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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 10 October 2018 at 4.00 pm

To be held at the Town Hall, Pinstone Street, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillor Pat Midgley (Chair), Sue Alston (Deputy Chair), Steve Ayris, David Barker, Mike Drabble, Adam Hurst, Talib Hussain, Francyne Johnson, Bob Johnson, Mike Levery, Martin Phipps, Chris Rosling-Josephs, Jackie Satur, Gail Smith and Garry Weatherall

Healthwatch Sheffield
Margaret Kilner and Clive Skelton (Observers)

Substitute Members
In accordance with the Constitution, Substitute Members may be provided for the above Committee Members as and when required.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Healthier Communities and Adult Social Care Scrutiny Committee exercises an overview and scrutiny function in respect of the planning, policy development and monitoring of service performance and related issues together with other general issues relating to adult and community care services, within the Neighbourhoods area of Council activity and Adult Education services. It also scrutinises as appropriate the various local Health Services functions, with particular reference to those relating to the care of adults.

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Members of the public have the right to ask questions or submit petitions to Scrutiny Committee meetings and recording is allowed under the direction of the Chair. Please see the website or contact Democratic Services for further information regarding public questions and petitions and details of the Council's protocol on audio/visual recording and photography at council meetings.

Scrutiny Committee meetings are normally open to the public but sometimes the Committee may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information about this Scrutiny Committee, please contact Emily Standbrook-Shaw, Policy and Improvement Officer on 0114 27 35065 or email emily.standbrook-shaw@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
10 OCTOBER 2018

Order of Business

1. Welcome and Housekeeping Arrangements

2. Apologies for Absence

3. Exclusion of Public and Press
To identify items where resolutions may be moved to exclude the press and public

4. Declarations of Interest (Pages 1 - 4)
Members to declare any interests they have in the business to be considered at the meeting

5. Public Questions and Petitions
To receive any questions or petitions from members of the public

6. Urgent Care - NHS Sheffield Clinical Commissioning Group response to Scrutiny (Pages 5 - 60)
Report of Brian Hughes, Director of Commissioning, NHS Sheffield CCG

7. Public Health Outcomes in Sheffield (Pages 61 - 66)
Report of Greg Fell, Director of Public Health.

8. Date of Next Meeting
The next meeting of the Committee will be held on Wednesday, 14th November, 2018, at 4.00 p.m. in the Town Hall.

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ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Audit and Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee

10th October 2018

Report of: NHS Sheffield Clinical Commissioning Group

Subject: Urgent Care – CCG Response to Scrutiny Committee

As per the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, the Healthier Communities and Adult Social Care Scrutiny Committee responded formally to NHS Sheffield Clinical Commissioning Group's proposals to change Urgent Primary Care Services in Sheffield.

Attached is the Clinical Commissioning Group's response to the Scrutiny Committee.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	**x**

The Scrutiny Committee is being asked to:

- Note and discuss the response from the CCG, and identify any further action required.

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Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

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2 October 2018

Dear Councillor Midgley

Thank you for the Committee's formal response to our proposals for changing Urgent Primary Care Services in Sheffield. We appreciate the time the Committee has put into considering the proposals and providing us with a comprehensive response.

As set out in our letter of the 13th September, having reflected on the Committee's response and the feedback from the consultation we have decided to reconsider the options for the reconfiguration of minor illness and minor injury services. However, our response to the issues and questions you raised is set out below, which we hope will be useful for the continuing scrutiny of our work to reconfigure urgent care services.

We found the format of the Committee's response very helpful so have followed the same approach to respond to the issues raised.

Consultation process

Q1: Do any of the suggestions raised through the consultation process provide feasible alternatives to the proposals that were consulted on, and how are they being considered by the CCG?

A total of 17 alternative suggestions were made in the consultation feedback, all of which have been considered to determine whether they could potentially be viable approaches and, if so, whether they offer any benefits that we should consider further.

The suggestions were reviewed at a number of workshops with providers, clinicians and commissioners to form a view on whether they could realistically be introduced within Sheffield over the next two to three years and potential benefits. The Urgent Care Public Reference Group also reviewed the suggestions and considered what they felt the pros and cons of each would be, plus any issues relating to access.

The outputs from the workshops were then reviewed by the CCG's Urgent Care Working Group to determine whether any of the suggestions could potentially be viable alternatives and have benefits that should be considered further. The feedback was considered alongside a number of other factors including the fit with the CCG's Primary Care, Care Outside of Hospital and Urgent and Emergency Care strategies.

In particular, the group considered whether activity levels would be sustainable (i.e. if services are likely to be too small to be economically viable or too large to be delivered safely); whether it enables the right thing to happen first time for each patient; and logistical feasibility (primarily whether there is likely to be sufficient workforce available to staff the model and whether it would meet the national Urgent and Emergency Care requirements).

As a result, six of the suggestions were determined to be unviable and the PCCC approved the recommendation that they should be discounted from further consideration (see appendix 1). The conclusions for the remaining 11 are attached as appendix 2. These would need full modelling and costing to confirm viability and for the consultation purposes the focus has been on understanding if there are any benefits from any of the alternative suggestions that should be considered against the options proposed.

Proposed siting of the Urgent Treatment Centre at the Northern General

Q2: Is there evidence available to demonstrate that siting a UTC at the Northern General is viable in terms of capacity and appropriateness of the site?
The proposals to site the adult UTC at NGH took into account the activity information given to us by the service providers and the physical capacity of the current services. The proposal was for the UTC to be based in the space under the helipad; this already houses the GP collaborative (which would be incorporated into the UTC) and the remaining space is currently unused and would accommodate the additional patient activity. Based on the information provided, the CCG's analysis confirmed that capacity would be sufficient. However in light of the comments made by Sheffield Teaching Hospitals during the consultation, we are currently reviewing this with colleagues at the Trust to verify our assessment.

Q3: What would the impact of siting the UTC at the NGH be, in terms of patient flow, increased number of journeys, traffic modelling etc?

In terms of impact, our modelling focused on patient flow. To estimate activity levels at the UTC, we took account of activity at all current services at different times of day and days of week. Overall, we estimate that c35% of WIC activity would go to the UTC, based on the figures from Rotherham CCG on use of the new urgent treatment centre at the hospital after the city's walk-in centre closed. For the minor injuries unit, we have assumed 90% of current activity will move to the UTC, based on the fact that 10% of current service users attend with illness rather than injury. We have also taken account of the number of people currently attending A&E who would be streamed to the UTC, which is approximately 30% (NB: 10% illness which are already being streamed and 20% minor injuries, based on an audit of MIU data).

This means a total of 576 additional patients per week at NGH, with the breakdown shown in table1 below:

Per week

	Estimated no of UTC patients	Of which, no from A&E at NGH	Of which, no from GP collaborative	Additional no at NGH
Weekday	689	312	14	362
Weekend	263	111	20	131
Twilight	263	157	23	83
TOTAL	**1,215**	**580**	**57**	**576**

Q4: How can access to services be improved for people in the south of the city, and those who would find it difficult to get to the NGH?

Overall, the proposals would mean that far fewer people need to travel for urgent care as more would be available in local GP practices. This would include the student population, many of whom use the walk in centre as an alternative to registering with a GP practice in Sheffield. This is matter of ongoing concern as it means not only that these students do not get the continuity of care afforded by being registered with a practice but also that the city does not receive the money for their care. Practices in the areas close to the university are continually promoting the benefits of registering and write to all new students to encourage them to register, as well as promoting this during the annual 'freshers' weeks'. Additional registrations would increase income to the practice, enabling them to increase their staffing if required to meet demand.

However, while the proposals would improve access for people with minor illness, we recognise that those with minor injuries would need to use the UTC and that this would impact on people in the South of the city in terms of travel times. Data on car ownership shows that there are high levels of car ownership in the South of the city so there is likely to be less reliance on public transport, and the majority of people currently using the MIU access the service by car. However, we are conscious that those using public transport are likely to find it harder to access NGH. The analysis we undertook showed that the majority of people in Sheffield (approximately 544,500) would be within an hour of NGH by public transport (see map attached as appendix 3) but we have considered mitigating actions we could take for those outside these areas.

Access to NGH was one of the key areas discussed in the workshops we held to consider the consultation feedback. From this, we agreed a number of actions that needed to be taken (attached at appendix 4), including work with STH, South Yorkshire Transport Executive and community transport providers to look at how transport to NGH could be improved. We have also committed to exploring the possibility of a shuttle service from the city centre and other alternatives to support people on low incomes to access services.

Q5: Are there repercussions to not following the national guidelines on Urgent Treatment Centres? Can the guidelines be met by retaining current arrangements? What have other areas done?

NHS England set out a number of requirements to improve urgent and emergency care including introducing standardised urgent treatment centres in every area. This includes the requirement for each area has to have at least one "standardised new **'Urgent Treatment Centres'** which will open 12 hours a day, seven days a week". These have to treat both minor illness and minor injuries and offer "appointments that are bookable through 111 as well as GP referral" (*Next Steps on the NHS Five Year Forward View, March 2017*).

All CCGs have to comply with this, and achieve the principles and standards set out by NHS England in the following document: https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf. In addition, NHS England is likely to associate failure to implement a UTC with poor A&E performance, which will put the city under increased pressure and scrutiny. It would also jeopardises access to the Sustainability and Transformation Funds that providers get if they achieve A&E targets, which could bring significant extra investment into the city. Negotiation on this if the target is narrowly missed would be supported if the system can demonstrate it has done everything required to achieve the target, such as establishing a UTC.

Retaining the current arrangement of having separate services for minor illness and minor injuries would not meet the requirements for a UTC, as this requires having a single service to treat both illness and injuries.

Other CCGs in South Yorkshire and Bassetlaw and more widely across the country are all working to introduce UTCs. Rotherham CCG closed its walk-in centre and created a UTC at the A&E department at Rotherham Hospital, which opened in July 2017. East Riding, North Tyneside and Derbyshire CCGs have also all either opened UTCs or are in the process of doing so.

Increasing capacity within Urgent Primary Care

Q6: How will the Neighbourhoods work together to provide additional appointments, is there evidence to demonstrate that this approach will work?

The neighbourhoods were established in 2016 so have already been working together for two years to coordinate health and social care, and deliver services to support the specific health and social needs of their area This has delivered a variety of improvements, including developing additional services to meet the needs of local communities, demonstrating the success of practices working together in this way. For example, practices in the Townships neighbourhood are already working together to provide shared appointments for patients with chronic pain. There are also examples

from other areas of the country that show how practices are successfully working together to deliver services at scale on the same basis as the neighbourhoods.
In view of the concerns raised about whether neighbourhoods would be sufficiently developed to deliver the proposed model, the CCG carried out a review of current maturity levels of maturity and future plans. This showed a commendable level of commitment to neighbourhood working, with an impressive number of initiatives taking place across the city. All neighbourhoods have identified patient cohorts to focus on based on their population needs – these include frail elderly, long term conditions, housebound diabetics and patients with mental health conditions.

Additional funding of £1 per head of population has been identified to develop neighbourhood services in these areas and work with key stakeholders to increase available resource in primary care. Working in a more integrated way with primary care and multi-disciplinary teams will deal with some of the same day demand and also free up GP and practice capacity to do this. This has demonstrated that neighbourhoods are already working successfully in the city and, with appropriate funding, are able to provide additional services for patients.

We understand that people would have liked to have specific details of how each neighbourhood would work together to provide appointments within 24 hours. However, the basis of neighbourhood working is that practices determine appropriate solutions for their local communities so each neighbourhood would need to develop its own approach to providing urgent care appointments for all patients who need them within 24 hours. There are a number of different ways that neighbourhoods might choose to do this, including sharing staff between practices or seeing each other's patients when they don't need continuity of care and some neighbourhoods are already working through potential approaches.

We have also continued discussions with GPs since the consultation to confirm that they are confident the proposals could be delivered. This has included discussions with individual practices, neighbourhoods, localities and the Local Medical Committee. This has shown that while some practices would want or need to work together as neighbourhoods to deliver the improvements, other practices feel that with additional investment they could meet the standards as individual practices and some said that they are already meeting them. This has led us to conclude that we would need a more flexible approach rather than mandating neighbourhood working to allow practices to work individually to provide urgent care appointments within 24 hours if they wish to do so.

