through a LIFT arrangement that incorporates “a shared vision for primary and community care development based on the health needs of the local population”. The geography of health service location is closely associated with equity (fairness) of access by different population groups with the result the ‘inverse care law’ becomes apparent, i.e.

“Communities in greatest need are least likely to receive the health services that they require” Health Inequalities, a framework for good practice in primary care (Northern & Yorkshire Modernisation Board 2001).

The term ‘health need’ is not explicitly defined in the current SSDP prospectus however, the health status of the population is well documented and the rationale for the two Primary Care Centres as well as services for the Local Care Centres are well evidenced. Bradshaw (see Edwards and Darch 1996) offers a taxonomy of ‘needs’ that comprises four elements:

- **Normative need**: where the need has been defined by the expert of professional
- **Felt needs**: what people want
- **Expressed need**: is felt need expressed as a demand for services
- **Comparative need**: which is the measure of the differences between the service levels in two similar populations

The geographical location of the LIFT centres and their new services will affect the supply and demand for services located in other areas. Key informants raised concern that the impact on other services, notably voluntary, would probably be negative over the long term as those services would lose demand to new services established elsewhere.

**Policy Questions:**
- What range of health needs have been considered when deciding the location of the Local Care Centres and Primary Care Centres?
- What mechanisms have the LIFT Project Board proposed to review the SSDP against the Bradshaw range of health needs? i.e. has an equity profile been proposed?
Transport
The accessibility, availability and affordability of public transport services and wider transport policies in Plymouth are significant contributing factors to the success, uptake and acceptance of new LIFT centres in Plymouth. Key informants identified that the new LIFT services would be utilised if public transport provision was frequent, reliable and easily accessible and subsidised, especially for vulnerable members of the community, such as the elderly, disabled and parents with young children.

"Access should be considered as an integral part of the health care package, rather than extraneous to it. For example, services that can be reached only by car……usually reduce access for more deprived groups." Promoting equity in healthy care (Donald 2001).

Public transport does serve the Mount Gould area (Plymouth City Council 2000). However a resident living either in Plympton or Plymstock and reliant on public transport, e.g. a Plymouth City bus to go to Mount Gould, (the proposed location of a Local Care Centre), would currently have to take two buses, change buses in the city centre, and have a journey time of approximately fifty and forty minutes respectively.

With nearly 16% of Plymouth’s population in retirement age (SSDP pp 4) the transport needs of older residents in an ageing population needs to be considered along with the distance to walk to the new LIFT centres for those disabled, or who have to manoeuvre push chairs etc. Without adequate transport provision, the LIFT services’ acceptability and uptake would be detrimentally affected in the view of the key informants.

Policy Questions:
• What discussions/proposals have taken place between the LIFT Project Board and the Public Transport service providers in Plymouth re transport provision to the new LIFT centres?
• What proportion of the population, who have transport needs and are vulnerable, will rely on public transport to access the LIFT centres?

Staffing new LIFT Centres
The provision of new LIFT Centres in Plymouth offers a paradox for employment opportunities for medical, non-medical and social care staff. Opportunities will exist for employment in purpose built and fit for purpose premises, which is obviously welcomed with related benefits to patient care and staff health, however the pool from which to recruit new staff is limited. Staff may be attracted from the Hospitals NHS Trust in Plymouth to the new LIFT centres, exacerbating any staff retention issues, and there is a national shortage of staff across a range of disciplines.

"General practice and nursing are both experiencing quite severe shortages as part of a wider recruitment and retention problem, which also affects NHS services as diverse as dentistry and physiotherapy." Staffing the NHS (Kings Fund 2001)

The NHS Plan (Department of Health 2000) has set in motion a training and recruitment strategy for medical staff and nurses with more staff being available by 2008. The impact of national labour market shortages is however outside the control of the LIFT Project Board.
Policy Questions:

- How far have the LIFT Project Board's plans developed towards introducing a sophisticated and holistic approach to workforce planning to meet the staffing needs of the new LIFT centres?

- How confident is the LIFT Project Board that the new LIFT centres will be fully staffed and thereby able to offer the range of services proposed in the SSDP?

LIFT Services; health advantage or disadvantage

The governance arrangements, as well as the range of service provision through LIFT centres in Plymouth, have a number of health impacts for the population of Plymouth. Key informants judged that the integration of mental health services might see less stigma attached to mental health issues. However, if other specialist services are spread thinly across Plymouth and become fragmented and lack co-ordination over time, it was felt that vulnerable groups, (people on low incomes, poorer families with children), would be disadvantaged.