Q7a: How many additional appointments are needed and in which parts of the city?

We analysed walk-in centre attendances by practice during core hours (ie when practices are open) to determine the likely impact and number of additional appointments required in GP practices, and understand which practices were most likely to be affected (see appendix 5). On average, this works out as between 1 and 8 additional appointments that are likely to be required. Discussions with the practices

likely to be most affected have confirmed that they are confident they could deliver the extra appointments required.

Q7b: Which groups and communities will be most affected by the proposals and what are the mitigations?

To understand the impact of the proposals, we need to look at minor injuries and minor illness separately. For minor illness, including mental illness, people in all parts of Sheffield will see a positive impact as more care would be available in local GP practices, making it quicker and easier for them to get the care they need.

For minor injuries, people would need to go to a UTC at NGH or SCH, so those likely to be most affected are those living in the city centre and the south of the city, as they would have to travel further than they do now. Those impacted positively would be those living closer to NGH, including some of the most deprived areas of Sheffield.

City centre residents

For adults living in the city centre, access to urgent care for minor illness (including mental illness) would be improved with appointments within 24 hours guaranteed at the practices in the city centre. This would include the student communities who are served by a number of practices in the city centre. Similarly, more people would be able to get care closer to home and not need to come into the city centre for treatment. The additional investment in primary care and neighbourhood working is also likely to mean an increased number of mental health specialists being available to see patients in practices.

People would need to travel further for minor injuries care, which would be provided at the UTC at NGH, and we are conscious that this is also a concern for people living in the South of the city. The majority of people using the minor injuries service currently access it by car or taxi but we recognise the need to consider actions to mitigate the issues raised for those using public transport.

Vulnerable groups

The consultation raised concerns about the potential impact on vulnerable groups, such as the homeless, those affected by substance misuse or asylum seekers. These groups have more complex health needs, which are best supported by continuity of care from their GP. There are a number of practices that offer services tailored to the needs of specific vulnerable groups and increasing the availability of appointments at practices would benefit these groups and help make sure they are seen at the most appropriate place for their needs. However, we recognise that there could be a detrimental impact on vulnerable groups in the city centre in terms of minor injury services, which would need to be addressed

People living in deprived areas

We have reviewed extensive information relating to health inequalities and the potential impact on those in more deprived communities. This shows that more people from the

most deprived areas in Sheffield can access NGH within 30 minutes by public transport compared to those who can get to the MIU within this time.
It also showed that people in these areas are more likely to use the A&E departments at NGH and SCH than the MIU and WIC, indicating that these locations are accessible and that siting the adult UTC at NGH should not deter them from accessing healthcare.

Mitigations
As detailed in the response to Q4, we have discussed potential actions to mitigate the main concerns raised in the consultation feedback and the agreed actions are set out in appendix 4. These include exploring providing transport for those without easy access to transport or on very low incomes and work with STH, South Yorkshire Transport Executive and community transport providers to look at how transport to NGH could be improved.

We are conscious of the point you make about the difficulties of accessing services via a telephone triage system for some groups, such as the homeless and those for whom English is their second language. As happens now, different arrangements would be put in place for these groups to ensure they were not disadvantaged, for example drop in clinics. It is also worth noting that some practices with high numbers of non-English speaking patients, such as Pitsmoor Surgery, currently use telephone triage and find it works well

Q8: What are the workforce requirements and is the workforce available in Sheffield?

Workforce challenges and ensuring future sustainability is one of the drivers behind the changes and has been a key consideration in developing the proposed options.

Workforce planning for the UTC was based on the forecast activity numbers (detailed in response to Q3) and took account of the staffing models at the current services. This identified that 60.56 wte clinical staff would be required to support the delivery of the preferred model (Option 1) as set out in appendix 6. This workforce will be formed from a combination of existing staff working in current services, existing staff with additional training e.g. prescribing pharmacists and some additional, new staff e.g. Physician's Associates, currently being trained in Sheffield. The workforce planning anticipated that sufficient staff would be available to deliver the model.

Appendix 7 sets out details of the approach the CCG is taking to address the workforce challenges facing primary care in Sheffield. This includes increasing the use of different health professionals in practices to reduce the pressure on GPs and provide the best care for patients, which is a key focus of both neighbourhoods and the GP Five Year Forward View. The implementation of this workforce strategy will support the delivery of the proposed model and mean that the workforce requirements can be met.

Q9: Is there evidence available to demonstrate that the primary care system is willing and able to make these proposals work?

The 11 formal responses we received from practices raised a number of queries around logistics, details of the proposed approach and whether it was necessary to work as neighbourhoods to deliver additional appointments. Several also raised concerns about access to a UTC at NGH in terms of travel and parking, and there were several who felt they were already providing effective triage and delivery of urgent appointments. One also raised concerns about losing the MIU, although was supportive of the walk-in centre closing.

While this is obviously a limited number of responses, as outlined in our response to Q6 we have had numerous meetings and discussions with GPs, neighbourhoods, locality councils and the Local Medical Committee both during the consultation and afterwards. Throughout conversations, there has been a consensus supporting the principle of increasing urgent care capacity in primary care and investing to make primary care sustainable and improve access. As previously detailed, not all practices feel they would need to work as a neighbourhood to deliver the improvements, which we have taken on board. However, while there are concerns regarding logistical issues, overall members are supportive of the proposed approach to invest in primary care to improve capacity for minor illness and are willing to work with the CCG to achieve this.
In terms of delivery, the discussions have shown that some practices feel they are already meeting the standards that would be required and that others feel that with additional investment they would be able to do so, either individually or as neighbourhoods. Meetings with the practices most likely to be impacted by changes to the walk-in centre have confirmed that they are confident they can accommodate the additional patient numbers.

The implementation of clinical triage would be key to enabling practices to deliver urgent appointments within 24 hours for all those that need them. Feedback from practices that triage all patients confirms that it enables them to signpost patients to the most appropriate service and clinician. It is also in line with the national requirements to increase the number of 111 calls which are managed by a clinician rather than a call handler.

Q10: How will the finances work? How much will it cost to create an Urgent Treatment Centre? How much will be invested in Primary Care, and in which areas/practices in the city?

The current spend on all urgent care activity is £11.3m and this was the allocated financial envelope for the proposed changes.
To develop the financial modelling, we assessed the current annual activity demand for all urgent care services within Sheffield and the impact of implementing a triage system on current minor illness activity, and then allocated a new destination for each patient. In summary, this assumed that 90% of MIU activity would continue and need to be seen at the UTC and that there would be a 30% reduction in WIC activity due to implementing triage. Of the remaining WIC activity, we estimate that 20% would present

as walk-ins at the UTC. Of the remaining 80%, we estimate 20% will attend the UTC and 80% a GP service.

Assumed costs were then applied for this activity to calculate the overall costs of the proposed model.. The proposed model released £992k which we allocated to reinvest into neighbourhoods/GP practices to support the additional urgent care activity they would be delivering. In addition, we estimate there would be up to £160k of set up costs. No additional capital investment has been identified at this stage. This would be considered as part of the Neighbourhood business cases but it is currently considered that services would be able to operate within existing premises.

We have not agreed investment by practice or area at this stage but the approach to allocating the additional money would be in line with the CCG's agreed approach of differentially investing to support areas of greatest need.

Additional points

In addition to the questions, there were a few points you made that we thought would be helpful to respond to.

Similarity of the three options

We accept that the three configurations for the UTC were very similar. We did consider a range of approaches when developing options and the shortlist for the options appraisal included two approaches where the UTCs would have been in the city centre. The criteria we used scored options on whether they would enable patients to get care in the right place first time and this was a key factor in the outcome as co-location with A&E was considered to give the maximum chance of achieving this. Similarly, it allows maximum workforce flexibility and integration so also scored highly against 'ensuring a sustainable workforce', which was one of the other criteria.

The decision to reconsider our proposals and develop alternative options will allow us to explore whether there are benefits in other approaches that would outweigh those of co-location with A&E and we will work with partners and the public to develop new criteria, taking account of the feedback we received in the consultation.

Engagement with public and statutory stakeholders

We were disappointed that the Committee felt there had been a lack of public engagement in drawing up the proposals. We spent a lot of time on this stage, including work with Healthwatch and in depth work with specific groups who could potentially be impacted by any changes, which received positive feedback from the Committee when we shared this work at the start of 2017.
We are committed to involving the public in this process and going forward, we are looking at ways to strengthen this further including working with both the Urgent Care Public Reference Group and members of the public to develop the scoring criteria and

alternative options. We would continue to welcome any suggestions from the Committee, particularly in terms of how members would like us to work with you and how best to involve you in this work going forward.

Consultation feedback

The Committee's response referred to the "overwhelmingly negative tone of responses" to the proposals. However, while there were some very strong views against regarding the adult UTC location and replacement of the MIU and WIC, it is important to acknowledge that there were also positive responses to all elements of the proposal and different opinions expressed in the representative telephone survey to those from people who chose to complete the consultation feedback form. We also saw a range of views at the workshop we held for the Urgent Care Public Reference Group and differences in opinion - for example, while some were strongly in favour of having more services at the Royal Hallamshire, lots of people highlighted concerns around access to both this site and the current WIC location.

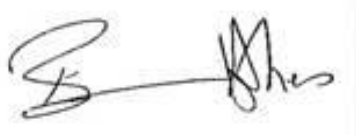
We mention this to highlight that we are trying to take account of a range of views and different opinions and also because there were some elements of the proposals that were clearly supported by the majority of people. In particular, there was widespread support for improving access to urgent same day GP appointments so we would want to make sure this remains a key focus of proposals.

Next steps

Following the decision to reconsider the reconfiguration of minor illness and minor injury services, we will be working with partners and the public to develop a new set of options for consultation. This will take account of both the feedback and the learning from the consultation, and include further consideration of the alternative suggestions that were put forward. We also recognise that there is a greater interest from the public in the data and information we have used than we had anticipated and have taken on board the level of detail required by the Committee to ensure thorough scrutiny of our work so going forward we will make sure this is provided.

As mentioned above, we would welcome views from the Committee as to how and when you would like us to engage with you throughout this process and look forward to discussing this further at the meeting on 10 October.

Yours sincerely



Brian Hughes
Director of Commissioning & Performance

Appendices

1. Unviable alternative suggestions
2. Review of remaining alternative suggestions
3. Areas within 1 hour travel time of NGH by public transport
4. Mitigating actions
5. WIC attendances by practice
6. Workforce modelling
7. Workforce strategy

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Central UTC
9 Set up a minor illness service alongside the Minor Injuries Unit at RHH

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen in a practice within their locality.

Adults with minor illness symptoms or minor injuries would be seen at the relevant illness or injury services at RHH during core hours, evenings and weekends. Children would be seen at SC(NHS)FT. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111 at the overnight illness service. **Further consideration would be needed to decide whether to keep this service sited at the NGH or move it to RHH.** Any patients requiring treatment for minor injuries overnight would be seen in the relevant ED.

<table>
<tr><th colspan="5">Future State System Summary</th></tr>
<tr><th>Weekdays
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08:00 – 18:30</th><th>Twilight
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<tr><td>Patients who need continuity of care seen within practice
Patients who do not need continuity of care seen within their practice or neighbourhood</td><td>Patients seen within a locality setting (service also provides planned care)</td><td>Patients seen within a locality setting (service also provides planned care)</td><td colspan="2" rowspan="2">Adults and children with illness symptoms at RHH (booked appointments only)
OR Leave location at NGH</td></tr>
<tr><td>Adult minor illness service at RHH</td><td>Adult minor illness service at RHH</td><td>Adult minor illness service at RHH</td></tr>
<tr><td>Adults seen at an injury service at RHH
Children at SC(NHS)FT</td><td>Adults seen at an injury service at RHH
Children at SC(NHS)FT</td><td>Adults seen at an injury service at RHH
Children at SC(NHS)FT</td><td colspan="2">Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service Minor Injury Service Minor Illness & Injury Service</td><td></td></tr>
<tr><th colspan="5">Option Viability Assessment</th></tr>
<tr><td>Sustainable Activity Levels</td><td colspan="4"></td></tr>
<tr><td>Right Thing First Time</td><td colspan="4">Patients may choose ‘wrong’ door first time and need to be sent next door for ‘right’ service</td></tr>
<tr><td>Logistical Feasibility</td><td colspan="4">Would not be the most efficient use of workforce
Does not comply with national guidance on UTCs</td></tr>
<tr><td>Recommendation</td><td colspan="4">Not viable</td></tr>
</table>

Central UTC

10 - Develop an urgent care village where all aspects of urgent care could be provided (for both adults and children)

This option emerged from the consultation and proposes commissioning an "Urgent Care Village" in a central location which would include the combination of a minor injuries service, a minor illness service and the EEC. **The Urgent Care Village would see both adults and children.**

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen in a practice within their locality.

Adults and children with minor illness symptoms and all those with minor injuries would be seen at the Urgent Care Village during core hours, evenings and weekends. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111 at the overnight illness service. **Further consideration would be needed to decide whether to keep this service sited at the NGH or move it to Urgent Care Village.** Any patients requiring treatment for minor injuries overnight would be seen in the relevant ED.

Future State System Summary			
Weekdays 08:00 – 18:30	**Weekends 08:00 – 18:30**	**Twilight 18:30 – 22:00 (7 Days)**	**Overnight 22:00 – 08:00 (7 Days)**
Patients who need continuity of care seen within practice Patients who do not need continuity of care seen within their practice or neighbourhood	Patients seen within a locality setting (service also provides planned care)	Patients seen within a locality setting (service also provides planned care)	Adults and children at **central Urgent Care Village** (illness symptoms and booked appointments only) **OR Leave location at NGH**
Adults & Children at Urgent Care Village (Illness & Injury)	**Adults & Children at Urgent Care Village (Illness & Injury)**	**Adults & Children at Urgent Care Village (Illness & Injury)**	Adults and children with injury symptoms seen within their respective EDs (walk in only)
Key	Minor Illness Service	Minor Injury Service	Minor Illness & Injury Service

Option Viability Assessment	
Sustainable Activity Levels	
Right Thing First Time	Strong consultation feedback that adult and paediatric care should be separated
Logistical Feasibility	Lack of specialist paediatric staff (drs and nurses) to cover 2 separate locations Recognition that the strong SC(NHS)FT brand is always going to encourages pts to attend SC(NHS)FT ED
Recommendation	Not viable

Other Options
14 - Have 4 urgent treatment centre hubs in primary care
13 – Keep all "primary care urgent activity" in primary care rather than establishing it at a secondary care provider site

These options were suggested via the consultation feedback and would require the CCG to expand the offer of the current minor illness service provided by the extended access hubs. Adult minor injury would be seen within A&E at NGH. Children would also have the option of being seen at SC(NHS)FT.

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen within their locality. Overnight, adults and children with minor illness symptoms would only be seen by the overnight illness service via an appointment booked through 111. **Further consideration would have to be given as to the location of this service.**

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<tr><td>Patients who do not need continuity of care seen within their practice or neighbourhood</td></tr>
<tr><td>Adults with minor injury seen at NGH A&E</td><td>Adults with minor injury seen at NGH A&E</td><td>Adults with minor injury seen at NGH A&E</td><td colspan="2" rowspan="2">Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service ☐ Minor Injury Service ☐ Minor Illness & Injury Service ☐</td><td></td></tr>
</table>

Option Viability Assessment	
Sustainable Activity Levels	
Right Thing First Time	If minor injuries treated at ED, potential for patients to go to the wrong service
Logistical Feasibility	Would require significantly increased workforce to staff multiple hubs Would need to significantly upskill staff to treat minor injuries if treated in in hubs Significant, unaffordable capital cost of placing diagnostics in multiple hubs if injuries treated in hubs Doesn't comply with UTC guidance and threatens implementation of national guidance
Recommendation	Not viable

Other Options
4 Reinstate A&E at RHH

This option was suggested via the consultation feedback and would require the CCG to recommission A&E at RHH.

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen within their locality. Overnight, adults and children with minor illness symptoms would only be seen by the overnight illness service via an appointment booked through 111. **Further consideration would have to be given as to the location of this service.**

Adult minor injury would be seen within either A&E department and children would be seen at SC(NHS)FT.

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<tr><td>Adults with minor injury seen either at NGH OR RHH A&E</td><td>Adults with minor injury seen either at NGH OR RHH A&E</td><td>Adults with minor injury seen either at NGH OR RHH A&E</td><td rowspan="2">Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service ■ Minor Injury Service ■ Minor Illness & Injury Service ■</td></tr>
</table>

Option Viability Assessment	
Sustainable Activity Levels	
Right Thing First Time	RHH doesn't have the necessary clinical services to support an A&E department
Logistical Feasibility	Lack of available workforce to staff a 2nd A&E department 2nd ED unaffordable to the system Unlikely to be deemed a trauma centre
Recommendation	Not viable

Other Options
3 No change – Status Quo

This option was suggested via the consultation feedback and would see no changes to services. Any services whose contracts were due to expire would be re-procured as per the normal procurement processes.

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(7 Days)</th></tr>
<tr><td>Adults and children with illness symptoms seen within practices</td><td>Patients seen within a locality setting (service also provides planned care)</td><td>Patients seen within a locality setting (service also provides planned care)</td><td rowspan="3">Adults and children with illness symptoms at overnight illness service (appointments arranged via 111)</td></tr>
<tr><td>Adults and children with illness symptoms seen at WIC</td><td>Adults and children with illness symptoms seen at WIC</td><td>Adults and children with illness symptoms seen at WIC</td></tr>
<tr><td></td><td>Adults and children with illness symptoms at Out of Hours service (appointments arranged via 111)</td><td>Adults and children with illness symptoms at Out of Hours service (appointments arranged via 111)</td></tr>
<tr><td>Adults with minor injury seen at MIU</td><td>Adults with minor injury seen at MIU</td><td>Adults with minor injury seen at MIU</td><td rowspan="3">Adults and children with injury or illness symptoms seen within their respective EDs</td></tr>
<tr><td>Adults with minor injury or illness symptoms seen at NGH A&E</td><td>Adults with minor injury or illness symptoms seen at NGH A&E</td><td>Adults with minor injury or illness symptoms seen NGH A&E</td></tr>
<tr><td>Children with minor injury or illness symptoms seen at SCH(NHS)FT ED</td><td>Children with minor injury or illness symptoms seen at SCH(NHS)FT ED</td><td>Children with minor injury or illness symptoms seen at SCH(NHS)FT ED</td></tr>
<tr><td>Key</td><td colspan="2">Minor Illness Service ☐ Minor Injury Service ☐ Minor Illness & Injury Service ☐</td><td></td></tr>
<tr><th colspan="4">Option Viability Assessment</th></tr>
<tr><td colspan="2">Sustainable Activity Levels</td><td colspan="2">Activity levels unsustainable without significant changes to service model and increase in workforce</td></tr>
<tr><td colspan="2">Right Thing First Time</td><td colspan="2">Continued inefficient use of tax payers money
Current barriers to doing right thing first time remain (lack of timely access, confusion, duplication etc)</td></tr>
<tr><td colspan="2">Logistical Feasibility</td><td colspan="2">Fails to overcome expected future workforce challenges – not sustainable
Does not comply with national guidance on UTCs</td></tr>
<tr><td colspan="2">Recommendation</td><td colspan="2">Not viable</td></tr>
</table>

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Appendix 2: Alternative Suggestions

The following summaries detail the outputs of the work done to review the alternative suggestions made in the consultation, including workshops held with providers and commissioners and the urgent care public reference group.

For the provider and commissioner workshops the suggestions were grouped under common themes, as several of the suggestions were similar and likely to have the same advantages and disadvantages. A summary has been produced for each group and details of which suggestions the group includes are included in the heading. As no details were provided for any of the suggestions, the summaries also set out how the CCG interpreted the way each suggestion would work.

Although consideration has been given to whether these could potentially be viable approaches, the main focus has been on understanding the potential benefits and consequences and whether these should be explored further. The conclusions for six of the 17 suggestions were presented to PCCC in August and these are the summaries for the remaining suggestions, which detail the conclusions reached under the following categories:

- Sustainable activity levels - whether numbers of patients will mean services are to be too small to be economically viable or too large to be delivered safely
- Right Thing First Time – whether the approach would enable patients to get the care they need at the first place they go
- Logistical Feasibility – including staffing requirements, compliance with national guidance, and building capacity
- Benefits
- Disadvantages
- View – the conclusion reached by the CCG about each suggestion

UTC at Northern General, plus additional service in city centre

Suggestion 1 - Keep the Walk In Centre open (and shut the Minor Injuries Unit)
Suggestion 2 - Keep the Minor Injuries Unit open (and shut the Walk In Centre)

This is based on having an adult UTC at NGH, children being seen at SC(NHS)FT and **the continuation of one of the centrally located minor illness or injury services in its current form.**

The GP Collaborative service would be decommissioned and the functions incorporated into or co-located with the NGH UTC in line with the Integrated Urgent Care specification.

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen in a practice within their locality. A minority of adults and children with minor illness symptoms and all those with minor injuries would be seen at their respective UTC during core hours, evenings and weekends. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111 at the NGH Urgent Treatment Centre. Any patients requiring treatment for minor injuries overnight would be seen in the relevant ED.

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<tr><td>Patients who do not need continuity of care seen within their practice or neighbourhood</td></tr>
<tr><td>Adults at NGH UTC (illness symptoms and minor injuries)</td><td>Adults at NGH UTC (illness symptoms and minor injuries)</td><td>Adults at NGH UTC (illness symptoms and minor injuries)</td></tr>
<tr><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td><td rowspan="3">Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Adult minor injury service in a central location OR</td><td>Adult minor injury service in a central location OR</td><td>Adult minor injury service in a central location OR</td></tr>
<tr><td>Adult minor illness service in a central location</td><td>Adult minor illness service in a central location</td><td>Adult minor illness service in a central location</td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service Minor Injury Service Minor Illness & Injury Service</td></tr>
<tr><th colspan="4">Option Viability Assessment</th></tr>
<tr><td colspan="2">Sustainable Activity Levels</td><td colspan="2">• Initial indication is that that activity levels sustainable for a UTC and one of the current services, however full feasibility modelling required</td></tr>
<tr><td colspan="2">Right Thing First Time</td><td colspan="2">• UTC and co-location with A&E allows patients to receive the most appropriate care expediently.
• However, would not eliminate confusion over which service to use</td></tr>
<tr><td colspan="2">Logistical Feasibility</td><td colspan="2">• Complies with national UTC guidance</td></tr>
<tr><td colspan="2">Benefits</td><td colspan="2">• Provides a secondary point of access in city centre negating some concerns about access to NGH site
• Retains a city centre service, which was highlighted as desirable in consultation feedback</td></tr>
<tr><td colspan="2">Disadvantages</td><td colspan="2">• Concerns raised re access to both Broad Lane (transport) and RHH sites (parking)
• Duplication of services/resource, especially for minor illness
• Could present with emergency complaint that requires transfer to A&E
• Will not release (as much) money to reinvest in primary care
• Lose opportunity to encourage continuity of care through GP</td></tr>
<tr><td colspan="2">View</td><td colspan="2">Could be benefits in retaining a service for injuries – less benefit in retaining illness service as preferable to provide in practices</td></tr>
</table>

UTC at Northern General, plus additional service in city centre

Suggestion 12 - Provide an enhanced minor ailments Walk In Centre staffed by prescribing nurses and prescribing pharmacists at the Wicker Pharmacy and Mobility shop

This consists of an adult UTC at NGH **plus a minor ailments service somewhere central**. The ailments service would be staffed by prescribing pharmacists and prescribing nurses but would not include GPs and would not have any diagnostic facilities. Children would be seen at SC(NHS)FT.

The GP Collaborative service would be decommissioned and the functions incorporated into or co-located with the NGH UTC in line with the Integrated Urgent Care specification.

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen in a practice within their locality. A minority of adults and children with minor illness symptoms and all those with minor injuries would be seen at their respective UTC during core hours, evenings and weekends. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111 at the NGH Urgent Treatment Centre. Any patients requiring treatment for minor injuries overnight would be seen in the relevant ED.