Positive outcomes were predicted for population health through the new LIFT centres offering flexible opening hours and better access to a range of locally based services with drop in services and more services for women’s health. However, service needs of groups would need to be carefully balanced to ensure one group’s needs did not take undue precedence over another.

Developing outreach services offers an opportunity for primary health services to reach black and minority ethnic groups, young people, the homeless, travellers and asylum seekers. However services would need to be developed that were sensitive to each groups needs and developed in an ethos of support, otherwise there is the potential of health needs remaining unmet in these groups.

Asylum seekers have difficulty in finding information on health services, in particular primary care. Furthermore, a problem often faced by healthcare professionals is their own lack of knowledge about other services and support which could help asylum seekers. Asylum seekers, meeting their health needs. (BMA 2002)

The contract arrangements of supporting services for the LIFT centres were of some concern to the key informants, e.g. the standard of cleaning services and hotel services etc. could be affected. However, it was noted that the smaller LIFT centres might have higher standards of environmental cleanliness compared to larger hospital sites.

Policy Questions:

- What governance proposals does the LIFT Project Board have which would ensure co-ordination and new service development, e.g. outreach services, across a number of sites in Plymouth so that vulnerable members of the community are not health disadvantaged?

- What quality assurance measures will be used in establishing contracts with support services for LIFT centres, e.g. cleaning, hotel services etc?
**Broad definitions of health**

Health is about more than illness; it is a broad concept and includes well-being and quality of life; the LIFT Centres offer the potential of embracing the concept and thereby promoting the health of the population of Plymouth. Key informants identified that providing traditional medical services along with advice services, leisure facilities and so on offered scope for health improvement and health promotion for vulnerable members of the community, especially if the services were modelled on a ‘healthy living centre’ concept. Conversely, however, it could prove problematic in tackling health inequalities if funding arrangements were overly complex, or were not secured for the voluntary sector in order to contribute to a social model of health.

To secure an infrastructure for health promotion, new mechanisms for funding it locally, nationally and globally must be found. Incentives should be developed to influence the actions of governments, nongovernmental organizations, educational institutions and the private sector to make sure that resource mobilization for health promotion is maximized. *The Jakarta Declaration* (WHO 1997)

**Policy Questions:**

- In what ways is the LIFT Project Board actively embracing the social model of health for its Centre’s services?
- What proposals are there via the LIFT Project Board for funding arrangements of the voluntary sectors involvement in LIFT services?

**Identifying with the Community**

The extent to which primary care through LIFT contributes to a community identity and the relationship that the services have to individuals in the community are important factors for the sense of ownership that the community feels for its local services. Key informants identified that community cohesion and community relationships with primary care would be strengthened through the provision of community-based services, e.g. health education, mums and toddlers groups etc. The design of LIFT centres should also be considered for the level of acceptance by the community, i.e. too large and they will become impersonal and might disenfranchise certain members of the community from using them, e.g. homeless people may be deterred because of an establishment image.

Twenty years ago (1970s) health centres represented some of the most modern premises in the region and high hopes were vested in them. They were developed particularly within the county of Devon through a health centre building programme…….health centres unfortunately have not fulfilled these hopes. *Planning Primary Care* (Pereira Gray 1992).

**Policy Questions:**

- How does the LIFT Project Board propose to encourage its Centres to identify with its local community and generate trust and acceptance of services?
- How far will local community acceptance of premises’ appearance influence the design of the new LIFT Centres
Asset use
Key informants predicted that NHS asset-use has a range of health impacts on local economic, social and ecological sustainability. The debate over the privatisation of the NHS via LIFT was raised as a speculative negative impact in the short term; it was felt that the decision to either retain or to sell NHS land would have positive and negative impacts respectively over the long term. Keys informants were positive about LIFT sourcing local businesses and employment opportunities to build the LIFT centres and the natural links to renewal and regeneration. Positive impacts were also predicted in the long term if the building design incorporated environmental impact measures. There was some concern however that the local environment might be affected if greenfield sites were chosen for LIFT developments and whether there was an intention to link into sustainable transport plans.

Primary Care Trusts will need to ensure that all costs, opportunity costs and the effects on local health economies have been fully accounted for. They will also need to ensure that they have put in place clear safeguards for monitoring quality. *Public, private partnerships and primary care. (Kings Fund and the NHS Alliance 2001)*

Policy Questions:
- What processes does the LIFT Project Board have in place to ensure that the best prevailing value for money option re NHS asset usage has been identified and selected?
- What procedures are proposed for the design and build of LIFT premises to take account of the impact on the environment?