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<tr><td>Patients who do not need continuity of care seen within their practice or neighbourhood</td></tr>
<tr><td>Adults at NGH UTC (illness symptoms and minor injuries)</td><td>Adults at NGH UTC (illness symptoms and minor injuries)</td><td>Adults at NGH UTC (illness symptoms and minor injuries)</td></tr>
<tr><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td><td>Children at SC(NHS)FT</td><td>Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Adult minor ailments service somewhere central</td><td>Adult minor ailments service somewhere central</td><td>Adult minor ailments service somewhere central</td><td></td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service ■ Minor Injury Service ■ Minor Illness & Injury Service ■</td></tr>
<tr><th colspan="4">Option Viability Assessment</th></tr>
<tr><td>Sustainable Activity Levels</td><td colspan="3">• Further work required to assess whether minor ailment activity levels sustainable</td></tr>
<tr><td>Right Thing First Time</td><td colspan="3">• UTC treating both minor illness and minor injury, plus co-location with A&E, allows most patients to receive the most appropriate care expediently
• However, likely to create confusion over which service to use / when to use minor ailments service</td></tr>
<tr><td>Logistical Feasibility</td><td colspan="3">• Complies with national UTC guidance</td></tr>
<tr><td>Benefits</td><td colspan="3">• Provides a secondary point of access in city centre negating some concerns about access to NGH site
• Use knowledge and skills of pharmacists</td></tr>
<tr><td>Disadvantages</td><td colspan="3">• Not able to cover all minor illness and minor injuries
• Unlikely to be seen as an alternative to WIC or MIU by public
• Poor parking</td></tr>
<tr><td>View</td><td colspan="3">Unlikely to add sufficient value to justify cost. Work already taking place to consider development of minor ailments services in city so may be progressed through that if there is found to be a need.</td></tr>
</table>

One Central UTC

Suggestion 5 - Site the UTC at the Walk In Centre (instead of NGH)
Suggestion 7 - Site the UTC at the Royal Hallamshire Hospital (instead of NGH)

This proposes commissioning 1 adult UTC for the city **somewhere central** that would provide a minor illness and injury service to adults. Children would be seen at SC(NHS)FT.

The GP Collaborative service would be decommissioned and would either be combined into any UTC service specification (minor illness service overnight) based in the central location. Otherwise a new service would be commissioned and based in the current location at NGH.

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen in a practice within their locality. A minority of adults and children with minor illness symptoms and all those with minor injuries would be seen at their respective UTC during core hours, evenings and weekends. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111 at the overnight illness service. **Further consideration would be needed to decide whether to keep this service sited at the NGH or move it to the central UTC** Any patients requiring treatment for minor injuries overnight would be seen in the relevant ED.

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<tr><td>Adults at centrally located UTC (illness symptoms and minor injuries)
Children at SC(NHS)FT</td><td>Adults at centrally located UTC (illness symptoms and minor injuries
Children at SC(NHS)FT</td><td>Adults at centrally located UTC (illness symptoms and minor injuries
Children at SC(NHS)FT</td><td>Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service Minor Injury Service Minor Illness & Injury Service</td></tr>
</table>

Option Viability Assessment	
Sustainable Activity Levels	• Activity levels sustainable (based on pre-consultation modelling)
Right Thing First Time	• Combines minor injuries and illness so more people will get right care first time. • However not co-located with A&E so risk of needing to travel if more complex care required.
Logistical Feasibility	• Complies with national UTC guidance • Would require further assessment to determine whether there is sufficient space to create a UTC in current MIU area
Benefits	• More central location allows for easier access by public transport • Would be more accessible for people libing in the south of the city
Disadvantages	• Not co-located with A&E so people presenting with emergency needs will have to be transferred • Concerns raised re access to both Broad Lane (public transport) and RHH sites (partking) • Limits the no of staff that could be redeployed into primary care/ED • Splits urgent and emergency care expertise across 2 sites • Negative imact on ability to staff other primary care services • May encourage duplication re minor illness • Loss of opportunity to encourage continuity of care through GP
View	Needs to be fully modelled to determine costs and workforce implications. Need to determine potential impact on reducing health inequalities and if this and other benefits outweigh the benefits of co-location with A&E.

2 UTCs - 1 at NGH plus 1 somewhere central

Suggestion 6 - Have a UTC in the south as well as one in the north
Suggestion 8 - Option 1 plus a second UTC at the RHH

This would require the CCG to commission 2 adults UTCs, one at the Northern General site and one somewhere central. Both services would see adults with minor illness and injury symptoms. Children would be seen at SC(NHS)FT.

The GP Collaborative service would be decommissioned and the functions incorporated into or co-located with one of the adult UTCs in line with the Integrated Urgent Care specification

The majority of adults and children with minor illness symptoms would be seen in their own practice or neighbourhood during core hours. During evenings and weekends patients needing urgent same day care (and those needing planned care) would be seen within their locality. Overnight, adults and children with minor illness symptoms would only be seen via an appointment booked through 111. **Further consideration would be needed to decide whether to keep this service sited at the NGH UTC or move it the central Urgent Treatment Centre service.** Insufficient staff are likely to be available to staff the overnight service at 2 UTC locations within the city.

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<tr><td>Adults at NGH UTC OR centrally located UTC (illness symptoms and minor injuries)
Children at SC(NHS)FT</td><td>Adults at NGH UTC OR centrally located UTC (illness symptoms and minor injuries)
Children at SC(NHS)FT</td><td>Adults at NGH UTC OR centrally located UTC (illness symptoms and minor injuries)
Children at SC(NHS)FT</td><td>Adults and children with injury symptoms seen within their respective EDs (walk in only)</td></tr>
<tr><td>Key</td><td colspan="3">Minor Illness Service
Minor Injury Service
Minor Illness & Injury Service</td></tr>
</table>

Option Viability Assessment	
Sustainable Activity Levels	• Initial indication that activity levels sustainable, requires full feasibility modelling to confirm
Right Thing First Time	• Combining minor illness and minor injury in both services, plus co-location of 1 UTC with A&E, allows more patients to receive the most appropriate care expediently
Logistical Feasibility	• Complies with national UTC guidance • Query over workforce sustainability and implications on wider system - need to fully model • Would require further assessment to determine whether there is sufficient space to create a UTC in current MIU area
Benefits	• More central location allows for easier access by public transport • Improved acces for people in South • Consistent approach – combines minor illness and minor injury
Disadvantages	• Not support best use of resources • Will incur capital costs • The south is not the area with the greatest health needs • Does not promote GP access / continuity of care
View	Needs to be fully modelled to determine costs and workforce implications. Could be opportunity for greater reduction in health inequalities if second UTC sited to support greatest need. Could have implications re investment in primary care / other areas.

Urgent Eye Care – No Change

Suggestion 15 - Keep the Emergency Eye Clinic open

This would see no changes to the current system with both urgent and emergency eye care being seen via a combination of EEC/ED and PEARs. Eye care overnight would be provided solely within ED.

Future State System Summary			
Weekdays 08:00 – 18:30	**Weekends 08:00 – 18:30**	**Twilight 18:30 – 22:00 (7 Days)**	**Overnight 22:00 – 08:00 (7 Days)**
Urgent eye care seen at EEC/ED/PEARs*	Urgent eye care seen at EEC/ED/PEARs*	Urgent eye care seen at EEC/ED/PEARs*	Urgent eye care seen at ED

Option Viability Assessment	
Sustainable Activity Levels	• Current service has sustainable activity volumes
Right Thing First Time	• No secondary referrals required as all conditions (including sight-threatening) can be treated
Logistical Feasibility	• Current service is feasible
Benefits	• Only requires high cost equipment at one site • No variation in quality of care • Good links to central public transport • Is recognised/trusted service
Disadvantages	• Access inequitable – depends on where people live • Does not use resources to best effect • Does not decrease geographical inequalities • Does not offer care closer to home • Poor parking at RHH
View	No change would not deliver the objectives of making more care available closer to home and making best use of resources. However, since the consultation providers have indicated they could now work together to meet these objectives through improved signposting rather than reconfiguring services.

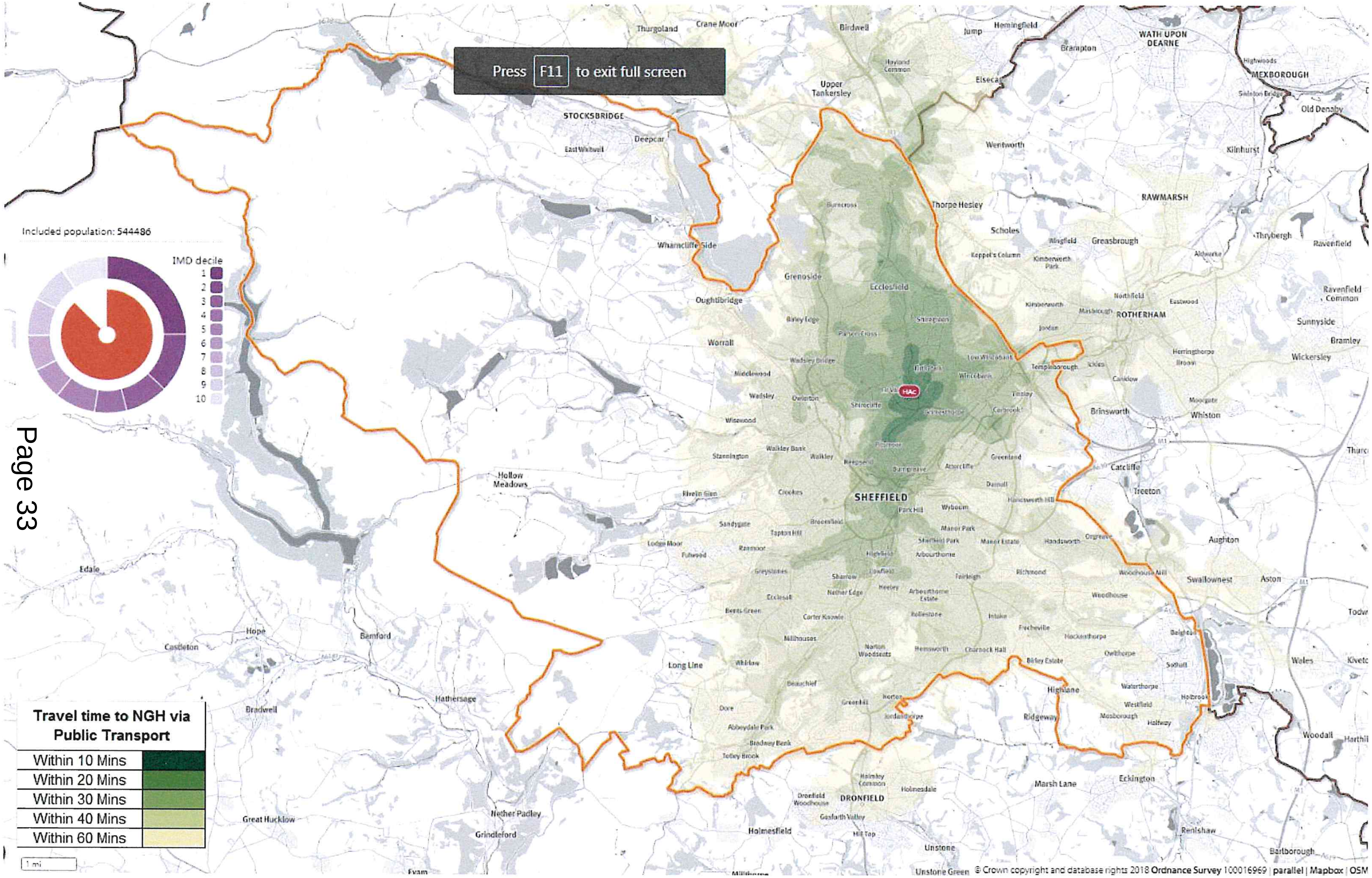
Urgent Eye Care provided in 'Optometry Cluster Locations'

Suggestion 16 - Scale up the existing PEARs service (to accommodate urgent eye conditions)
Suggestion 17 - Use optometrists working in clusters similar to neighbourhoods

This is similar to the CCG's proposed community-based option but would instead see optometrists operating in clusters similar to primary care neighbourhoods.

Future State System Summary			
Weekdays 08:00 – 18:30	**Weekends 08:00 – 18:30**	**Twilight 18:30 – 22:00 (7 Days)**	**Overnight 22:00 – 08:00 (7 Days)**
Urgent eye care is undertaken in the community across a number of sites			Urgent eye care seen at ED

Option Viability Assessment	
Sustainable Activity Levels	Based on the modelling for the proposed option, activity levels could be sustainable
Right Thing First Time	This would be the case for those sent by NHS 111. However, patients self-referring would need to be able to determine whether their condition needed urgent or emergency care which could delay treatment if judgement is incorrect.
Logistical Feasibility	• This is very similar to the proposed option so assumption is that this would be feasible • Potential capital costs for equipment required to set up
Benefits	• Providing in local areas / closer to home improves ease of access (which is particularly important given age profile and nature of conditions) • Able to influence geographical spread of locations across city to ensure equity of access • Integration of optometry and ophthalmology – city-wide solution • Longer opening hours
Disadvantages	• Cluster approach is less close to home than proposed dispersed model • Potential risk of service variation
View	This is very similar to the option proposed, however offers fewer benefits as would mean services not as close to home if in clusters and would be more complicated to implement


Press F11 to exit full screen
Included population: 544486
IMD decile
1
2
3
4
5
6
7
8
9
10
Travel time to NGH via Public Transport
Within 10 Mins
Within 20 Mins
Within 30 Mins
Within 40 Mins
Within 60 Mins
SHEFFIELD
ROTHERHAM
DRONFIELD
STOCKSBRIDGE
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Appendix 4: Summary of actions identified to mitigate key issues from the consultation

Issue	Actions to mitigate
Parking and travel to NGH	Considerations • Increased availability of urgent appointments in primary care will mean fewer people need to travel • Majority travel by car Actions • Explore ideas for providing transport for those without easy access to transport and factor costs into business case (eg shuttle bus between city centre and NGH, park and ride facility) • Explore potential for using technology to reduce need for face-to-face appointments • Provide information on travel to NGH site (bus routes /frequency) • Discuss parking capacity at NGH with STH • Discuss how could improve transport to NGH site with providers, South Yorkshire Transport Executive and community transport providers (NB – already
Potential exacerbation of health inequalities	• Disproportionately invest our effort and resources into those communities with most need • Address registration issues for homeless and other vulnerable groups • Maintain approaches being used successfully for non-English speaking patients and share best practice with all practices in Sheffield • Link in with the ongoing work on digital literacy taking place in city to address digital exclusion. • Run targeted education / awareness campaigns to increase understanding of services available and how to access, including signposting and self-care • Consider skill mix of workforce, including mental health, in the UTC and extended access hubs
Loss of services in city centre	• Redistribution of resources and investment into primary care to allow access through local services • Improved signposting/triage to local services

	• Ongoing support in place to support practices, including those in city centre, to ensure sustainability and resilience • Review GP services for homeless to ensure sufficient capacity • Review the extended access (hub) provision • Work with city centre practices to encourage more students to register with a GP in Sheffield.
Do-ability re neighbourhoods/ primary care	• Ongoing use of non-recurrent funding to develop practices, increase sustainability and resilience and improve access • Share work already taking place to improve access, quality and sustainability to increase general awareness and confidence • Explore different contractual mechanisms to support practices to deliver our commissioning intentions • Invest in estate development in line with the CCG's primary care estates strategy • Continue work with practices to support signposting and increase awareness of local services to help reduce demand on practices • Continue work re workforce development and skill mix in practices/neighbourhoods • Continue to support neighbourhoods to introduce governance frameworks • Continue work to deploy new technologies to support practices, including city-wide Wi-Fi and e-consultations

Appendix 5 - WIC Attendances by Practice

The table below shows the number of WIC attendances per each practice within Sheffield ranked by total number of attendances. It also shows the list size for each practice and the attendance rate per 10,000 population.

Practice Name	WIC Attendances	List Size	Rate per 10,000 Pop
University Health Service Health Centre	3543	31961	1108.54
Porterbrook Medical Centre	2921	27747	1052.73
Clover Practice	2514	16471	1526.32
Baslow Rd	1783	12633	1411.38
Upperthorpe Medical Centre	1409	11471	1228.31
Devonshire Green Medical Centre	1388	6992	1985.13
Walkley House Medical Centre	1339	11825	1132.35
Sloan Practice (Main)	1229	13024	943.64
Clover City Practice	1178	4429	2659.74
Burncross Surgery	1004	15393	652.24
Handsworth Medical Practice	980	9914	988.5
Carterknowle Road Surgery	966	12393	779.47
Woodhouse Health Centre	965	12206	790.59
The Mathews Practice Belgrave	960	8575	1119.53
Tramways Medical Centre (Milner)	958	10652	899.36
Broomhill Surgery	890	9669	920.47
Dovercourt Group Practice	889	8421	1055.69
The Crookes Practice	857	8010	1069.91
Pitsmoor Surgery	781	9407	830.23
Far Lane Medical Centre	780	7225	1079.58
Duke Medical Centre	767	7010	1094.15
Tramways Medical Centre (Dr O'Connell)	747	8545	874.2
White House Surgery	743	6408	1159.49
Dykes Hall Medical Centre	727	9752	745.49
Richmond Medical Centre	685	8841	774.8
Nethergreen Surgery	635	9325	680.97
Woodseats Medical Centre	630	9859	639.01
Burngreave Surgery	610	6810	895.74
Sharrow Lane Medical Centre	609	3857	1578.95
Sothall Medical Centre	585	10180	574.66
The Hollies Medical Centre	577	9158	630.05
Heeley Green Surgery	574	5949	964.87
Shiregreen Medical Centre	558	7854	710.47
Firth Park Surgery	545	9917	549.56
Gleadless Medical Centre	541	8846	611.58
Birley Health Centre	537	8515	630.65
Manor Park Medical Centre	528	4413	1196.46
Grenoside Surgery	527	7409	711.3

Practice Name	WIC Attendances	List Size	Rate per 10,000 Pop
Richmond Road Surgery (Dr Mehrotra)	511	3426	1491.54
Meadowgreen Health Centre (Old School)	500	9642	518.56
Norwood Medical Centre	499	8035	621.03
Ecclesfield Group Practice	480	8246	582.1
Wincobank Medical Centre	461	7643	603.17
East Bank Medical Centre	452	5676	796.34
Page Hall Medical Centre	449	7739	580.18
The Medical Centre Crystal Peaks	432	6610	653.56
Park Health Centre	432	5082	850.06
Norfolk Park Medical Centre	432	4501	959.79
Hackenthorpe Medical Centre	416	6730	618.13
The Healthcare Surgery	412	5074	811.98
Foxhill Medical Centre	399	6186	645
The Avenue Medical Pract	366	7147	512.1
Buchanan Road Surgery	363	4718	769.39
The Manchester Rd Surgery	342	4724	723.96
Barnsley Road Surgery	338	2636	1282.25
Elm Lane Surgery	332	5187	640.06
Harold Street Surgery	331	3426	966.14
Valley Medical Centre	327	9612	340.2
Oughtibridge Surgery	322	5834	551.94
Greystones Medical Centre	304	3676	826.99
Jaunty Springs Health Centre	303	3649	830.36
Mosborough Health Centre	301	6630	454
Rustlings Road Med. ctr.	288	4597	626.5
Charnock Health Primary Care Centre	274	5421	505.44
Owlthorpe Surgery	269	4598	585.04
Stonecroft Medical Centre	261	4105	635.81
Dunninc Road Surgery	254	2973	854.36
Totley Rise Medical Centre	246	3460	710.98
Upwell Street Surgery	245	4729	518.08
The Flowers Health Centre	244	4917	496.24
Sheffield Medical Centre	243	1738	1398.16
Falkland House	241	3955	609.36
Mill Road Surgery	240	5279	454.63
Southey Green Medical Centre	211	2957	713.56
Abbey Lane Surgery	211	3193	660.82
Selborne Road Med. Ctr.	199	2724	730.54
Stannington Medical Centre	198	3232	612.62
Deepcar Medical Centre	158	5239	301.58
Carrfield Medical Centre	108	1255	860.56
Veritas Health Centre	101	1473	685.68
The Medical Centre	43	1190	361.34

Number of wte staff required per site to deliver activity volumes

			5			4			5			6			5			5		
			Option 1			Option 2			Option 3			Option 4			Option 5			Option 6		
		no. sites	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming
no. minutes assumed			10	15	10	10	15	10	10	15	10	10	15	10	10	15	10	10	15	10
8am – 8pm weekdays	HUBS	16	**3.23**	-	-	**3.23**	-	-	**3.23**	-	-	**3.23**	-	-	**3.23**	-	-	**3.23**	-	-
	UTC	1	**0.45**	**2.46**	1.52	**0.63**	2.46	1.52	-	**2.46**	1.52	**0.45**	-	1.52	**0.63**	-	1.52	-	-	1.52
	STH ED	1	-	-	-	-	-	-	-	-	-	-	**2.46**	-	-	**2.46**	-	-	**2.46**	-
	UTC (P)	1	**0.18**	-	1.55	-	-	-	-	-	-	**0.18**	-	1.55	-	-	-	-	-	-
	SCH ED	1	-	**0.35**	-	-	**0.35**	1.55	-	**0.35**	-	-	**0.35**	-	-	**0.35**	1.55	-	**0.35**	-
	City UTC (A+P)	1	-	-	-	-	-	-	**0.63**	-	1.55	-	-	-	-	-	-	**0.63**	-	1.55
8am - 8pm weekends	HUBS	4	**0.38**	-	-	0.38	-	-	0.38	-	-	0.38	-	-	0.38	-	-	0.38	-	-
	UTC	1	0.19	0.80	0.62	0.33	0.80	0.62	-	0.80	0.62	0.19	-	0.62	0.33	-	0.62	-	-	0.62
	STH ED	1	-	-	-	-	-	-	-	-	-	-	0.80	-	-	0.80	-	-	0.80	-
	UTC (P)	1	0.14	-	0.60	-	-	0.60	-	-	0.60	0.14	-	0.60	-	-	0.60	-	-	0.60
	SCH ED	1	-	0.11	-	-	0.11	-	-	0.11	-	-	0.11	-	-	0.11	-	-	0.11	-
	City UTC (A+P)	1	-	-	-	-	-	-	0.33	-	-	-	-	-	-	-	-	0.33	-	-
8pm – 11pm every day	HUBS	4	0.30	-	-	0.30	-	-	0.30	-	-	0.30	-	-	0.30	-	-	0.30	-	-
	UTC	1	0.12	0.56	0.90	0.20	0.56	0.90	-	0.56	0.90	0.12	-	0.90	0.20	-	0.90	-	-	0.90
	STH ED	1	-	-	-	-	-	-	-	-	-	-	0.56	-	-	0.56	-	-	0.56	-
	UTC (P)	1	0.08	-	0.97	-	-	0.97	-	-	0.97	0.08	-	0.97	-	-	0.97	-	-	0.97
	SCH ED	1	-	0.16	-	-	0.16	-	-	0.16	-	-	0.16	-	-	0.16	-	-	0.16	-
	City UTC (A+P)	1	-	-	-	-	-	-	0.20	-	-	-	-	-	-	-	-	0.20	-	-
11pm – 8am (7 days a week)		1	0.28	0.22	0.80	0.28	0.22	0.80	0.28	0.22	0.80	0.28	0.22	0.80	0.28	0.22	0.80	0.28	0.22	0.80

Minor injuries co-located at NGH and seen in SCH ED

			Option 1	Option 2
Eye Care			**Urgent eye care undertaken at**	Urgent eye care undertaken by
Eye Care				

TOTAL WTE REQUIRED FOR EACH TIME SLOT

8am - 8pm mon- Friday	52.38	2.81	3.07	52.38	2.81	3.07	52.38	2.81	3.07	52.38	2.81	3.07	52.38	2.81	3.07	52.38	2.81	3.07
8am - 8pm Sat + Sun	1.85	0.91	1.23	1.85	0.91	1.23	1.85	0.91	1.23	1.85	0.91	1.23	1.85	0.91	1.23	1.85	0.91	1.23
8pm - 11pm 7 days	1.39	0.72	1.87	1.39	0.72	1.87	1.39	0.72	1.87	1.39	0.72	1.87	1.39	0.72	1.87	1.39	0.72	1.87
11pm - 8am 7 days	0.28	0.22	0.80	0.28	0.22	0.80	0.28	0.22	0.80	0.28	0.22	0.80	0.28	0.22	0.80	0.28	0.22	0.80