Down-stream services
Key informants predicted that there might be changes on the level of service demands in secondary care arising from the implementation of the LIFT. For example, positively, there may be less demand on secondary care services because of new services operating at a primary care level, however it was also felt negatively, but with less certainty, that demand on secondary care services might increase as the new primary care services referred more patients onto secondary care.

Evaluation and monitoring systems will determine where objectives are being met or where they require attention, their level of impact, and contribute to the development of new approaches that will be of greatest benefit, using existing resources. The aim will be to provide the information needed to assess policy impact at all levels. *Health for All in the Twenty-first century (WHO 1995)*

Policy Questions
- What proposals does the LIFT Project Board have in place to monitor the effect on secondary care service demands because of the new LIFT centres?
- What mechanisms are proposed by the LIFT Project Board to evaluate referral patterns from the LIFT centres to secondary care?
Study Limitations

The study is a rapid prospective and desktop health impact assessment; timing and staffing resources did not permit a comprehensive HIA (see Ison 2000), to be undertaken and it is based on the HIA judgements of the key informants drawn from the Social Inclusion Partnership (SIP) along with reference to the published literature. Whilst the SIP is an appropriate pool from which to draw views, the key informants attending the HIA workshops were those who responded to the invitation, i.e. self-selected. Self selection may lead to bias in views expressed, for example if there were a particular interest group attending. The SIP does not represent geographical communities in Plymouth. However, as this study operated at a policy level it was believed that the key informants views were well informed on health and social policies in Plymouth due to the nature of the partnership, and provided valuable insights. The key informant’s views however should not be taken as representative of the total population of Plymouth and could not be generalised elsewhere. It is recommended that the findings from this HIA study should be read in conjunction with the outcomes of the public consultation exercise and other stakeholder events under the LIFT scheme.

CONCLUDING REMARKS

The introduction of a Local Improvement Finance Trust in Plymouth over the next twenty years intends to focus on the health needs of deprived areas, and to invest in primary care infrastructure replacing sub-standard and no longer fit for purpose premises. This is the first rapid prospective health impact assessment study undertaken by the Primary Care Trust on one of its major policies of investing in improving the primary health care experience for the population of Plymouth.

Some of the impacts identified in this HIA are outside the control of the LIFT Project Board, i.e. reconciling new employment opportunities in LIFT Centres against a backdrop of national labour market shortfalls. Some impacts are more in-direct, i.e. the changes in service demand for secondary care, other impacts can be directly influenced by the LIFT Project Board’s intervention, for example the provision of public transport services to the LIFT centres plays an important role in their uptake and acceptance by the public.

This prospective HIA contributes to the dialogue of implementing a new government initiative for public-private partnerships in the NHS, it has raised positive and negative consequences of implementing the current SSDP and the LIFT Project Board is afforded an opportunity to evaluate all the impacts; to enhance the positive impacts, and where possible minimise negative impacts through policy discussion responses. The policy questions in the discussion section are therefore designed to promote debate within the PCT and the LIFT Project Board and to act as signal to the health impact issues that may be raised in the selection of the private sector partner for the LIFT in Plymouth.

Clearly, there are benefits from the early involvement of key informants in identifying health impacts arising from the development and implementation of a policy. With second tranche LIFT Centres proposed, there is an opportunity to consider undertaking a comprehensive HIA study, allowing for a longer lead in time and wider stakeholder involvement with the local community. For the PCT there is also the opportunity to consider using this study as a model for integrating HIA into other PCT policy areas within its sphere of influence.
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<td>Northern &amp; Yorkshire Modernisation Board ((2001) (WWW)</td>
<td>Health Inequalities, a framework for good practice in primary care. <a href="http://www.haznet.co.uk">www.haznet.co.uk</a> Site accessed 11/12/02</td>
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Plymouth Primary Care Trust (2003) Strategic Service Development Plan to support the Local Improvement Finance Trust. Plymouth: Plymouth Primary Care Trust


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Appendix 1: Plymouth Health Profile