Minor injuries in Eds

Number of wte staff required p																				
				5			4			5			6			5			5		
				Option 7			Option 8			Option 9			Option 10			Option 11			Option 12		
		no. sites	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming	Illness	Injuries	GP streaming
no. minutes assumed																						
8am – 8pm weekdays	HUBS	16																				
	UTC	1																				
	STH ED	1																				
	UTC (P)	1																				
	SCH ED	1																				
	City UTC (A+P)	1																				
8am - 8pm weekends	HUBS	4																				
	UTC	1																				
	STH ED	1																				
	UTC (P)	1																				
	SCH ED	1																				
	City UTC (A+P)	1																				
8pm – 11pm every day	HUBS	4																				
	UTC	1																				
	STH ED	1																				
	UTC (P)	1																				
	SCH ED	1																				
	City UTC (A+P)	1																				
11pm – 8am (7 days a week)		1																				

Eye Care		
Eye Care		

TOTAL WTE REQUIRED FOR EAC

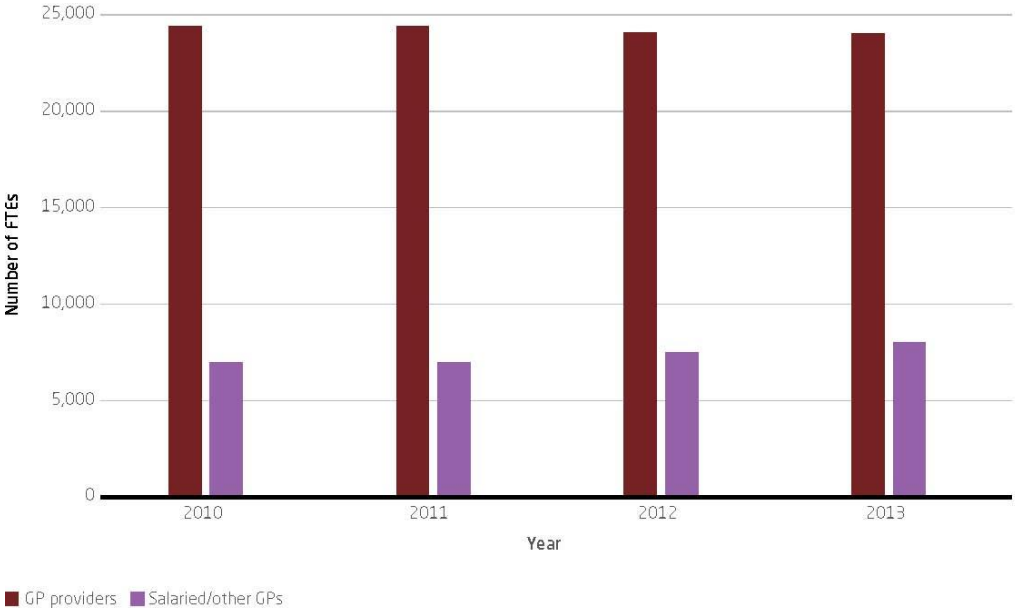
8am - 8pm mon- Friday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8am - 8pm Sat + Sun	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8pm - 11pm 7 days	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
11pm - 8am 7 days	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Appendix 7: Workforce planning for Urgent Primary Care

Current Workforce Position

1. General Practitioners

The total number of GPs in England has increased by 2.3% from 2010-2013 (Kings Fund - April 2015). This must be taken with caution as further modelling has demonstrated that the rate of increase will not actually meet the future demands (HEE 2015). Indeed the Centre for Workforce Intelligence (2014a) has stipulated that there is expected to be a major under supply of GPs by 2020.



Source: Health and Social Care Information Centre 2014a

Estimate of general practitioners (excluding registrars and retainers) 2010—13 (FTE)*1

* Figure is taken from HSCIC's report on GP practice staffing, and has data on GP practitioner FTEs since 2003. However, a change in the estimation of headcount figures means that there may be a break in the data in 2010, making it more accurate, but incomparable with that which was estimated before. Direct comparisons should not be made between any time period after 2010 and any period before then. The most recent data only covers the period 2010–13, so no information is available for 2014 at the time of publication. GP providers Salaried/other GPs 2010 Year 2011 2012 2013 0 5,000 10,000 15,000 20,000 25,000 Number of FTEs

Additionally when looking at the longer term it is apparent that the supply may be further complicated by the increases in medical workforce within secondary care. This then creates difficulties in delivering the national expectations of care closer to home and the Forward View.

The RCGP estimates that the number of unfilled GP posts has increased fourfold since 2010 and in 2014 approximately 12% of GP training posts were unfilled (HEE 2015).

Support and Grow the Workforce

Workforce Analysis (Jul-Sep 2014)

NHS Sheffield CCG

Health Education
Yorkshire and the Humber

Aggregated Workforce Profile

Job Role	Under 25		25-34		35-44		45-54		55+		Total
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
GP	2.78	2.00	19.86	39.13	39.81	52.25	51.48	47.39	20.06	23.53	298.29
GP Partner	0	0	4.73	5.47	33.14	28.74	46.62	32.12	18.39	20.14	189.35
GP Salaried	0.78	0	6.28	12.28	4.03	18.35	4.64	14.71	1.67	3.39	66.13
GP Registrars - years 3 & 4	1.00	1.00	4.49	17.05	1.25	4.72	0	0	0	0	29.51
GP Foundation Registrar - years 1 & 2	1.00	1.00	4.36	2.89	1.00	0	0	0	0	0	10.25
Locum - other	0	0	0	1.00	0.39	0	0.22	0.56	0	0	2.17
Locum - covering maternity/paternity	0	0	0	0.44	0	0.44	0	0	0	0	0.88
Practice Nurses	0	1.72	0.80	9.04	0	24.78	1.96	60.81	0.61	36.44	136.16
Advanced Nurse Practitioners	0	0.85	0	1.80	0	6.28	1.96	13.29	0.61	16.43	41.22
Extended Role Practice Nurses	0	0	0	1.00	0	1.51	0	2.47	0	0.20	5.18
Specialist Practitioner Nurse	0	0	0	0	0	0	0	5.61	0	1.36	6.97
Practice Nurses	0	0.87	0.80	4.48	0	14.30	0	39.44	0	18.45	78.34
New Practice Nurse	0	0	0	1.76	0	2.69	0	0	0	0	4.45
Direct Patient Care	0	3.28	0	7.68	1.00	13.67	0.61	31.24	0.93	17.33	75.74
Health Care Assistant	0	2.94	0	7.36	1.00	11.92	0.40	24.15	0.93	13.62	62.32
Therapists	0	0	0	0	0	0	0	0.27	0	0	0.27
Phlebotomists	0	0.11	0	0.32	0	0.16	0	2.35	0	1.72	4.66
Other	0	0	0	0	0	1.00	0.21	1.97	0	1.16	4.34
Dispenser	0	0	0	0	0	0	0	2.27	0	0.54	2.81
Pharmacist	0	0.23	0	0	0	0.59	0	0.23	0	0.29	1.34
Practice Management	3.22	26.57	13.08	43.91	11.40	77.69	6.27	173.83	4.00	170.04	530.01
Admin & Clerical	0.99	7.88	6.81	15.13	3.52	21.85	0.65	53.09	0.32	59.01	169.25
Other Practice Staff	0	1.00	0	2.00	0	1.00	0	5.04	0.69	1.48	11.21
Temporary Worker	0	0.80	0.13	0	0	0	0	0	0	0	0.93
Reception Staff	1.23	16.76	0.81	22.68	1.53	45.08	0	88.91	0.28	83.49	260.77
Practice Manager	0	0	3.80	3.56	4.39	7.25	5.62	20.00	1.56	15.04	61.22
Prescription Clerk	0	0	0	0.43	0	0	0	0.67	0	1.76	2.86
Summariser	1.00	0.13	1.00	0	1.00	0.69	0	1.80	0.61	5.14	11.37
Cleaner	0	0	0.53	0.11	0.96	1.82	0	4.32	0.54	4.12	12.40
Apprentices	1.00	10.76	0	0	0	1.05	0	1.76	0	3.72	18.29
Administrative & Clerical	1.00	10.76	0	0	0	1.05	0	1.76	0	3.72	18.29
Total	7.00	44.33	33.74	99.76	52.21	169.44	60.32	315.03	25.60	251.06	1058.49

* Please note. The staff in the 'Partner' job role have been excluded from the Particpation Rate calculation.

Sheffield Age Profile

GPs	50.72 WTE of 320.71 over 55	(15.8%)
Practice Nurses	44.58 WTE of 147.47 over 55	(30.23%)
Other Direct Patient Care	18.94 WTE of 80.98 over 55	(23.38%)
Practice Management	202.08 WTE of 586.26 over 55	(34.47%)
Practice manager	22.05 WTE of 68.17 over 55	(32.35%)

4.2.1 Comparison to South Yorkshire & Bassetlaw

The table below shows the whole time equivalent Staff per 1,000 patients broken down into cities within South Yorkshire & Bassetlaw.[1]

Table 1: South Yorkshire and Bassetlaw WTE Staff per 1,000 Patients

Staff per 1000 patients	GP	Nursing	Direct Patient Care	Practice Management
NHS Barnsley CCG	0.81	0.32	0.23	1.18
NHS Bassetlaw CCG	0.79	0.36	0.15	1.39
NHS Doncaster CCG	0.8	0.34	0.14	0.96
NHS Rotherham CCG	0.8	0.27	0.16	0.97
NHS Sheffield CCG	0.97	0.24	0.11	0.72

[1] Information provided by HSCIC (now NHS Digital)

Note - Direct patient care relates to other clinical roles within the GP practice team e.g. pharmacists.

The workforce intelligence data tells us that there are significant workforce gaps which we will need to manage in Sheffield in the near future. The main issues will be in practice nursing and administrative/practice management roles because the age profile tells us that more than 30% of the workforce are over the age of 55 and likely to retire, especially nursing staff with Special Class Status. The data also informs us that Sheffield is considerably behind in other roles associated with delivering direct patient care which will require us to concentrate on this if we are to truly shift care out of hospital into primary care and the community.

The role of the practice manager (PM) needs to change and the skills and expertise required to meet the future needs to be developed. The CCG will identify several experienced managers who can act as mentors to more junior staff, increasing their opportunities to learn and to enable PMs to have a competent assistant to delegate tasks to when leaving the practice to assist in Neighbourhood working, for example. In addition we have commissioned a series of study afternoons to address some of the challenges that PMs may find themselves faced with. The intention is to offer places to every PM across the city to update and improve their knowledge levels.

Increasing Resources

Our GP 5YFV workforce plan is being developed and will incorporate the national 10 point plan. This plan will include our priorities for developments around care navigation, training administrative staff, upskilling unqualified staff, nurse leadership and developing our practice and business managers to have the skills to lead a future primary care infrastructure.

Our plans include the development of more specialist roles, better utilisation of existing clinical skills and the opportunity to have clearer career paths within the primary care setting across a wide range of disciplines. Our plan will also include looking at the potential utilisation of other roles that may have significant benefit to primary care, emergency care practitioners, physiotherapists, clinical pharmacists, mental health clinicians, child health nursing and better links and integration with the third sector.

Based on modelling in the workforce data below from Health Education England[2] we expect Sheffield to see their proportion the workforce grow from new STP investment to support general practice and meet NHS requirements to address aspects of the GP forward view . This requires the following to happen each year for 2017 to 2021:

- Maintain training output of 100 new General Practitioners per year in SY&B
- 40 new nurses per year working in general practice in SY&B
- 20 new 'pharmacists in primary care' per year
- 20 new advanced practitioners per year
- 20 physician associates per year
- Major development of the primary care support worker based in general practice comprising;
    - 100 new clinical support workers per year
    - Conversion of 50 practice clerical support workers per year into clinical support (patient facing) roles
    - Training of existing and new volunteers as community champions, wellbeing experts and experts by experience.
    - A development programme to support practices rethink and redesign 'who does what' in a general practice setting using workforce tools such as the Calderdale Framework.

Nursing & Support Staff

Sheffield has been delayed in diversifying the workforce due to having a historically strong GP ratio creating less of a need to do so. As the GP ratio changes, we will need to support GP practices to ensure the nursing workforce can respond to the shift of work from GPs to nursing roles.

Some Sheffield practices have committed to the student nurse training scheme and one of our GP federations is delivering the Advanced Training Practice scheme for nursing. Many of our practices now have apprenticeships in both administrators and support working. We are keen to ensure that our practices mentor newly qualified student nurses in an attempt to increase the numbers of nurses coming into primary care from trainees and secondary care.

[2] Information submitted by Health Education England to South Yorkshire & Bassetlaw STP executive and Local Workforce Action Board

In order to widen the opportunities for new staff to be exposed to the opportunities offered by a career in primary care we need to ensure that there are nurse mentors in as many practices as possible in Sheffield practices. We aspire to train 10 each year of the GPFV monies enabling more practices to join the ATP scheme and allow student nurses the chance to consider primary care as a destination. It is also a requirement of the GPN ready scheme that nurse mentorship is available to the newly qualified nurses.

In order to prioritise our developments in primary care nursing, it is therefore proposed to utilise funding to employ two senior experienced practice nurses with additional administrative support from 2016. These nurses will provide leadership, development and support to and ensure that general practice nursing teams across Sheffield are equipped to deliver the current and future primary care agenda.

Clinical Pharmacists

One of our Prime Ministers Challenge Fund (PMCF) work-streams included clinical pharmacy input into general practice in Sheffield. The pharmacists that have been involved with the scheme have been involved in undertaking medication reviews and long terms condition management amongst many other developments. This pilot programme has been recognised nationally and is influencing developing a model for primary care locally. The CCG plans to develop this work further in developing the role of the clinical pharmacist to improve integration within the primary care setting. We are currently awaiting the evaluation of this work which will help inform the CCG when we seek to secure additional 120 clinical pharmacists as below.

In line with the GPFV we will be looking to secure an additional 120 clinical pharmacists in Sheffield working with the model of 20 senior pharmacists across the neighbourhoods (1 WTE per 30,000 population) with an additional 100 pharmacists working in each and every primary care setting.

Management and Administrative Staff

Significant business acumen will be required of the role of the practice manager in order to support primary care operating at scale. We intend to support those managers through networks, education, training, and the business management skills to equip them for the changes ahead. By doing this we will be working to identify our future primary care leaders.

The role of front-line administrative staff will need to be empowered and enhanced to provide more support to patients and clinical staff. We plan to embark on a programme of training and development for this key group of individuals who tend to know the patient population very well and contribute to the overall care and quality of a service. We will utilise GPFV monies to facilitate training sessions in relation to care navigation, customer care and medical documentation.

We intend to learn from the Wakefield Vanguard in delivering successful care navigation to the entire front-line workforce; enabling appropriate signposting to other community services and creating additional capacity required in general practice. This priority both complements and magnifies the benefits of social prescribing and it is key to reiterate the need to think and act laterally, across strategies, to respond to both the improvement of primary care services (GPFV) and the integration of health and social care for holism (Better Care Fund/Sheffield's Integrated Commissioning Programme).

Physician Associates

The CCG has been involved with the Universities in Sheffield regarding Physician Associate (PA) training and some practices have already adopted this role into their teams. Further scoping is required to address concerns raised mainly among GPs as to the clinical training and expertise of PAs, the training support required and how this role compares to Advanced Nurse Practitioners; a role that may require less GP direction, is able to independently prescribe refer and order some diagnostic tests.

Yorkshire and Humber have invested significantly in this role and are keen to facilitate internships and support placements. This will need further exploration.

The role of the PA will continue to be explored with our key partners and universities to ensure that Sheffield will be able to deploy the trainees into primary care appropriately. A meeting is planned for January 2016 to discuss how the CCG might be involved in a "recruitment fair" planned for March.

Mental Health Workers in General Practice

We are developing alternative models of service delivery outside of specialist mental health services. The role and skills required in primary and community care will need to have a strong focus on providing community based alternatives and holistic mental health care recognising that physical and mental health needs should work together collectively. Some local learning (e.g. Pitsmoor Mental Health Project) will be key in the development of alternative models of delivering integrated primary care mental health.

As part of our developing models of service, key areas for primary care include:

- Primary care mental health workers; with an increase of at least a further 23 WTE therapists working alongside IAPT in an "IAPT Plus" model co-located in primary care and working across the neighbourhoods;
- Developing our Psychiatric Liaison service; consisting of a multi-skilled team that provides a comprehensive assessment of a person's physical and psychological well-being at key points in the mental health pathway. Our ability to respond rapidly to people that traditionally would have required acute beds will benefit from an enhanced service working closely with primary care and neighbourhood services developing the alternatives to acute admissions;

Integrated physical and mental health provision for people with serious mental illness; we are keen to develop a response to tackling Serious Mental Illness (SMI) across the neighbourhoods jointly with our secondary care provider and recognise that these people are some of the most vulnerable in our society with work yet to be done to improve the parity of esteem given to those that suffer from mental ill health compared to physical ill health.

We will be working closely with our NHS England colleagues to ensure that our GPs are connected into accessing the free emotional wellbeing support for GPs suffering with mental health problems and burnout.

Training & Development

Development of the workforce is essential to transforming primary care in Sheffield. As part of our primary care workforce planning a skills audit to determine the readiness of our workforce to become future leaders as well as the skills required in delivering out of hospital care will be undertaken. The results of this audit will be used to determine the skills and qualifications required to then map the needs of our neighbourhoods and work closely with our universities in developing the right training and workforce required in the future. This intelligence will also be used to inform our workforce plan.

The CCG currently has 32 training practices and all Sheffield training places have been filled this academic year. Sheffield has mainly been successful in its GP training placements, clearly this plays a significant role in supporting new GPs to the area and encouraging them to stay in Sheffield once they have qualified. The CCG continues to support GP practices to develop their training facilities and will prioritise investment (e.g. via core capital funding) to practices aspiring to increase or develop this further.

We would wish to see the number of training practices within the City increase further over the next 3-5 years. We will work with practices to explore how, in the currently challenging climate, practices can be encouraged to seek training status or work within training hubs in addition to offering training opportunities to members of the wider primary care/neighbourhood team.

Our estates strategy will need to link closely with said intentions to support the development of practices into teaching units/neighbourhood training hubs, and our investment criteria will reflect, support and encourage this development.

Sheffield is looking to utilise the funding opportunities from GPFV to increase the spend into primary and community care via additional educational and support in the form of:

- The Productive General Practice programme and/or support to put in place relevant high impact changes for every practice;
- Expansion of the Resilience Funding work and a support programme for primary care to explore federations and models of primary care at scale;
- A programme of education for reception teams which will include care navigation and enhanced medical documentation/read coding training for every practice;
- Releasing GP leaders to make this significant change within practices;
- Developing Practice Managers to lead different business models in the future;

- Working with our Advanced Training Provider (ATP) in the North of the city (The Foundry Medical Group) to help us scope out the opportunities around teaching and training and the support required for primary care;
- Work with the ATP programme to support practices to host the GPN ready scheme
- Academic Health Science Network (AHSN) supported work to primary care leaders in sharing best practice and developing knowledge and expertise on potential new contract models within the new models framework;
- Action learning approach to support leaders (clinical and non-clinical) within the emerging neighbourhood approach;
- Supporting our citywide provider company for general practices, Primary Care Sheffield (PCS), to develop its primary care at scale offer to support much of the above and progress the emerging new models of care approach within the city.

The above workforce strategy can therefore be seen to adequately mitigate against any clinical workforce demands that the new Urgent Primary Care will result in.

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee

10th October 2018

Report of: Greg Fell, Director of Public Health

Subject: Public Health Outcomes in Sheffield

The Director of Public Health is attending the meeting to give an update on Public Health outcomes in Sheffield and take questions from the Committee.

Sheffield's Health Profile for 2018 is attached for information.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**x**
Other	

The Scrutiny Committee is being asked to:

- Discuss health outcomes in Sheffield and identify any further action or information required.

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Public Health England

Protecting and improving the nation's health

Sheffield

Unitary authority

This profile was published on 3 July 2018

Local Authority Health Profile 2018

This profile gives a picture of people's health in Sheffield. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Health in summary

The health of people in Sheffield is varied compared with the England average. Sheffield is one of the 20% most deprived districts/unitary authorities in England and about 22% (21,600) of children live in low income families. Life expectancy for both men and women is lower than the England average.

Health inequalities

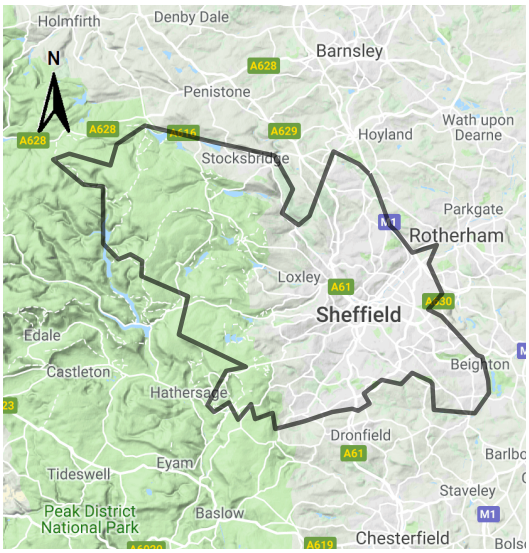
Life expectancy is 9.9 years lower for men and 8.6 years lower for women in the most deprived areas of Sheffield than in the least deprived areas.**

Child health

In Year 6, 21.2% (1,219) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 23*, better than the average for England. This represents 27 stays per year. Levels of GCSE attainment and smoking at time of delivery are worse than the England average. Levels of breastfeeding initiation are better than the England average.

Adult health

The rate of alcohol-related harm hospital stays is 695*, worse than the average for England. This represents 3,575 stays per year. The rate of self-harm hospital stays is 132*, better than the average for England. This represents 797 stays per year. Estimated levels of adult physical activity are worse than the England average. The rate of TB is worse than average. Rates of sexually transmitted infections and people killed and seriously injured on roads are better than average.



For more information on priorities in this area, see:

- https://www.sheffield.gov.uk/home/public-health/health-wellbeing-needs-assessment.html

Visit www.healthprofiles.info for more area profiles, more information and interactive maps and tools.

Local Authority Health Profiles are Official Statistics and are produced based on the three pillars of the Code of Practice for Statistics: Trustworthiness, Quality and Value.

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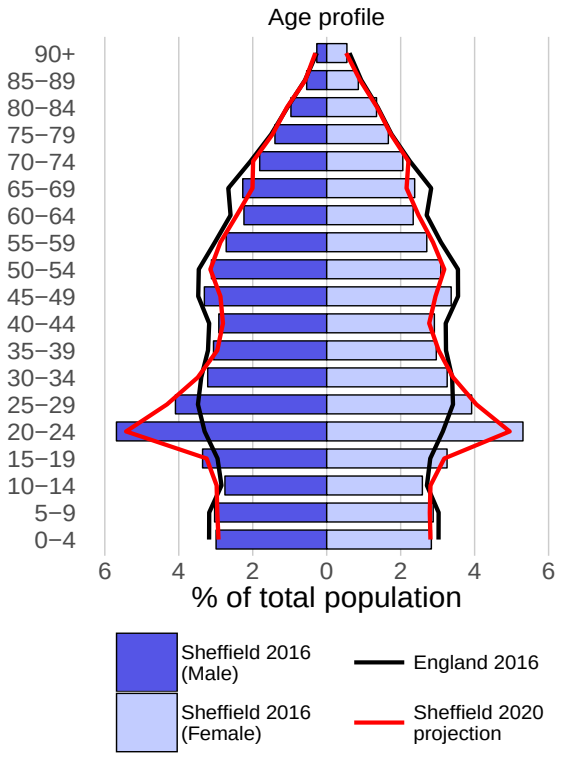
* rate per 100,000 population

** see page 3

Population



Understanding the sociodemographic profile of an area is important when planning services. Different population groups may have different health and social care needs and are likely to interact with services in different ways.