Plymouth mini-health profile

- In 2001, the GP registered population of Plymouth was 259,396 people, of which 128,410 (49.5%) were male and 130,986 (50.5%) were female. 5.2% (13,661) of the GP registered population were under 5 years of age and 15.4% (40,071) were post retirement age, and of these 12.4% (5,002) were aged 85 plus.
- The 2001 Census gives a resident population for Plymouth of 240,718 of which 117,558 (48.8%) were males and 123,160 (51.2%) were female. 5.4% (13,221) of the resident population were under 5 years of age and 15.9% (38,477) were post retirement age, and of these 12.3% (4,770) were aged 85 plus.
- The variation between the GP (registered population) and the Census (resident population) is likely to be the result of people living outside the City being registered with City practices.
- According to the 1991 Census, Plymouth’s ethnic minority groups accounted for less than 1% of the total population. This figure is expected to have increased when the 2001 Census results become available.
- The initial results from the 2001 Census (see population pyramid below) shows that Plymouth has a similar demographic structure to the national average, with the exception that there are more people in the 15-24 year old age group.

Inequalities in Health

- People living in Plymouth wards cover the extremes of affluence and poverty and their health experience reflects this. The following statistics reveal marked differences in the health of the population, in access to health care and in the level of risk factors for developing health problems.

Live Births and Infant Mortality

- In 2000, there were 16 infant deaths in Plymouth, which is higher than the national average.

Low Birth Weight

- Within Plymouth in 2000, 12.7 of live births in St Peter ward were under 2500 grams, compared to Plymstock Radford ward where no babies were born under weight.
Deaths
- Standard Mortality Rates (SMRs) are one measure to gauge the health of an area and values greater than 100 are indicative of poor health status (compared to England and Wales generally) and vice versa
- The SMR for all causes of death and all ages in Plymouth was 98 in the period 1998-2000, which appears to indicate that Plymouth is a relatively healthy place to live
- However, in the same period, 14 of the 20 electoral wards in the city had SMRs in excess of 100 for people aged under 75, indicating the extent of poor health status within the City.
- Clearly, the city-wide average masks the considerable health inequalities that exist.

Life Expectancy at Birth
Life expectancy at birth in Plymouth (1998-2000) for males was 75.3 years and 80.6 for females, compared to the UK figures of 75.2 and 80.1 respectively
Of the twenty wards in Plymouth, there is a six year difference in life expectancy at birth between the top ranked ward, Plymstock Radford, of 81.1 years compared to the lowest ranking, Stoke Ward, which had a life expectancy of 74.4

Leading Causes of Death
- Deaths from cancers and circulatory diseases account for 65% of deaths and for 21869 actual years of life lost (up to ages 75) of Plymouth residents
- Residents who live in deprived areas of Plymouth suffer more from these illnesses and die from them earlier

Deprivation
- The index of Multiple Deprivation 2000 (IMD2000) is the current official measure of deprivation
- On two other commonly used measures of deprivation (the Jarman Score and the Townsend Score) Plymouth City ranks 64th and 67th respectively out of 354 local authorities (1st being the area with the highest levels of deprivation)
- There is a considerable difference in Plymouth between wards on the IMD2000 ranging from 249th for St Peter ward to 5719th for Plymstock Dunstone ward where 1 is the most deprived ward in the country and 8414 is the least deprived

Plymouth Wards: Index of Deprivation
Appendix 2: Small Group Work Tasks

PART 1: Brainstorming session (15 minutes)

Working in your groups and using a broad definition of health, we would like you to:

1) Brainstorm on the worksheets A* & B*, the potential health impacts that might arise from implementing the SSDP
2) Distinguish between impacts that may arise in the short term (within 5 years) and longer term impacts that may arise over the 20 year period
3) Distinguish between positive and negative impacts
4) Consider the impacts on specific groups of people in the population of Plymouth:
   - Families with children, pregnant women, young children and teenagers
   - Vulnerable people, including those who are mentally or physically disabled, frail older people, and those with learning disability and carers
   - People who may be disadvantaged by reason of their gender or sexuality
   - Black and minority ethnic communities (including asylum seekers & refugees) and those who find communication in English difficult


Group Work Part 2: Identifying the Impacts (60 mins)

Using worksheet C & D*, select the impacts you consider most significant (use your lists from worksheet A & B)

Completing Worksheet D

Name the impact (Column 1)
State whether it is a positive or negative impact (Column 2)
State when the impact will occur (Column 3)
List what is likely to cause the impact (Column 4)
Say who is most likely to be affected from the different groups of people (Column 5)
Decide how likely it is that the impact will occur (Column 6)
State how it will be possible to find out whether or not the impact has occurred (Column 7)
Appendix 3: Group discussion prompts

WORKSHEET C: IDENTIFYING THE IMPACTS – ISSUES TO CONSIDER
(refer to the Evidence on Inequalities for more information)

- What health impact(s) will the provision of new Local Care Centres & Primary Care Centres have on communities that tend to experience the least satisfactory access to health care services, e.g. those on low pay and the long-term unemployed, minority ethnic communities, hard to reach women in deprived areas with preventative services such as breast and cervical screening etc?

- Are there particular health risks in the different groups (below) that can be expected to decrease or increase as a result of implementing the Strategic Service Development Plan (SSDP)?

- What impacts on health will become apparent in the short term (within 5 years) and in the long term (over 20 years)?

- Will the SSDP proposal promote or limit access to services for the groups described below; e.g. are there regular public transport services, are they affordable?

- What are the potential health impacts for other health and social care providers in the City because of the SSDP, e.g. Derriford Hospital, community and voluntary groups?

- What health impacts might arise in the short or long term, for the population of Plymouth through the management of the Local Improvement Finance Trust (LIFT), e.g. commitment to community involvement in service planning?

Groups:
- Families with children, pregnant women, young children and teenagers
- Vulnerable people, including those who are mentally or physically disabled, frail older people, and those with learning disability and carers
- People who may be disadvantaged by reason of their gender or sexuality
- Black and minority ethnic communities (including asylum seekers) and those who find communication in English difficult
### Appendix 4: Impact recording chart

**SSDP Impact on Inequalities Worksheet D**

<table>
<thead>
<tr>
<th>IMPACT</th>
<th>TYPE</th>
<th>TIMING</th>
<th>CAUSES</th>
<th>AFFECTED PARTIES</th>
<th>LIKELIHOOD</th>
<th>MEASUREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better access to primary health care</td>
<td>+</td>
<td>ST &amp; LT</td>
<td>Building primary care centres</td>
<td>All population of Plymouth</td>
<td>D</td>
<td>Patient satisfaction surveys</td>
</tr>
<tr>
<td>?Shift in workforce from PHT to PCT</td>
<td>0</td>
<td>ST</td>
<td>New posts in the Local Care Centres will attract experienced staff from the PHT</td>
<td>Delivery of health care services at Derriford</td>
<td>S</td>
<td>Workforce development plans</td>
</tr>
<tr>
<td>Increased demand on secondary health care services</td>
<td>0</td>
<td>LT</td>
<td>New services at local level could see the demand for secondary health care services increase</td>
<td>Vulnerable groups may experience greater difficulty in accessing health care due to demand</td>
<td>S</td>
<td>Performance indicators</td>
</tr>
<tr>
<td>Disruption to service provision</td>
<td>0</td>
<td>ST</td>
<td>Commissioning new services in the new Local Care Centres may cause disruption to service provision in primary care</td>
<td>All population</td>
<td>P</td>
<td>SSDP Evaluation</td>
</tr>
<tr>
<td>What is the impact?</td>
<td></td>
<td></td>
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<tr>
<td>Is it a positive (+) or a negative (0) impact?</td>
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<tr>
<td>When will the impact occur?</td>
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<tr>
<td>Short term ST (within 5 years), long term LT or both</td>
<td></td>
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<tr>
<td>What will cause the impact?</td>
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<tr>
<td>Who will be affected by the impact? [which groups]</td>
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<tr>
<td>How sure are you that the impact will occur? [Definite (D), Probable (P), Speculative (S)]</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>How can the impact be measured?</td>
<td></td>
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</tr>
</tbody>
</table>
## Appendix 5: HIA Questions for Bidders

### HEALTH NEEDS ASSESSMENT
- How will population ‘health needs’ be assessed and reviewed over the life of the SSDP against Bradshaw’s taxonomy of need?

#### Bradshaw’s Taxonomy of need
- **Normative need**: where the need has been defined by the expert of professional
- **Felt needs**: what people want
- **Expressed need**: is felt need expressed as a demand for services
- **Comparative need**: which is the measure of the differences between the service levels in two similar populations

### TRANSPORT
- What proposals are there for joint planning of public service transport provision, i.e. with the Local Authority and other public transport providers, to ensure equitable accessibility to LIFT Centres?

### HOLISTIC HEALTH
- In what ways will the design of LIFT Centres support the social model of health for the delivery of medical and non-medical health and social care interventions?

### COMMUNITY INVOLVEMENT
- How will local community acceptance of premises’ appearance influence the design of the new LIFT Centres?

### SUSTAINABILITY
- In what ways will the design proposals, and build of LIFT premises, take into account the impact on the environment?