	Sheffield (persons)	England (persons)
Population (2016)*	574	55,268
Projected population (2020)*	588	56,705
% population aged under 18	20.3%	21.3%
% population aged 65+	16.1%	17.9%
% people from an ethnic minority group	13.2%	13.6%

* thousands

Source:
Populations: Office for National Statistics licensed under the Open Government Licence
Ethnic minority groups: Annual Population Survey, October 2015 to September 2016

Deprivation

The level of deprivation in an area can be used to identify those communities who may be in the greatest need of services. These maps and charts show the Index of Multiple Deprivation 2015 (IMD 2015).

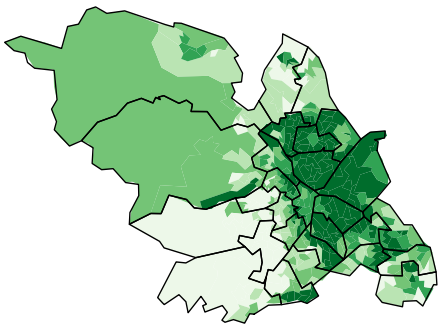
National

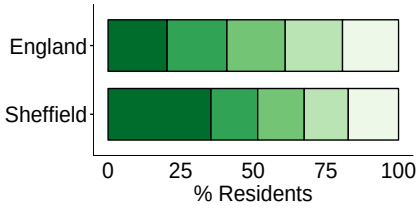
The first of the two maps shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of IMD 2015, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

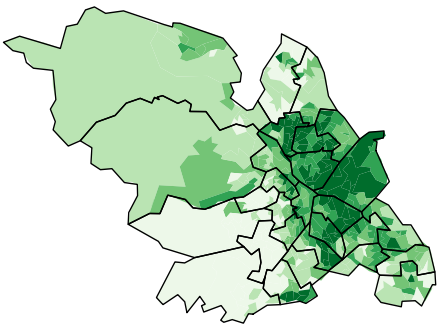
The chart shows the percentage of the population who live in areas at each level of deprivation.

Local

The second map shows the differences in deprivation based on local quintiles (fifths) of IMD 2015 for this area.







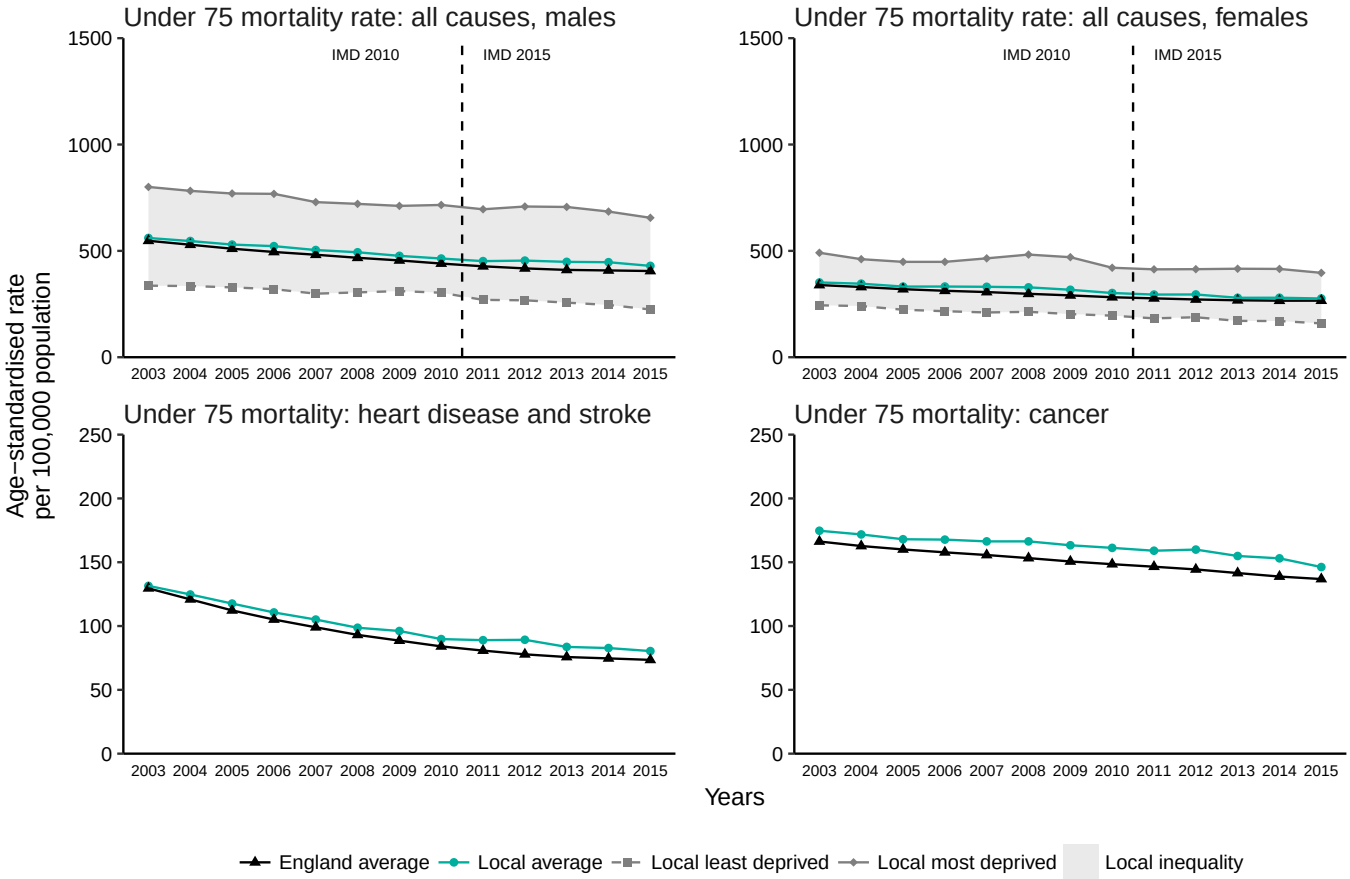
Lines represent electoral wards (2017). Quintiles shown for 2011 based lower super output areas (LSOAs). Contains OS data © Crown copyright and database rights 2018. Contains public sector information licensed under the Open Government Licence v3.0

Health inequalities: life expectancy

The charts show life expectancy for males and females within this local authority for 2014-16. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015). The life expectancy gap is the difference between the top and bottom of the inequality slope. This represents the range in years of life expectancy from most to least deprived within this area. If there was no inequality in life expectancy the line would be horizontal.

Trends over time: under 75 mortality

These charts provide a comparison of the trends in death rates in people under 75 between this area and England. For deaths from all causes, they also show the trends in the most deprived and least deprived local quintiles (fifths) of this area.



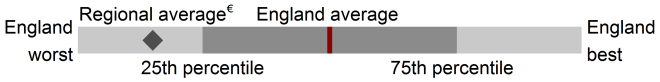
Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with the time period of the data. This provides a more accurate way of examining changes over time by deprivation.

Data points are the midpoints of three year averages of annual rates, for example 2005 represents the period 2004 to 2006. Where data are missing for local least or most deprived, the value could not be calculated as the number of cases is too small.

Health summary for Sheffield

The chart below shows how the health of people in this area compares with the rest of England. This area's value for each indicator is shown as a circle. The England average is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator. However, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



	Indicator names	Period	Local count	Local value	Eng value	Eng worst	Eng best
Life expectancy and causes of death	1 Life expectancy at birth (Male)	2014 – 16	n/a	79.0	79.5	74.2	83.7
	2 Life expectancy at birth (Female)	2014 – 16	n/a	82.6	83.1	79.4	86.8
	3 Under 75 mortality rate: all causes	2014 – 16	4,542	350.8	333.8	545.7	215.2
	4 Under 75 mortality rate: cardiovascular	2014 – 16	1,021	80.4	73.5	141.3	42.3
	5 Under 75 mortality rate: cancer	2014 – 16	1,849	146.2	136.8	195.3	99.1
	6 Suicide rate	2014 – 16	132	9.0	9.9	18.3	4.6
Injuries and ill health	7 Killed and seriously injured on roads	2014 – 16	534	31.2	39.7	110.4	13.5
	8 Hospital stays for self−harm	2016/17	797	132.1	185.3	578.9	50.6
	9 Hip fractures in older people (aged 65+)	2016/17	557	582.5	575.0	854.2	364.7
	10 Cancer diagnosed at early stage	2016	1,081	51.7	52.6	39.3	61.9
	11 Diabetes diagnoses (aged 17+)	2017	n/a	76.8	77.1	54.3	96.3
	12 Dementia diagnoses (aged 65+)	2017	4,894	79.8	67.9	45.1	90.8
Behavioural risk factors	13 Alcohol−specific hospital stays (under 18s)	2014/15 – 16/17	81	23.3	34.2	100.0	6.5
	14 Alcohol−related harm hospital stays	2016/17	3,575	695.3	636.4	1,151.1	388.2
	15 Smoking prevalence in adults (aged 18+)	2017	77,719	17.0	14.9	24.8	4.6
	16 Physically active adults (aged 19+)	2016/17	n/a	63.8	66.0	53.3	78.8
	17 Excess weight in adults (aged 18+)	2016/17	n/a	60.7	61.3	74.9	40.5
Child health	18 Under 18 conceptions	2016	186	21.2	18.8	36.7	3.3
	19 Smoking status at time of delivery	2016/17	782	12.9	10.7	28.1	2.3
	20 Breastfeeding initiation	2016/17	5,047	78.3	74.5	37.9	96.7
	21 Infant mortality rate	2014 – 16	103	5.2	3.9	7.9	0.0
	22 Obese children (aged 10−11)	2016/17	1,219	21.2	20.0	29.2	8.8
Inequalities	23 Deprivation score (IMD 2015)	2015	n/a	27.6	21.8	42.0	5.0
	24 Smoking prevalence: routine and manual occupations	2017	n/a	27.3	25.7	48.7	5.1
Wider determinants of health	25 Children in low income families (under 16s)	2015	21,610	21.9	16.8	30.5	5.7
	26 GCSEs achieved	2015/16	2,879	54.0	57.8	44.8	78.7
	27 Employment rate (aged 16−64)	2016/17	256,800	69.0	74.4	59.8	88.5
	28 Statutory homelessness	2016/17	472	2.0	0.8		
	29 Violent crime (violence offences)	2016/17	10,226	17.9	20.0	42.2	5.7
Health protection	30 Excess winter deaths	Aug 2013 – Jul 2016	748	16.4	17.9	30.3	6.3
	31 New sexually transmitted infections	2017	2,330	608.0	793.8	3,215.3	266.6
	32 New cases of tuberculosis	2014 – 16	218	12.8	10.9	69.0	0.0

For full details on each indicator, see the definitions tab of the Health Profiles online tool: www.healthprofiles.info

Indicator value types
1, 2 Life expectancy - Years 3, 4, 5 Directly age-standardised rate per 100,000 population aged under 75 6 Directly age-standardised rate per 100,000 population aged 10 and over 7 Crude rate per 100,000 population 8 Directly age-standardised rate per 100,000 population 9 Directly age-standardised rate per 100,000 population aged 65 and over 10 Proportion - % of cancers diagnosed at stage 1 or 2 11 Proportion - % recorded diagnosis of diabetes as a proportion of the estimated number with diabetes 12 Proportion - % recorded diagnosis of dementia as a proportion of the estimated number with dementia 13 Crude rate per 100,000 population aged under 18 14 Directly age-standardised rate per 100,000 population 15, 16, 17 Proportion - % 18 Crude rate per 1,000 females aged 15 to 17 19, 20 Proportion - % 21 Crude rate per 1,000 live births 22 Proportion - % 23 Index of Multiple Deprivation (IMD) 2015 score 24, 25 Proportion - % 26 Proportion - % 5 A*-C including English & Maths 27 Proportion - % 28 Crude rate per 1,000 households 29 Crude rate per 1,000 population 30 Ratio of excess winter deaths to average of non-winter deaths (%) 31 Crude rate per 100,000 population aged 15 to 64 (excluding Chlamydia) 32 Crude rate per 100,000 population

€"Regional" refers to the former government regions.

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk