

Primary Care Strategy for Sheffield

Governing Body meeting

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Is your report for Approval / Consideration / Noting	
Approval	
Are there any Resource Implications (including Financial, Staffing etc)?	
A detailed implementation plan will follow if the primary care strategy is approved; this will have resource implications.	
Audit Requirement	
<p><u>CCG Objectives</u></p> <p><i>Which of the CCG's objectives does this paper support?</i></p> <ol style="list-style-type: none"> 1. To improve patient experience and access to care 2. To improve quality and equality of healthcare in Sheffield 3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield 4. To ensure there is a sustainable, affordable healthcare system in Sheffield. 	
<p><u>Equality impact assessment</u></p> <p><i>Have you carried out an Equality Impact Assessment and is it attached?</i></p> <p>Yes, EIA attached.</p>	
<p><u>PPE Activity</u></p> <p><i>How does your paper support involving patients, carers and the public?</i></p> <p>Information from Speaking with Confidence, National Voices, Healthwatch, Sheffield Fairness Commission and the BMA survey results included in their 2015 paper, Responsive, safe and sustainable has been used to develop the strategy. As a result an underpinning element of the strategy is the person-centred care approach – ensuring people are motivated to manage their own health needs and empowering them to get support to address non-medical determinants of health (housing, employment, transport, benefits etc). If implemented the strategy will mean significant changes to the way services are delivered – a public engagement and education programme will be needed to support the successful implementation of this and the wider out of hospital strategy.</p>	

Recommendations
The Governing Body is asked to approve the strategy

Fit for the Future
A Strategy for Primary Care
Services in Sheffield

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Executive summary

This strategy is about future primary care services in Sheffield and how they might work differently. Our vision for primary care in the city is three fold:

To improve the health and well-being of people in the city

To have high quality, sustainable primary care services that are fit for purpose now and in the future

To see health, social and voluntary care services working collaboratively for the benefit of individuals and in tune with the needs of the particular population they serve.

If the changes in this strategy are implemented we can expect the following outcomes:

Better equality in health outcomes for people living in Sheffield; this means improving how people manage their own health and ill health and making sure they have equal access to the support they need, regardless of their social circumstances

Stable primary care services with sufficient numbers and skill mix of staff to manage the demand plus IT and buildings that support and enhance service provision

People receiving the right interventions at the right time from the right professional – mostly in their local neighbourhood.

The above objectives and outcomes are what we are setting out to achieve. How we will achieve them is described in this document. To achieve these objectives will require a change in behaviour and culture for patients, providers and commissioners:

The public will be encouraged and enabled to seek support and interventions from a wider range of professionals and not use their GP as the default option for all health queries; they will play a much bigger part in managing their own health

Providers of primary care services will be encouraged and enabled to work differently – from the way they interact with patients to their working relationships with the health, social care and voluntary sector to sharing contracts and resources with other providers

Commissioners of health and social care services will need to make changes to enablers within the system, i.e. change the way they contract and pay for services, shift more resource into primary care and lead on the changes needed to grow the primary care workforce and develop the right IT and estate infrastructure.

Our vision

We know there will be big improvements in people's health and well-being if the existing services already rooted in local communities – health, social care, voluntary sector, police, education and others – work in a more collaborative way. There is a growing recognition that organisational boundaries have prevented healthy collaboration in the past and that this culture is now shifting. Collaboration between services covering populations of 30-50,000 people is recommended in a number of national documents¹; we refer to this as a neighbourhood and it forms a key part of our strategy.



People will achieve the best health outcomes for themselves if these services work in a truly integrated way. This means each service being able to quickly and easily respond to requests from neighbourhood colleagues for advice or input to an individual patient and, for individuals with more complex needs, working in partnership with a multi-disciplinary team of neighbourhood professionals. Central to our vision are patients who take a much more active role in improving their own health, managing their own ill health and being better informed about which professional is best able to help them.

Of course, not all services can or should be provided at a neighbourhood level; high volume services needed by lots of people will be provided to smaller units of population and more specialist services

¹ Reference is made to services being delivered to a population of 30,000-50,000 in Five Year Forward View, NHS England, October 2014; Place-based systems of care. A way forward for the NHS in England, The Kings Fund, November 2015; General Practice Forward View, NHS England, April 2016; The Primary Care Home, National Association of Primary Care.

will be provided on a city wide basis. The following picture illustrates our vision for Primary Care, Active Support and Recovery (AS&R) and Urgent Care services within the broader range of out of hospital services:



These changes will need to be made in the next 5-10 years. Some pilot work is already underway; the next step for the CCG will be to agree detailed implementation plans for:

- Primary care workforce
- Primary care estate
- Primary care IT
- Provider support
- Contracting and
- Patient education and engagement.

1. The strategic context and case for change

1.1 The strategic context: Out of hospital services

The purpose of the health and social care sector is to improve the health and well-being of the local population. Sheffield CCG and Sheffield City Council have a leadership role to play in signalling the changes that need to be made and in enabling the system to make the necessary changes through the intelligent use of commissioning. The organisations are working jointly to define a system of services that will deliver the highest quality health and social care for people living in Sheffield². As part of this work the CCG has set out a strategy for Care Outside of Hospital³ which takes a whole system approach to the planning and delivery of all care services provided in a community or primary care setting.

The detail of the changes to be made is described in the Primary Care strategy, Urgent Care strategy and Active Support and Recovery (AS&R) strategy.



In summary, the strategies collectively describe how services will be provided differently in the future:

- Managing greater volume of demand by using workforce skills more appropriately; keeping the most skilled resource for the patients in greatest need and maximising the use of resources across different size population groups according to need.
- Maintaining and seeing patients at home or in a community setting rather than in a hospital⁴.
- Working as a single team across organisational boundaries.

² Transforming Sheffield Structure, consultation draft, March 2016.

³ Care Outside of Hospital: An Overarching Strategy, Idris Griffiths. Sheffield CCG Governing Body, January 2016.

⁴ The Clinical Assessment Service, Education and Support model (CASES) is one of the vehicles for delivering this part of the strategy.

1.2 The case for change – national and local drivers

Sheffield Clinical Commissioning Group is responsible for commissioning the majority of healthcare for the population of Sheffield City (approx. half a million people). To date it has not been responsible for commissioning contracted primary care services (GP, pharmacy, dental and optometry services); from April 2016 this will change as the CCG takes on a co-commissioning role with NHS England for GP services. Pharmacy, dental and optometry services will continue to be commissioned solely by NHS England.

Primary care services are an integral part of the wider health and social care system with no part of the system working in isolation. The interdependencies are myriad and complex. Planning the provision of primary care services must, therefore, be considered within the context of community, mental health, hospital, social care, voluntary services and specialist services.

There are many drivers for change within health and social care. The most significant of these is the ever increasing rise in the volume of demand for services. This is being experienced within all parts of the system; the resultant pressure from this will impact on the quality of services if it is not addressed.

National drivers for change

These drivers are well documented⁵ and can be summarised as:

- The number and proportion of older people in the population is increasing; the health and social care needs of older people are often more complex.
- There are more people being diagnosed with long term conditions and a greater proportion of people living with co-morbidity; this increases the demand for services and demands a different type of service provision.
- Greater prevalence of mental health needs and co-morbidity of physical and mental health illness.
- The healthcare expectations of the population are changing in line with greater consumer choice, 24/7 access, fast response times and better informed consumers.
- The approach to healthcare provision is shifting away from a paternalistic model with a greater onus on patients taking a more active role in the care of their own health; the Collaborative Care and Support Planning (CCSP) or person-centred care approach⁶.
- Significant differences in health outcomes for different population groups; a persistence of health inequalities.
- Funding levels have decreased in real terms; the same resources are being spread more thinly requiring more efficient use of funds available.
- Greater integration between health and social care commissioners as a result of the Care Act and introduction of the Better Care Fund (BCF).

⁵ Five Year Forward View, NHS England, October 2014 and General Practice Forward View, NHS England, April 2016.

⁶ Stepping Forward. Commissioning Principles for Collaborative Care and Support Planning. Professor Nigel Mathers, RCGP Clinical Innovation and Research Centre, 2015.

- Changes in technology are enabling improved survival rates, more complex conditions to be managed in a community or home setting and alternative ways of seeing and assessing patients.
- There are significant workforce issues in many parts of healthcare and this is keenly felt in primary care where fewer GPs are entering the profession and more are leaving it early⁷; there are too few practice nurses and a lack of dedicated training and career structure; physician’s assistants courses are in their infancy.
- A combination of workload and workforce pressures and, in some cases, reductions in funding, are pushing some general practices to consider closure⁸.
- A shift in culture towards patient centred care (see Appendix A).

Local drivers for change

There are many local drivers for change; the most pressing of these are:

- The variation in quality and length of life of people living in different parts of the city and in different social circumstances. Not only are those living in deprived areas, with a disability or with a mental health illness more likely to die at a younger age but they are also more likely to live their life in poorer health and find it harder to get the healthcare services they need.
- There are not enough staff to manage the growing need for services and the number of staff approaching retirement or leaving their jobs early due to work pressures suggest that the workforce will shrink over the next few years; this has been further exacerbated by the primary care funding equalisation exercise.

It is imperative that the strategy for primary care addresses these 2 issues. Primary care services must:

- Be of a consistent standard and quality
- Engage with and be accessible to anyone, regardless of their social circumstances
- Offer the same level of service to people with mental ill health and disability as is available to the rest of the population
- Have the right workforce, IT and buildings to be able to do their job.

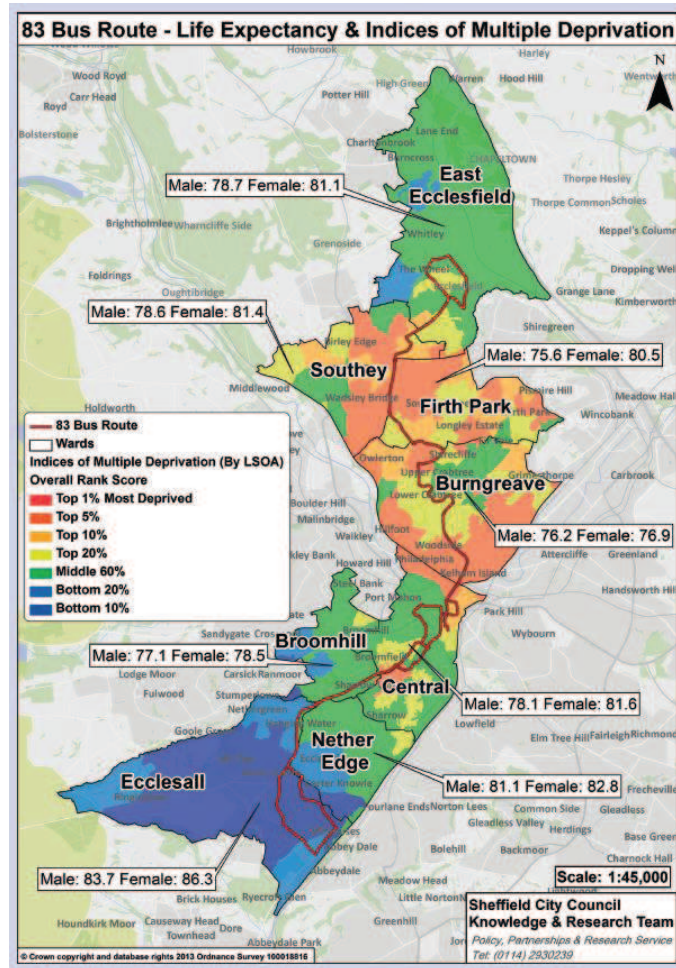
Local drivers – demographics and health outcomes

The resident population of Sheffield is increasing and this will inevitably have an impact on demand levels for primary care services. Projections indicate that the population will continue to grow along with the percentage of the population with multiple long-term conditions; the complexity of which creates additional burden on primary care services. For further information see Appendix B.

Inequalities in health outcomes across the city are apparent from life expectancy data. The following ‘bus route’ through the city demonstrates the difference in life expectancy in different wards:

⁷ Responsive, safe and sustainable. Towards a new future for general practice, British Medical Association, 2015.

⁸ General Practice Forward View, NHS England, April 2016.



“The 65 minute journey on the number 83 bus shows these stark differences in life expectancy across the city. The journey starts at Millhouses ... where female life expectancy is 86.3 years. By the time the bus has travelled down Ecclesall Road and into the city centre, female life expectancy has dropped to 81.6 years, and by the time it makes its way into Burngreave ward just 40 minutes from the start of the journey, female life expectancy is 76.9 years.”⁹ For further information see Appendix B.

Local drivers – pressures in general practice

Many GP practices in Sheffield are reporting that they are under increasing pressure due to a number of factors. These include:

- A significant proportion of GPs and practice nurses approaching retirement age and difficulties in recruiting replacements.
- Fewer GPs entering the profession and increased numbers leaving early due to work pressures and concerns about income;
- Long hours and insufficient capacity to meet the demands of their practice populations;

⁹ Sheffield Fairness Commission report ‘Making Sheffield Fairer’ available at <http://www.sth.nhs.uk/clientfiles/File/Enclosure%20J3%20-%20Fairness%20Commission%20Report.pdf>

- Reductions in funding for some practices;
- A transfer of workload from secondary to primary care without sufficient funding;
- Increased administrative work, e.g. from CQC and CQRS;
- Systems not in place to support patients' needs; GPs spending large amounts of time trying to organise support to enable patients to stay at home;
- Increased numbers of patients with complex needs, including frail elderly and those with co-morbidities;
- Inequities in service provision to housebound patients with long term conditions;
- Greater level of patient expectation – for faster access and more services;
- Negative media and increased public criticism.

More detailed information on the primary care workforce in Sheffield is provided in Appendix C. The workload pressures experienced by GPs in Sheffield are being felt across the country; a study published in the Lancet¹⁰ of over 100,000,000 general practice consultations showed that the number of consultations per person per year has increased by 10.5% between 2007/08 and 2013/14. A separate study¹¹ found that the number of consultations in general practice increased by more than 15% from 2010/11 to 2014/15; the biggest growth in activity was in contacts with people over the age of 85.

1.3 Development of the primary care strategy

For a number of years Sheffield Clinical Commissioning Group (CCG) has been engaging with local people who have told us that¹²:

- They are confused about what services to use for what type of need;
- The health and social care system is complicated, fragmented and lacks communication between services and organisations – services need to be joined up better with greater integration across health and social care;
- They want services in their local community;
- They need more publicity about public and voluntary services in their local area and how they can use these to address their health needs before escalating to their GP, 999 or A&E;
- They want to be treated as a whole, with their mental health needs treated as equal to their physical needs;
- They use urgent care services for convenience if they have difficulty in getting a GP appointment.

The CCG has listened to these messages and to what providers of primary care services across the city are saying; these discussions have generated ideas and momentum and have resulted in the development of this strategy. In addition to the regular Governing Body, City-wide Locality Group and Locality meetings, where these issues have been discussed during the last year, there have been a number of events and meetings dedicated to debating and formulating a strategy for primary care; these are outlined in Appendix D.

¹⁰ Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007-14, The Lancet, April 2016.

¹¹ Understanding pressures in general practice, The Kings Fund, May 2016.

¹² From Speaking with Confidence Briefing, Communications and Engagement Team, NHS Sheffield CCG.

Whilst this strategy focuses on the future role of general practice, pharmacy, dental and optometry services across Sheffield it is written within the context of the wider system of health and social care. Of the 4 independent contractor services, general practice has the greatest ability to impact on the health of a population and is therefore the main focus of this strategy. There is an increasingly central role for community pharmacists to play in out of hospital services and, hence, neighbourhoods; this is covered within the strategy.

2. The current picture of Primary Care provision in Sheffield

2.1 General Practice services

There are 85 general practices across Sheffield City with list sizes ranging between 1,200 and 27,000 and an average list size of 6,800. As each practice is independently contracted, the way services are provided varies, for example, different practices will have different systems in place for accessing services, providing long term conditions management, in the skill mix of their practice team and so on.

For the purpose of provision, general practices mostly operate as separate entities. Each has a national contract which is currently managed by NHS England (NHSE) and may also have one or more contracts for Locally Commissioned Services (LCS); these contracts are between each individual practice and Sheffield CCG. The majority of income for a practice will come from the national contract which operates as a 'one size fits all' and does not allow for differential investment. Whilst LCS contracts do allow for differential investment, they are typically used to contract for smaller services and are cumbersome and bureaucratic for both commissioners and providers.

A city wide primary care organisation, Primary Care Sheffield (PCS), has recently been established, the membership of which includes the majority of practices within the city. This has opened up the possibility of commissioning general medical services at scale and is a model that many other health systems are striving for.

PCS have been successful in their application for Prime Ministers Challenge Fund (PMCF) money which has been used to fund a number of pilot schemes across the city aimed at:

- Providing additional capacity in general practice services;
- Supporting the use of technology in the assessment and treatment of patients;
- Addressing the needs of specific populations;
- Developing integrated working across health, social care and the voluntary sector.

2.2 General Pharmaceutical services

There are currently 128 pharmacies across Sheffield providing care and support to their local populations through the provision of core NHS contractual services such as; dispensing medicines and appliances, advice on self-care, disposal of patient returned medicines, sign-posting and health promotion as well as national and locally commissioned services. There are currently four nationally commissioned services; the medicines use review service (MUR), appliance use review service (AUR), the new medicine service (NMS) and a national flu vaccination service (commissioned for 2015/16). The current locally commissioned services in Sheffield are:

- Minor ailments scheme
- Not dispensed scheme
- Anticoagulation service
- Extended hours
- Carpal tunnel splints
- Advice to care homes
- Emergency 111 supply

- Assured availability of palliative care drugs
- Sub-cut fluid service
- Stop smoking Varenicline patient group directive
- Stop smoking nicotine replacement therapy (NRT) voucher scheme
- Stop smoking one to one service
- Supervised methadone consumption
- Needle exchange
- Needle exchange condom supply scheme
- Emergency Hormonal Contraception (EHC) patient group directive
- Chlamydia Screening

2.2.1 Developing joint working between general practice and community pharmacy

There is currently an ambitious, city wide programme of Community Pharmacists, working with GPs at scale across Sheffield which is successfully demonstrating a new model of care. Community Pharmacists are making a significant impact on reducing GP workload, improving medicines optimisation and driving the patient-centred care agenda. Facilitated by Primary Care Sheffield and Sheffield Clinical Commissioning Group, funded by the Prime Ministers Challenge Fund and supported by Community Pharmacy Sheffield, this is the first example of large scale collaborative working between General Practice and Community Pharmacy in the country. Further information on the programme, and the impact so far, is provided in Appendix E.

This new model has clear benefits and has demonstrated how the skills of community pharmacists can be used more effectively. The funding for this project will continue to March 2017 and will possibly be expanded further following the recent publication of the General Practice Forward View.

2.3 General Ophthalmic services

There are 62 optometry practices in Sheffield providing services through the national contract. The CCG and Local Optometric Council (LOC) have worked together in recent years to provide optical services in the community for non-sight threatening eye conditions that would otherwise have resulted in a patient attending secondary care. The following locally commissioned services are the product of this joint work, which is very well developed when compared to extended community based optometry provision in most parts of the country:

- Primary eyecare acute referral scheme (PEARS)
- Triage
- Glaucoma referral refinement (GRR)
- Contact applanation tonometry (CATS)
- Child eye screening (PRR).

These services are commissioned by the CCG via Primary Eyecare Sheffield (PECS), a limited company formed by participating optometry practices in the city, which successfully tendered to provide the services from April 2015. There are regular meetings between the CCG and PECS to review activity, performance and quality and to work together to solve any issues. There are clear criteria identified for each scheme that participating practices must meet.

There is good coverage of all the above services across the city with around half of all practices belonging to PECS and participating in one or more of the schemes.

2.4 General Dental services

There are 77 general dental practices in Sheffield providing NHS services and 4 specialist orthodontic practices. As with general medical, pharmaceutical and ophthalmic services there is a national contract for general dental provision. There is an alternative national contract currently being trialled across the country and 3 of the dental practices in Sheffield are on this contract.

The CCG does not commission any local services with dentists in Sheffield, however, the local area team of NHS England contracts with 10 practices for Residential Oral Care Sheffield (ROCS) providing services to 78 care homes and with 2 practices for tier 2 Minor Oral Surgery services.

2.5 Co-commissioning of primary care services

Since the advent of CCGs, primary care services commissioning has been the remit of NHS England. From April 2016 the CCG has delegated responsibility from NHS England for the management of Primary Care contractual issues.

Initially this co-commissioning responsibility extends only to general practices, however, we anticipate that in the future it is likely that responsibility for general pharmaceutical contracts will also be delegated, signalling the growing recognition that community pharmacists have an increasingly important role to play in working with general practices and patients in supporting the day to day delivery of primary care services. Currently there is no move to include responsibility for general ophthalmic or dental services within the co-commissioning agenda though we recognise that this may change at some point in the future.

Co-commissioning is about enhancing and building upon the national contracts already in place for practices. As contracts change so will our co-commissioning approach. The approach is not without risks however the CCG Governing Body feels strongly that the risks are outweighed by the benefits of:

- Stronger practice engagement enabling 'whole system' conversations
- Enhanced engagement in primary care contracting and support
- Supporting quality improvement of primary care provision
- Supporting the delivery of the CCG's emerging strategies such as Active Support and Recovery (AS&R)
- Supporting a high quality, less bureaucratic approach for Locally Commissioned Services.

As the CCG takes on a more significant role in the commissioning and contracting of general medical services it will be working more closely with individual practices and groups of practices, supporting them in their development and implementation of changes.

2.5.1 Changes to primary care contracts

The bulk of services currently provided by GPs, community pharmacists, optometrists and dentists are included within separate national contracts which are subject to national negotiation. Contract

changes over the next 5-10 years have not been signalled; the CCG will keep abreast of changes as they are announced and will work with contractors as appropriate. Changes known or proposed for 2016/17 are outlined in Appendix F.

3. A primary care service for 2021

Sheffield CCG aims to commission and support the provision of primary care services that improve health outcomes for all people in the city. This means reducing the gap in life expectancy and healthy life expectancy described earlier and ensuring that everyone who needs primary healthcare services has access to them, that they are of the highest quality and that they are delivered in a way that everyone can benefit from them. The vision set out below focuses mostly on general practice and community pharmacy services, recognising that these are areas where most positive impact can be made.

3.1 What do we need from a primary care service?

Primary care services refer to general medical, pharmaceutical, ophthalmic and dental services which any member of the public can refer themselves to. People want to be able to access these services easily without travelling long distances; as a CCG we expect these services to be of a high quality and to positively impact on the health outcomes of the local populations they serve. We anticipate that ophthalmic and dental services will not be significantly changed and have focused our attention in this section on general medical and pharmaceutical services.

“Patients want high quality care, provided by a familiar team of GPs who know their medical history, and they want to be able to receive that care in a timely fashion when they need it.”¹³

We want to see a primary medical service that retains the core values of general practice, as identified by a group of Sheffield GPs at a seminar in October 2015¹⁴:

- Care centred around the person
- Shifting power to the patient
- An holistic approach to care
- Advocacy.

Maintaining the system of list-based care is key to retaining these core values and puts general practice at the heart of a patient’s care. The continuity of care that results from many years of the GP and patient working together brings significant benefits.

The patient-GP relationship has become increasingly important as the health and social care system has evolved and become more fragmented; the range of services available to people and the number of agencies involved in delivering these services has increased over the last two decades.

The patient receiving input from multiple parts of the system must feel that they are at the heart of a single system that knows them, understands their physical health, mental health and social care needs and delivers those needs, in line with their own health goals, without delay or interruption. We believe that GPs must be able to easily access and deploy other parts of the health, social care and voluntary sector in the interest of their patients.

¹³ From deliberative events with patients to inform: Responsive, safe and sustainable. Towards a new future for general practice. BMA, 2015.

¹⁴ From Sheffield CCG Future of Primary Care Seminar held on 13 October 2015.

In addition to providing continuity of care for many of their patients, GPs also provide 1st point of contact services for their local population, managing acute presentations and undifferentiated need on a daily basis. We see these elements of service continuing to be managed within the primary care setting and believe that:

- Some services must be provided in a different way in order to have a greater impact on health outcomes for some population groups
- Some services must be provided in a different way in order to manage the increasing demand
- General practice, community and mental health providers, social care providers and the voluntary sector must be enabled to coordinate their care around the needs of the patient.

The third element of provision for the primary care setting is a greater range of specialist services. We recognise that there has been a shift from secondary care to primary care for some services in recent years and believe it is beneficial for patients to be managed at home/in their local community where this is clinically appropriate. We would like to enable all providers of primary care to deliver a broader range of services and acknowledge that this must be supported by a different contractual approach.

To summarise, we would like all people in Sheffield to be able to access the following out of hospital services:



AS&R: Active Support and Recovery

CASES: Clinical Assessment Service, Education and Support model

To have maximum impact on the health and well-being of local populations we believe that these 3 elements of service must all be delivered in a way that:

- Addresses mental and physical health needs concurrently.
- Adopts a person centred care approach to all interactions with patients.

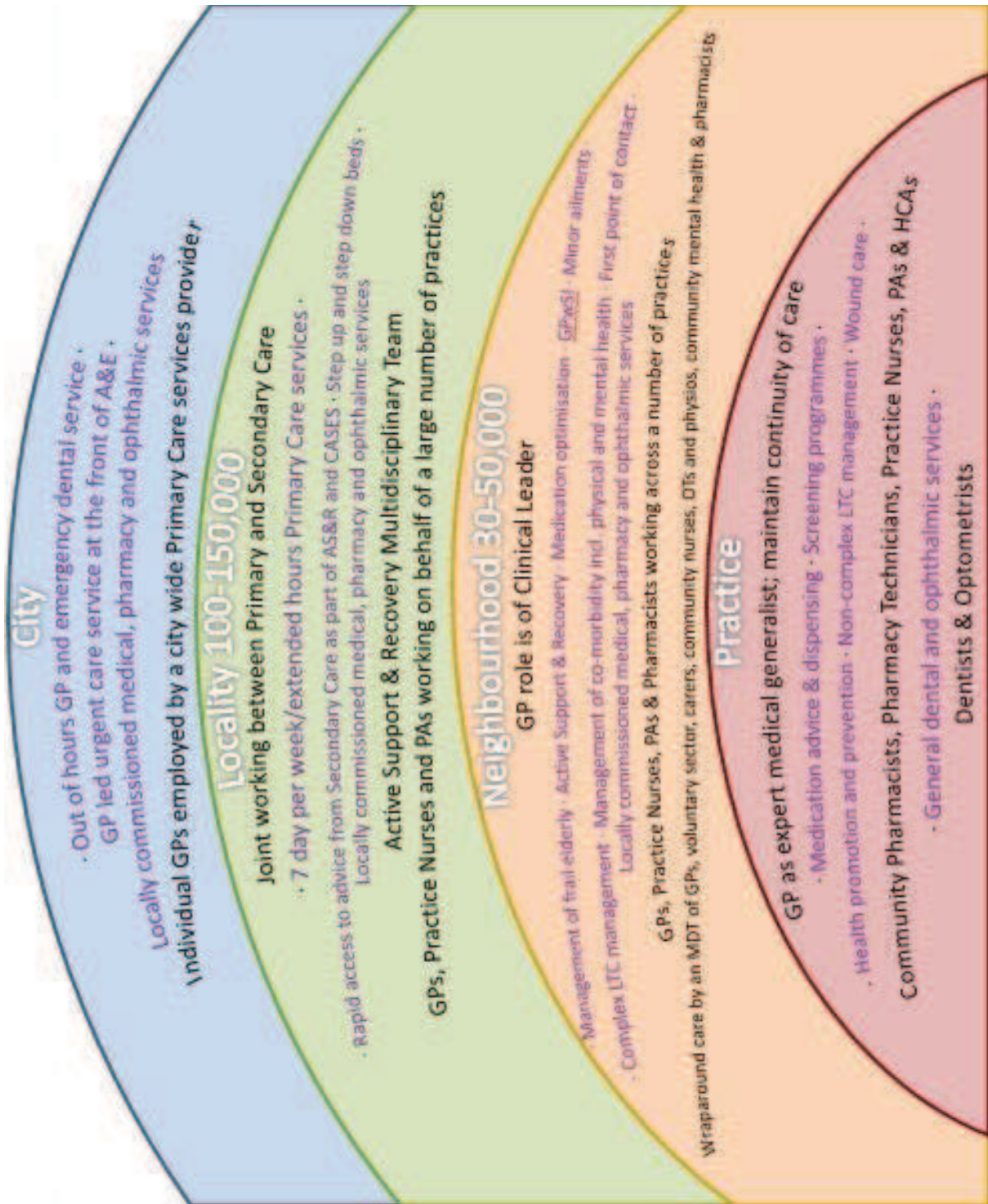
3.2 What do we want a future primary care service to look like?

As with the current system of primary care the GP-Patient relationship will sit at the centre. Health, social and 3rd sector services will be better integrated, with GPs providing leadership on individual patient care within this wider system. There are many ways of describing how this complex system might work in practice and the following takes the perspective of services provided to different size population groupings.

The CCG wants to see primary care resources being used to maximum efficiency and proposes that services are organised in 'layers' of different size populations:

- A typical practice population
- A neighbourhood population of 30,000-50,000 people
- A locality population of 100,000-150,000 people
- A city wide population.

To help achieve this the CCG will encourage larger scale, more collaborative and coherent working between practices and other organisations.



This model proposes one way forward for primary care services and will need further discussion with providers on what the implications of it would be and how it might be implemented. The change in how primary care professionals may work within this model is described below and reflects the change in direction identified in the CCGs Care Outside of Hospital paper.

3.3 Working in neighbourhoods

Active Support and Recovery and People Keeping Well

Central to this model is the introduction of neighbourhood working – health and social care professionals and the voluntary sector providing services to population groupings of 30,000-50,000 people. Although these professionals may work for a range of organisations and agencies the intention is for them to work as a single, multi-disciplinary team for the benefit of individual patients.



Population groupings of this size are being favoured across the country as the size allows for professionals to know each other, know the patients, know the local voluntary sector services available and easily access resources within their neighbourhood¹⁵. Active Support and Recovery (AS&R) will be one of the services on offer. Those patients with more complex needs living within the neighbourhood would work closely with a team of health, care and voluntary sector

¹⁵ Delivering integrated services to populations of 30,000-50,000 is recommended in Place-based Systems of Care (The Kings Fund), General Practice Forward View (NHS England), The Primary Care Home (National Association of Primary Care) and many other national documents.

professionals to get the inputs needed to keep them well in their home setting or to support them during periods of ill health in their home setting. Under this model, professionals working within a neighbourhood would build close relationships with those patients with more complex needs; this more intimate knowledge of individuals will mean services that are better tailored, more effective and seamless, reducing the gaps, duplication and confusion often reported by this cohort of patients in the current system of provision. It is anticipated that the GP would lead the multi-professional team, identifying jointly with the patient the inputs needed and overseeing their single care plan. GPs would lead the care of those complex patients already on their list.

3.4 Empowering clinicians

The role of GPs – practice level

GPs are shown as having a role within every layer; to do this we see GPs operating more as clinical leaders and expert medical generalists¹⁶. At the less complex end of need, GPs would no longer directly provide the service but would oversee other professionals providing those services on their behalf. This model is already in operation in most practices where the practice employs nurses and healthcare assistants to carry out some of this work and this is likely to continue on this basis (management of less complex long term conditions, health checks, screening, vaccinations etc.)

At the practice level, GPs would continue to see patients registered with them who have long term conditions, co-morbidities and/or are frail elderly and are accessing AS&R services at a neighbourhood or locality level. This element of the service is key to retaining the unique GP-patient relationship and the benefits of the resultant continuity of care.

The role of GPs – neighbourhood level

For some services it will make sense for nurses, healthcare assistants or physician's associates to provide these across a group of practices (minor ailments, minor illness) with the GP in an overseeing role, available for advice to the professionals directly providing the service. Some specialist GP services may also be provided directly by GPs across a group of practices. Sharing resources and services across practices would take a big shift in mind set for the majority of practices; the CCG recognises that to build these relationships and foster a greater level of collaboration will need time and may need external support.

For the management of more complex long term conditions, co-morbidity and the frail elderly the model proposes that services provided by health, social care and the third sector would be integrated around neighbourhood populations of approximately 30,000-50,000. It would be logical to provide these services across a number of practice populations and would be dependent on virtual teams of professionals from multiple agencies working closely together. The cultural change needed to effect this change is acknowledged and the role of system leaders in enabling this change is critical.

In this model GPs would provide leadership to the integrated neighbourhood team in respect of the clinical and support needs of individual patients. They may oversee the care of these more complex patients and ensure that the right team of health and social care professionals are meeting the

¹⁶ Dr. Alan McDevitt, Item 27 LMC Conference, 2015.

needs of individual patients. GPs would be able to work more closely with patients and their carers to determine the type and level of input required but would not then be responsible for mobilising this input, which is often reported as being time-consuming and frustrating by GPs working within the current arrangements and a poor use of their time. GPs would continue to lead on the care of those patients with complex long term conditions, co-morbidities and/or the frail elderly who are on their registered list; the care of these patients would originate with the registered practice and their continuity of care would be maintained through this on-going relationship. This service is described in detail in the emerging AS&R strategy paper¹⁷.

Where there are specific, non-generic health needs across population groupings, specialist services may also be provided at a neighbourhood level. This might apply to areas where there is a higher concentration of people whose 2nd language is English or refugee/asylum seeker populations.

The role of GPs – locality level

At a locality level, individual GPs may be undertaking roles on behalf of a large number of practices, for example, to provide 7 day and extended hours services. This category of primary care service would be commissioned at scale rather than via individual practice units and is likely to require a form of primary care provider that operates across a much larger population base. There may also be elements of AS&R services provided across larger population groups, for example, step-up beds and joint working between GPs and secondary care consultants.

The role of GPs – city wide level

GP out of hours services are currently commissioned on a city wide basis and this will continue. The Urgent Care strategy signals the intention to establish a GP led urgent care service at the front of A&E which would be available to the city wide population¹⁸.

The uptake and engagement of practices and pharmacists with the range of initiatives set up via the Prime Ministers Challenge Fund (PMCF) has shown that primary care providers are willing to change. The learning from PMCF will help neighbourhoods determine how to develop services such as planned and unplanned 7 day access and how to work collaboratively with other practices and pharmacists.

The role of the wider general practice team

For GPs to concentrate their time on treating and managing those patients with more complex needs would require other health professionals to provide services to people with less complex needs, for example, practice nurses, community pharmacists, physician's associates and health care assistants. Practices or groups of practices may choose to operate a telephone triage or other triage system to help manage much of the first point of contact work. How this is provided will be for practices to decide themselves.

The current wider general practice team workforce is not enabled to deliver this volume of service nor is it large enough; developing a robust workforce will be critical to the success of this model and

¹⁷ AS&R Strategy as set out in the AS&R Scoping Document, Sheffield CCG, October 2015.

¹⁸ Urgent Care Strategy in development. For consideration at Sheffield CCG Governing Body meeting, June 2016.

the CCG recognises the system wide role it has in enabling this. A clear career structure for HCAs, practice nurses, pharmacists and physician's associates would be needed. As practices work more collaboratively together there will be more opportunities to develop and new roles and a career structure for the wider primary care workforce.

The role of community pharmacists

The CCG would like to see community pharmacists taking on a much broader role than they have to date. The majority of the work of community pharmacists currently is focused on dispensing medicines.

There have been a number of schemes and local contracts for services such as minor ailments, smoking cessation, needle exchange/supervised consumption plus the recent work of the Prime Ministers Challenge Fund where some medicines optimisation work is being trialled through pharmacists working sessions in GP practices. However, it is widely acknowledged that community pharmacists could have a much higher impact role in primary care services provision and are valuable clinical resources, currently being under-utilised.

Primary care services could be enhanced by freeing community pharmacists up from spending most of their time dispensing medicines to enable them to:

- Provide medicines advice directly to patients.
- Work as prescribers within community pharmacies.
- Directly support patients with long term conditions
- Have a bigger role in health promotion, education and changing behaviours contributing to primary prevention of long term conditions and reducing health inequalities.
- Undertake medicines optimisation work to help improve patient safety and reduce the effects of poly pharmacy through medicines review, especially post discharge from hospital, domiciliary visits to housebound patients and patients living in residential or nursing homes.
- Provide follow up care to patients who have been newly prescribed medication by their GP or secondary care for a long term condition to help fine tune dosages, address side effects early and improve compliance; patients could be referred for this part of their care by the GP to the pharmacist.
- Provide screening services (e.g. lung function, AF).
- Undertake medicines management work within practices and from community pharmacies to improve safety and achieve increased efficiencies.
- Manage all repeat prescribing.

For community pharmacists to take on these roles they would need to work much more closely with GP practices and would need to have access to patients medical records. Some practices have started to employ pharmacists directly¹⁹ and this is one option available to primary care providers. However, it would also be practical for independently contracted community pharmacists to work in close partnership with their nearest GP practices which will signal the need for system wide changes; these are considered in more detail in section 4.

¹⁹ How we survived losing 37 GP sessions a week. Katie Slack, Pulse, 7 July 2015.

It is recognised that these changes are likely to need a different contractual model and investment of funding in an alternative way of working for community pharmacists. The role described here for community pharmacists would complement but is different to that of the current medicines management service offered to practices from the CCG.

The role of optometrists

Sheffield CCG currently commissions a number of services from local optometry practices that are aimed at improving access and reducing referrals to secondary care for non-sight threatening eye conditions. It is expected that these services will continue to be commissioned and further possible schemes are being explored by PECS and Sheffield Teaching Hospital, supported by Sheffield CCG.

The role of dentists

There is little joint work currently between the CCG and dental practices in Sheffield and, unlike optometry services, the CCG does not commission any local services from dentists. The alternative contract now being trialled across the country is more focused on prevention services and encouraging more complex dental care to be managed in a primary care setting rather than on simply buying units of dental activity (UDA). The uptake of this new contract format has not been as high as anticipated so calls into question whether the contract will be implemented. However, if it is adopted this would be likely to signal closer working relationships between the CCG and dental practices.

Oral surgery was reported as the biggest cause of elective admission to hospital for children aged between 5 and 9 in 2014²⁰, pointing the way for a greater focus on prevention and for closer working between CCG the and providers of general dental services in the city.

3.5 Neighbourhoods and the voluntary sector

Sheffield has an active and diverse voluntary and community sector. Many of the smaller local organisations share a similar focus of community and neighbourhood to general practice. Voluntary, Charity and Faith (VCF) organisations have a track record of being able to work flexibly and collaboratively to meet the needs of local people. Additionally, many organisations in this diverse sector work with local people, recognising their contribution to community life, and enable local people to develop their own skills, capability and capacity to cope and respond positively to their own health issues.

The voluntary and community sector has an important role to play in helping rebalance health and care provision so that people can be supported to live successfully in their homes and communities. Central to this is the role of smaller community organisations and so called Community Anchors; generic neighbourhood based organisations.

A number of general practices have long standing collaborations with their local voluntary organisations - these include specialist organisations working with particularly vulnerable people such as the homeless, substance misusers and migrants and asylum seekers, people with disabilities and long term conditions and people from different ethnic backgrounds.

²⁰ The British Dental Health Foundation and The Sunday Times, July 2014, reporting on data from The Health and Social Care Information Centre.

The neighbourhood described above incorporates the voluntary sector which is now being seen by the public sector as a partner provider of services to local people. There is a recognition that we need to move from a reliance on ad hoc commissioning of voluntary sector services to a more systematic approach which will give greater stability allowing development and innovation.

VCF and other organisations in Sheffield were recently invited to form, develop and manage Collaborative Partnerships (CPs), via a pseudo-framework²¹, covering geographic areas of the city of between 20,000 and 30,000. 11 CPs have now been formed all of which have general practices as partners. Once on the framework the CPs can provide PKW services. The Council and the CCG will approach CPs on the framework when investing in neighbourhood based preventative health and wellbeing services.

CPs will take on the delivery of more local health and wellbeing services over time, using their local intelligence and flexibility to: support more people to improve their health and wellbeing; target their support intelligently; and, to ensure that the development of community services and activities meets local needs.

The geographic coverage of each CP will be proposed by the partnership and will be aligned with neighbourhood boundaries as closely as possible to enable more integrated working within the neighbourhood.

3.6 Empowering patients

The CCG acknowledges and values the central role that patients play in the effective planning and delivery of primary care. Putting patient care at the heart of this strategy is vital to ensuring that primary care remains focused on improving patient outcomes and experience. Sheffield CCG is committed to ensuring that patients remain at the heart of systems and processes, and that patients' views and experiences are listened to and acted upon as part of this commitment.

Sheffield CCG will ensure that patients know that their voices have been heard and that consideration has been given to their views. Patients will continue to responsibly access health and social care services and, to support them with this, Sheffield CCG will provide patients with the resources to enable them to make informed, positive choices for themselves and their families.

Patients will be empowered to manage their own health and ill health through the use of a person-centred care approach. Social prescribing will become a core part of the services available to enable people to address other issues in their lives that are impacting on their ability to address their health/ill health such as employment, housing, benefits, transport etc.

The People Keeping Well (PKW) initiative will form part of the offer of services within each neighbourhood and uses a proactive, preventative, community based approach made up of a mix of the following six elements²²:

- Local advice and information that helps people maintain independence and wellbeing

²¹ 'Pseudo-Framework' is the commercially compliant title for a framework contract that is flexible enough to periodically re-open to new and changed partnerships.

²² See Appendix G for further detail

- Risk stratification to identify people at moderate to high risk of being admitted to hospital, including those not registered with a GP
- A range of community assets and activities tailored to the needs of people at risk
- Sort and support services to help people support themselves
- Life navigators to provide more intensive support to people at greater risk of declining health and wellbeing
- Wellness planning and self-care – enabling people to set their own goals and action plans in order to better manage their condition, retain maximum independence and make better use of health and social care services.

The purpose of the initiative is to enable people to help themselves, to access the right services for their need at the right time and reduce unnecessary usage of health and social care services.

Case Study

Elsie²³ is an 84yr old lady who lives alone. She has poor eyesight, severe mobility problems and suffers from Crohn’s disease. Due to her health conditions Elsie was housebound and was beginning to struggle to manage her small flat independently. Elsie was referred to a Community Support Worker (CSW) by her GP because she reported being isolated and was struggling with her home.

The CSW visited Elsie and sorted out an assisted weekly shopping trip to a local supermarket and helped her submit a claim for Attendance Allowance which was successful.

Elsie now pays for a weekly cleaner who has befriended her and helps her manage her life. Elsie said this.....

“I think I would be dead by now if it wasn’t for my CSW. She helped get me some money that I use to pay for a cleaner and trips out. I now have a close circle of friends who I know I can call for a chat or if I need any help. Before there was just me and these four walls, I’ve got something to live for now and feel so much better.”

²³ Patient’s name has been changed.

4. Achieving the vision – Providers

To deliver the vision articulated above all providers and commissioners working within the primary and community care arena will have to make changes. Some of these changes will be at a very local, individual practice level whilst others will be dependent on system wide changes, both across Sheffield and nationally.

For all providers working jointly to improve the health and well-being of their local populations, adopting a person-centred care approach will be critical if healthcare professionals are to make a real impact on the health inequalities that Sheffield people currently experience. In order for patients to be engaged in improving their own health or in managing their own ill health, other services and support might need to be accessed first. Further information is provided in Appendix A.

For some healthcare professionals this way of working will be a confirmation or extension of what they already do. For all healthcare professionals to deliver services that are of benefit to each and every patient will require intimate knowledge and understanding of the health, social care and voluntary services available in their local area and the establishment of excellent working relationships with them.

4.1 General Practice

From listening to local practices we believe that there is a real appetite to make radical change and address some of the pressures primary care providers have been reporting for some time. There will be room for 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. The role of the GP as a Clinical Leader within the neighbourhood will enable them to provide leadership on the care of complex patients without having to also be the hub that mobilises this care.

It will, of course, be for providers of primary care services to determine what changes they want to implement within their own practice and between practices.

At the current time the CCG continues to support smaller practices and in the future will encourage a move towards greater collaboration between practices, in line with the direction for general practice expressed by NHS England, the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), the Kings Fund and the National Association of Primary Care (NAPC).

The CCG believes that GP practices will be better able to operate and thrive in the future if they work more closely together and cover larger population groupings of 30,000-50,000. This may be through joint working between practices with shared governance agreements or practices may choose to adopt a more formal federated model. By using this approach practices will be better able to meet the needs of the communities they serve by:

- Sharing knowledge of local population needs and agreeing locally how these needs are best met;
- Sharing knowledge of local services and resources and using these in a planned way, working as collaborative partners with social care and the voluntary sector;

- Providing a range of interventions from universal to targeted, according to need; some interventions will need to be provided by one practice on behalf of a number of practices and some will need to be provided by all practices;
- Sharing knowledge, expertise and best practice to continuously improve the quality of services provided;
- Pooling practice resources and using the range of skills and knowledge they have between them to best effect, in line with the needs of their local population;
- Jointly developing the local primary care workforce by offering shared posts and training placements for GPs, nurses, pharmacists, physicians associates and HCAs;
- Contributing to a city wide primary care workforce development programme that has clear career paths for GPs, nurses, pharmacists, physicians associates, HCAs and others;
- Forming strong working relationships with other health, social care and voluntary sector providers operating within the same local area. This will involve regular meetings to build knowledge of each other, build a shared knowledge of the local needs, plan and implement jointly according to these needs using the combined resources of all local providers.

This work has already started in Sheffield and pilot areas for establishing neighbourhood working are being identified via the CCG. Concurrently, the City Council is identifying Collaborative Partnerships for the People Keeping Well Framework. The CCG and City Council will pool this information and support joint planning between health, social care and voluntary sector providers within these pilot areas to enable them to start operating this year.

The recently published General Practice Forward View²⁴ has committed to supporting practices financially through a 3 year programme, Releasing Time for Patients, with the aim of freeing up 10% of GPs' time. The programme will spread successful innovations adopted in practices across the country including the ten high impact actions.

The CCG welcomes the emergence of a city wide primary care organisation that has made a strong start in attracting £9.3m of central funding and is engaging with the provider alliance in relation to the AS&R and CASES initiatives. The CCG will continue to work to support practices that are in need of help; resources will be targeted at those practices that are working in line with the primary care strategy.

4.2 Pharmacists

The CCG is mindful of the current consultation on the proposed pharmacy contract changes. For community pharmacists to work to the model described above there will need to be radical changes to the current contract arrangements, direct employment opportunities with primary care providers or significant investment in locally enhanced services by the CCG.

As with general practice, community pharmacists are encouraged to build strong working relationships with other health, social care and voluntary sector providers in their area and to become part of the neighbourhood model of care described above. This will involve regular meetings to build knowledge of each other, build a shared knowledge of the local needs, plan and implement jointly according to these needs using the combined resources of all local providers.

²⁴ General Practice Forward View, NHS England, April 2016.

5. Achieving the vision – implementation for Commissioners

Not all changes required can be effected by providers of primary care. The CCG will need to implement system wide changes to enable this new model of working in the following areas:

- **Educating and engaging with the public** on how to access and use services
- **Developing IT** to support collaborative working, self-care and providing services closer to home
- **Developing a primary care workforce** that is fit for future purpose
- **Developing governance systems and contracts** that support collaborative working
- Ensuring we have the **right buildings in the right places**.

None of these can be addressed in isolation by the CCG and it is critical that joint plans are developed with Sheffield City Council (SCC) and other public sector providers; the proposed framework is included in Appendix H.

5.1 Patient education and engagement

The changes described have implications for people delivering services and also for those receiving services. Local people find it difficult to navigate the current system and have asked to be better informed about how best to use it:

“We should encourage people to think of non-medicalised remedies first. If they don’t work then people should go to their GP.²⁵”

Local people need to know if there is another health or care professional that can help them. They need to know how and when to access that person. People also need to know what is expected of them when they see a health professional and what they can do to manage their own health. An on-going education and engagement campaign for local people will need to be run as part of the implementation of the strategy.

5.2 Information Technology

Information technology (IT) needs to support and enable the provision of GP and primary care services. Strategy” in July 2015. City wide IT developments and GP IT developments are both critical to supporting the Primary Care Strategy.

The scale and pace of progress for the city wide and General Practice IT ambitions below will be dependent upon securing the funding required, and on effective collaborative working across the Sheffield (and wider) health and social care system.

Strategic Ambitions

The strategic ambitions from Sheffield CCG’s “Information Management & Technology Strategy” (July 2015) for city wide working are:

- To enable Integrated Care.

²⁵ From Speaking with Confidence Briefing, Communications and Engagement Team, NHS Sheffield CCG.

- To empower staff across care settings to work together in the best interests of their patients through shared electronic care records within a common user interface.
- To connect staff with their customers, partners and patients through agile communication and collaboration tools securely, anytime and anywhere.
- To “give care professionals and carers access to all the data, information and knowledge they need”, i.e. make available real-time digital information on a person’s health and care by 2020 for all NHS-funded services, and comprehensive data on the outcomes and value of services to support improvement and sustainability – as stated in the national Personalised Health Care 2020 plans²⁶.
- To “bring forward life-saving treatments and support innovation and growth” – make England a leading digital health economy in the world and develop new resources to support research and maximise the benefits of new medicines and treatments, particularly in light of breakthroughs in genomic science to combat long-term conditions including cancer, mental health services and tackling infectious diseases – as stated in the national Personalised Health Care 2020 plans.
- To “support care professionals to make the best use of data and technology” – in future all members of the health, care and social care workforce must have the knowledge and skills to embrace the opportunities of information – as stated in the national Personalised Health Care 2020 plans.

In addition to the above city wide strategic ambitions we have also stated for General Practice IT that we need to maximise the value of IT for general practices.

City wide working

The CCG is co-ordinating the production of a city wide Digital Roadmap which will form part of the local Sustainability and Transformation Plan. City wide priorities identified to date are for IT to support:

- Shared Records including patient access, and city wide governance arrangements.
- Transfer of Care between services.
- Medicines Management.
- Wi-fi for public & staff.
- Prevention, covering health and social care, self-care, support for patients and citizens.

Joint working will mean that patients will be seen in a variety of settings across a range of provider organisations. To enable this, the primary care health record, or part of it, will need to be visible to a range of providers and be able to be fed into and out of. Inter-operability between systems is critical. Development of the Digital Roadmap currently covers some health providers but not all primary care health providers, for example, community pharmacists, optometrists and dentists; its coverage will need to be extended to incorporate these.

The ‘Sustainability and Transformation Plan’ is at South Yorkshire and Bassetlaw level; it is probable that joint working on IT plans will extend to the Sheffield City region and beyond.

General Practice IT

²⁶ Personalised Health and Care 2020. Using Data and Technology to Transform Outcomes for Patients and Citizens. A Framework for Action. National Information Board, November 2014.

The CCG is developing the GP IT plans and implementation to support this. Initial priorities identified to date are for GP IT to support:

- Shared Records and Interoperability.
- Online appointment booking and prescription ordering for patients.
- E-consultations.
- Mobile Working.
- Technology to support the remote assessment and treatment of patients in their own homes via telemedicine and self-observation.
- Patient access to records.
- Use and accreditation of apps to support treatment and intervention.

5.3 Primary care workforce

It is critical that a workforce plan for primary care is agreed; the CCG recognises that it has a lead role in developing this with partners. Until recently there has been no formal workforce planning within primary care due to the independent contractor nature of this sector and the fact that it is made up of multiple small employers. The current and projected numbers of staff in some primary care professions means it is imperative that this issue is now tackled at scale. It is not possible for an individual general practice to develop new roles, alternative career structures or to have an overseas recruitment programme. However, these are all possible when they are done on a city or locality wide basis or wider, across the following partner organisations:

- Collaborations of primary care providers
- Sheffield CCG
- Health Education Yorkshire and Humber (HEYH)
- Local education and training providers
- Neighbouring CCGs.

Health Education Yorkshire and Humber (HEYH) now regularly collect workforce data from practices which, for the first time, is providing a picture of skill mix and age profile and allows some projections to be made about numbers of staff approaching retirement etc. This is important in the current environment where GPs are feeling under increasing pressure and some are choosing to leave the profession early. Using this data as a basis the CCG is now in a position to develop a primary care workforce plan that will:

- Project the numbers of staff needed within each profession in 2021 and 2026, taking into account changes in skill mix needed to meet the strategic aims for primary care
- Estimate the gap and, therefore, the number of additional staff to be recruited or developed
- Identify how the workforce gaps will be addressed through a combination of recruitment, retention, training and development.

HEYH oversees the commissioning and support of training and development across Yorkshire and Humber and are implementing plans to help address projected workforce gaps through training and

development²⁷. The schemes they have set up will go partway to addressing the projected gaps in the workforce and they are reliant on their CCG partners to work with constituent practices to encourage and facilitate uptake of the training opportunities on offer. The Advanced Training Practices network has been set up to promote the training schemes available and, where these are not being taken up, the CCG has a role to understand and address the reasons for this.

Training and development is one part of a workforce plan - other elements of primary care workforce development are not within the remit of HEYH and must be led by the CCG. Examples of areas to be covered within a primary care workforce plan are:

Complete an accurate baseline position of all primary care staff working in Sheffield - for GPs, practice nurses, health care assistants, practice managers and admin staff, physician's associates, pharmacists, pharmacy support staff, physiotherapists, dentists, optometrists etc.
Project numbers of primary care staff retiring within the next 5 years
Develop a map of potential roles (junior through to senior) and possible career routes in all primary care professions
Project primary care staffing levels, across all professions from junior to senior level, required within next 5-10 years
Identify which staff groups can be recruited to - explore national and international recruitment options
Agree a recruitment plan - this will necessitate having the ability to employ primary care staff on a cross Sheffield basis
Implement recruitment plan
Agree a retention plan for primary care staff in Sheffield including developing alternative roles for existing staff, training and development opportunities, creating placements etc. Identify where staff are planning to leave and work with practices to address staff concerns where possible.
Assist primary care contractors in establishing best practice HR systems; this may be more easily facilitated on a cross Sheffield basis
Identify where gaps in projected workforce are unlikely to be filled via recruitment and retention - estimate numbers and types of post that are likely to remain unfilled - feed this information into the Sheffield Transformation Programme workforce enabling group
Sheffield Transformation Programme workforce enabling group to work strategically with neighbouring health and social care economies, HEYH, education and training providers etc. to identify all avenues for developing the workforce required
Work jointly with relevant partners to create placement and mentoring opportunities, create new roles and inform the development of training and education courses

5.4 Contracting – financial and quality

To realise the vision for primary care the CCG recognises that the way some services are contracted must change. It is widely acknowledged that secondary care contracts incentivise providers to see more patients in a secondary care setting rather than less and that this naturally sets up boundaries

²⁷ Details of the training and development initiatives are available from Health Education Yorkshire and Humber.

between secondary and primary care. To support a significant shift in services from a secondary to primary care setting will require alternative contracting mechanisms to be developed across the wider system. For example, a way of contracting from a collaboration of primary, secondary and social care providers will need to be developed which enables the sharing of both risk and gain across partner providers. This wider system transformation work will be described in the Sustainability and Transformation Plan (STP) for South Yorkshire and Bassetlaw which is currently being agreed.

The proposals for AS&R services adopt a system wide contract mechanism which allows for risk and gain share across providers. The development of an at-scale primary care provider will support an alternative approach to contracting.

Quality

The CCG has clear responsibilities in relation to commissioning for quality, informed by the NHS constitution (2011) which is further supported in the delegated commissioning arrangements where “CCGs will remain accountable for meeting their own pre-existing statutory functions, for instance in relation to quality.”²⁸

Our ambition is to be an excellent performing CCG, commissioning services that ensure that the residents of Sheffield receive high quality, safe health care, delivered in the right place by staff with appropriate skills.

Current quality measures²⁹ for primary care focus on assurance, value for money and inputs and there will continue to be a place for this where the measures are supported by an evidence base. However, health providers, commissioners and the public will also want to be able to assess service quality based on outcomes for patients. The National Voices paper (2012) and the new integrated health platform require us to refocus and shift our perception of how quality is measured and what this shift may look like in order to deliver the services that best meet the needs of our population. The CCG recognises that outcome measures will need to be developed locally and in a way that takes into account the specific needs of a local population.

Determining what quality measures to use in primary care and the unintended negative consequences resulting from some of the current quality measures has been the subject of much discussion³⁰. What is clear is that assurance processes would benefit from being streamlined and/or lighter touch for those practices meeting current criteria.

In the absence of further national measures of primary care quality being developed, the CCG will need to decide whether to develop its own set of primary care quality measures and if so, what measures to adopt. There is little consensus but plenty of suggestions on what quality measures to use – a Kings Fund survey of GPs in 2010 found that the dimensions of primary care the GPs surveyed thought should be prioritised for improvement were: continuity of care; management of

²⁸ Next steps towards primary care co-commissioning, NHS England 2014.

²⁹ These include the Quality and Outcomes Framework, Care Quality Commission, NHS England and CCG inspections and appraisals and revalidation.

³⁰ See for example How to assess quality in primary care, BMJ, November 2015; The quality of care in general practice – capturing opinions from the front line, The Kings Fund, October 2010; Quality assessments in general practice – have we gone too far? E Ng, BMJ, September 2015.

long term conditions; time spent with patients and better care coordination. Many other studies suggest a wide range of alternative measures.

What is known is that primary care services across all communities vary in quality and this variation can impact on the health outcomes of patients. Determining and implementing a set of quality measures in primary care would be a significant commitment for the CCG and a range of stakeholders would need to be involved in developing a set of quality indicators for primary care locally.

Currently there is no mechanism for practices to highlight and report service to service issues or incidents to the CCG. In other areas, a real time reporting of both incidents and concerns has been implemented and proven to have had a positive impact on the quality of services provided and patient outcomes, releasing financial resources from both the practice and CCG and also freeing up time valuable practice time.

It is suggested that there be the development of a real time reporting system to improve the quality of care the patient receives and problem solve; this can also be used to feed into the commissioning process by highlighting service gaps that have been identified through the reporting mechanism.

5.5 Primary care estate

The Draft Sheffield Strategic Estates Plan, 2016-2020, identified 113 general practice properties in and around Sheffield; these figures include main and branch surgery sites. In addition, there are premises for each of the pharmacy, optometry and dental practices, amounting to a further estimated 260 sites.

The table³¹ of Sheffield GP practice premises below shows that Sheffield has a high proportion of small practices operating from converted premises:

Property Type	Main Surgery	Branch Surgery	Total
Purpose Built	53	17	70
Converted Premises	34	9	43

There are 7 NHS Local Improvement Finance Trust (LIFT) buildings across Sheffield, offering purpose built accommodation. Current utilisation of these buildings is poor; usage of one site was assessed over an extended period and found to be 34%. Usage across all 7 LIFT buildings is estimated at 33-50% of potential capacity; further detailed utilisation studies are planned for all LIFT buildings. The potential to use these buildings to accommodate multi-specialty community providers has been identified within the Draft Strategic Estates Plan. The CCG has a strong financial and quality incentive to improve the utilisation of LIFT assets but also recognises that there are barriers within

³¹ Source: Draft Sheffield Strategic Estates Plan, 2016-2020, Sheffield City Council and Sheffield CCG.

the system that can prevent this from happening. As a system enabler and leader it is part of the job of the CCG to find solutions to obstacles that are preventing the strategy from being implemented.

The initial assessment of all health and social care property in Sheffield suggests that there is an oversupply; more detailed work is being undertaken to establish whether this is the case and, if it is, to agree how the estate can be better used or released.

To support the model of working described above primary care will need buildings based in neighbourhoods in which they can jointly work with health, social care and voluntary sector colleagues. Most of these buildings will already exist; there is a real need and opportunity for public services to work more collaboratively to reduce duplicated overhead costs and to deliver more joined up services at a local level.

The following principles for improvement have been agreed across public sector organisations in Sheffield as part of the Strategic Estates Plan:

- Divest poor quality, poorly performing and surplus assets
- Public and patient facing services prioritised for use of high quality assets
- Develop assets for the delivery of new models of care and service delivery
- Prioritise and enable use of high quality assets, such as LIFT
- Co-locate services in assets where possible, with shared and/or sessional use
- Increase utilisation of health and local authority assets, to create surpluses
- Develop agile working across each organisation – in practice.
- Co-locate support functions where possible, if not integration yet
- Support the continued rationalisation of Sheffield City Council asset base
- Develop agreement on the cost gain / pain share across organisations
- Plan for replacement of aging, poor quality and ineffective assets collaboratively.

Sheffield Strategic Estates Plan makes it clear that significant efficiency and quality gains are achievable with limited investment; a smaller, higher quality estate can be provided at lower cost and the additional costs associated with out-of-hospital care can be significantly mitigated.

Primary Care Transformation Fund (PCTF)

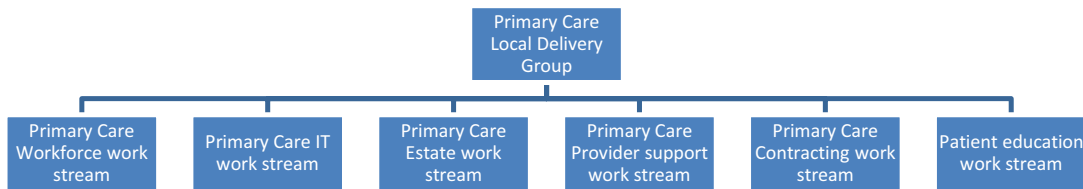
The Primary Care Transformation (formerly Infrastructure) Fund (PCTF) is a four-year investment programme to help general practice make improvements in premises and technology. It is part of the additional NHS funding, announced by the Government in December 2014, to enable the direction of travel set out in the NHS Five Year Forward View.

CCGs have been invited to propose schemes for 16/17 that support delivery of their primary care strategy. NHS England have published criteria in line with the General Practice Forward View³² against which bids will be assessed which include improving the quality of the Primary Care Estate, improving the utilisation of fit for purpose assets and supporting joint working across groups of practices. Schemes will need to be transformational and promote greater access to services, support 7 day access and have the full financial commitment of the CCG in terms of revenue costs.

5.6 Strategy implementation and resourcing

If the strategy is approved by the CCG Governing Body the intention is to agree an implementation plan as quickly as possible. Some of this work has started and actions for the CCG have been identified in sections 5.1-5.5. The changes will have resource implications and the CCG will need to take early decisions about the level of resource it is able to invest in delivering the strategy as this will determine which elements can be implemented.

A Primary Care Local Delivery Group has been established, with membership from Healthwatch, the CCG, primary care providers, Local Medical, Pharmaceutical, Dental and Optometric Committees, Sheffield City Council and locality GP representatives. This group will oversee the development of an implementation plan in line with the strategy and will oversee a number of work streams as follows:



The work of the Primary Care Local Delivery Group will need to feed into the Sheffield Transformation Programme; in some cases plans developed for specific work streams will inform implementation work that is being led elsewhere in the system, in other cases the work stream will be responsible for leading the implementation of plans directly.

³² General Practice Forward View, NHS England, April 2016.

6. Conclusion

Change needs to happen. This is clear when current primary care provision is looked at from all perspectives – patients, providers and commissioners.

This strategy sets out a proposed direction that addresses the issues that have evolved within primary care and that fits within the overall strategic approach of Sheffield CCG and Sheffield City Council. Change within primary care is just part of the story of wider reaching change across the whole system of health, social care and integrated working with the voluntary sector.

The cultural change required to deliver this model of working cannot be over-stated. It has implications for relationships between different provider organisations, different agencies and, more importantly, implications for relationships between individuals working within these settings. Organisations will need to overcome traditional boundaries between themselves and others, some of which will have translated into habitual behaviours in staff. As well as the cultures within health, social care and voluntary sector organisations changing, successful implementation implies changes in patient behaviours and expectations.

Whilst the model may be logical, the emotional route to implement it will require leadership by example at all levels, across all the organisations involved. As system leaders, the role of the CCG is to facilitate these changes, both intellectual and emotional.

We recognise the challenge that this strategy sets but believe it is fundamental to maintaining a strong and sustainable primary care service for the future.

Fit for the Future
A Strategy for Primary Care
Services in Sheffield
Supporting Appendices

APPENDIX A – Patient centred care approach

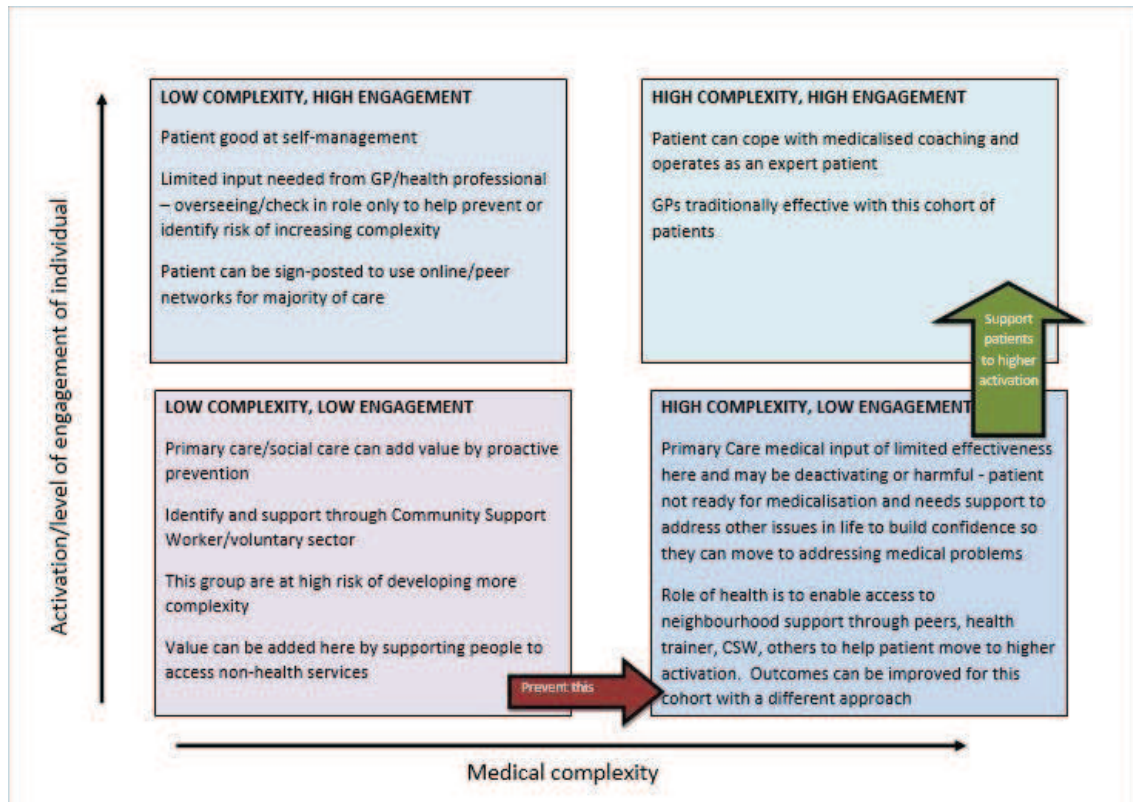
Putting patients' at the centre of their own care enables and supports them to be the best self-support and resource to themselves that they can be and achieve outcomes that are of greatest importance to them. This shift in culture in the way that patients and health professional interact is gaining momentum both nationally and locally and is central to our vision. Referred to as Person-centred care approach or Collaborative Care and Support Planning (CC&SP) the Royal College of GPs (RCGP) states that:

“There is now general consensus amongst policy makers, professional bodies, health charities and NHS managers that safe and effective care can only be achieved when patients are ‘present, powerful and involved’ at all stages.”

Stepping Forward. Commissioning Principles for Collaborative Care and Support Planning. Professor Nigel Mathers, RCGP Clinical Innovation and Research Centre, 2015.

Person-centred care recognises that patients must be ‘activated’ to help plan and manage their own health needs and that activation may not be possible for people who have housing, social, employment or other issues that are a higher priority for them. To help patients become activated and enable them to make positive health choices it is critical that healthcare professionals help them to address these other issues first; this is dependent on having knowledge of and access to a range of social care and voluntary sector services to provide support tailored to the individual’s needs.

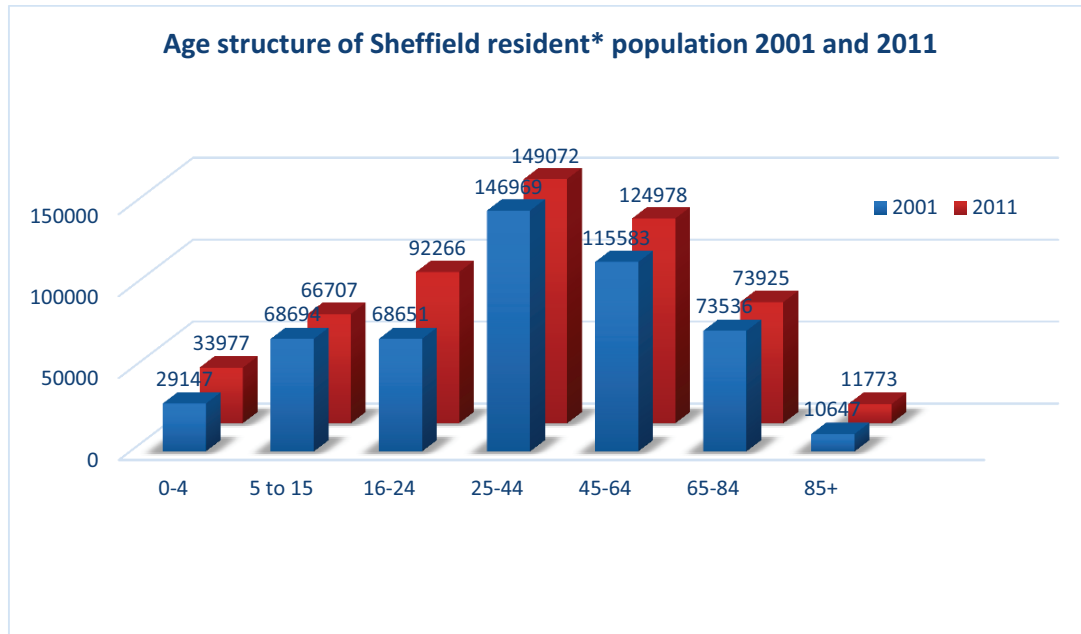
The following model has been observed by Dr Ollie Hart, a GP in Sheffield who is actively involved in implementing person-centred care across Sheffield. It proposes a method to map patient need to the health and social care teams who might be best placed to lead the care of the patient at that time. There is of course a risk of oversimplification, but this could work as a ‘conversation starter’ for how all providers might co-produce and operate a systematic approach to care.



APPENDIX B

Demographic and health outcomes data

In 2011 was 552,698 people; an increase of approximately 7% (40,000 people) from 2001 (total 513,227). This has inevitably had an impact on demand levels for primary care services.



*The registered population of Sheffield, i.e. the number of people registered with a Sheffield GP, is approximately 585,000 (2016).

Projections indicate that the population will continue to grow and that this growth will be mainly seen in the 0-16 and over 65 age groups.

The likelihood of presenting with multiple long term conditions increases with age and the complexity of such cases creates additional burden on primary care services. Nationwide, the number of people with one long term condition is projected to remain relatively stable, however those with multiple long term conditions (i.e. more than 2) is set to rise from 1.9million in 2008 to 2.9million in 2018.¹ In Sheffield, approximately 11% of the population reported that they have multiple long term conditions² and the average complex patient has 7 inpatient admissions per year across 3 different conditions³. Studies into multiple long-term conditions are few, but the evidence that does exist suggests that collaborative and integrated care models, with comprehensive continuity of care, leads to better quality care both for mental and physical health⁴.

¹ Department of Health 'Long Term Conditions Compendium of Information 3rd edition'. Gateway reference 17485

² NHS England, GP Patient Survey 2014/15

³ NHS England 'Commissioning for Value: Integrated Care Pathways Sheffield CCG February 2015'. NHSE Gateway ref 03066

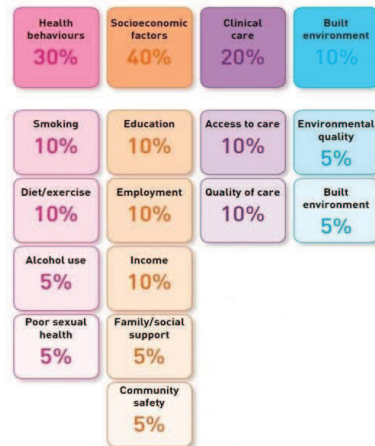
⁴ The Kings Fund, 'Managing people with long-term conditions' (2010)

The Marmot Indicators in Sheffield⁵ show that the city is significantly worse than the England average for life expectancy and healthy life expectancy. The life expectancy for both men and women in Sheffield has not improved over the last 10 years and remains at 78.8 years for men and 82.4 years for women (compared to the national average of 79.4 years for men and 83.1 years for women). There are also significant differences in life expectancy for disabled people and for those suffering with mental ill health. The Sheffield Fairness Commission⁶ found that people with serious mental disorders die 20 years younger than people with no mental health diagnosis.

The picture for healthy life expectancy tells a similar story; how healthy people are during their lifetime varies according to their social circumstance. People living in deprivation, with a disability or with mental illness have poorer health.

Health outcomes are determined by a number of factors including clinical care⁷, as shown in the diagram below. It is estimated that 20% of health outcomes are attributable to high quality and timely clinical care, with 10% of this from access to care, and 10% from quality of care received. Since the vast majority of NHS patient contact takes place in primary care, this sector plays a significant role in the healthcare contribution to improving health outcomes and reducing health inequalities. For example, in Sheffield there are significantly more people than average diagnosed with cancer through an emergency admission to hospital, with poorer health outcomes as a consequence. Whilst health behaviours and socioeconomic factors contribute significantly to this, variability in access to and quality of primary care is also important.

Determinants of health outcomes



The burden of ill health, disability and early death continues to fall disproportionately on both children and adults in the more deprived areas of the city, according to Public Health analysis of neighbourhoods and wards. This perpetuates the ‘inverse care law’ proposed over 40 years ago –

⁵ Marmot Indicators for Local Authorities in England 2015 Institute of Health Equity (University College London) – www.instituteofhealthequity.org

⁶ Sheffield Fairness Commission report ‘Making Sheffield Fairer’ available at <http://www.sth.nhs.uk/clientfiles/File/Enclosure%20J3%20-%20Fairness%20Commission%20Report.pdf>

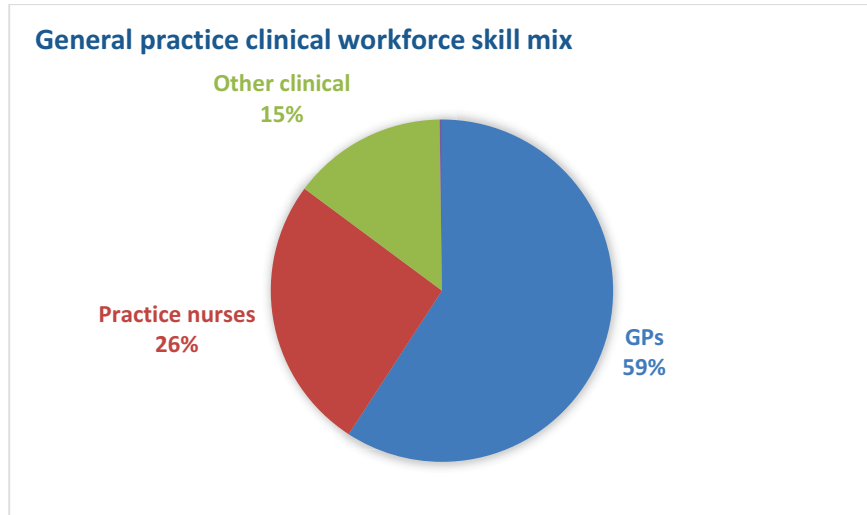
⁷ Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute

that those who have most need of healthcare services are often less likely to receive or access them. Smoking, physical inactivity, poor diet and alcohol misuse are the critical health risk behaviours for the four main causes of preventable, premature deaths in Sheffield. Cancer, cardiovascular disease, respiratory disease and liver disease account for almost half (48%) of preventable deaths in Sheffield.

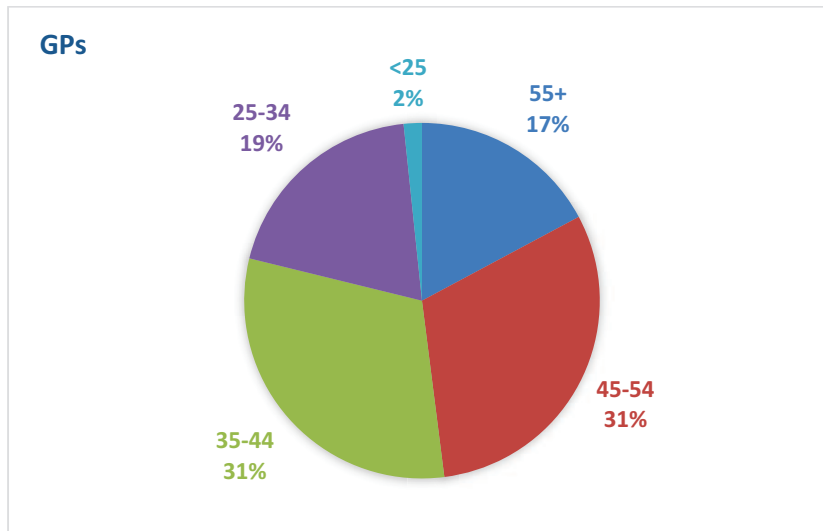
Inequalities are also found in the provision of services to people suffering from mental ill health, particularly in the assessment and treatment of any physical health problems they may present with. The Sheffield Fairness Commission received evidence that 75% of people who committed suicide in Sheffield had not been in contact with mental health services but 90% had seen a GP in the month prior to their suicide.

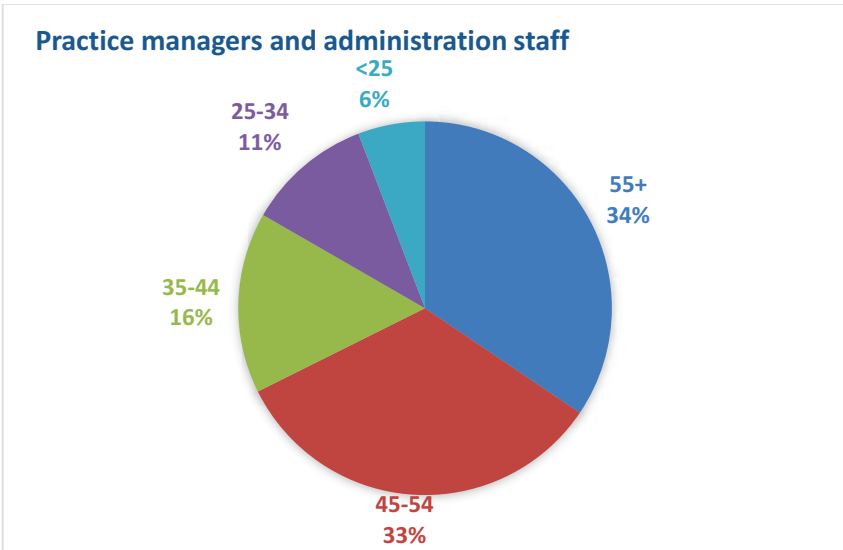
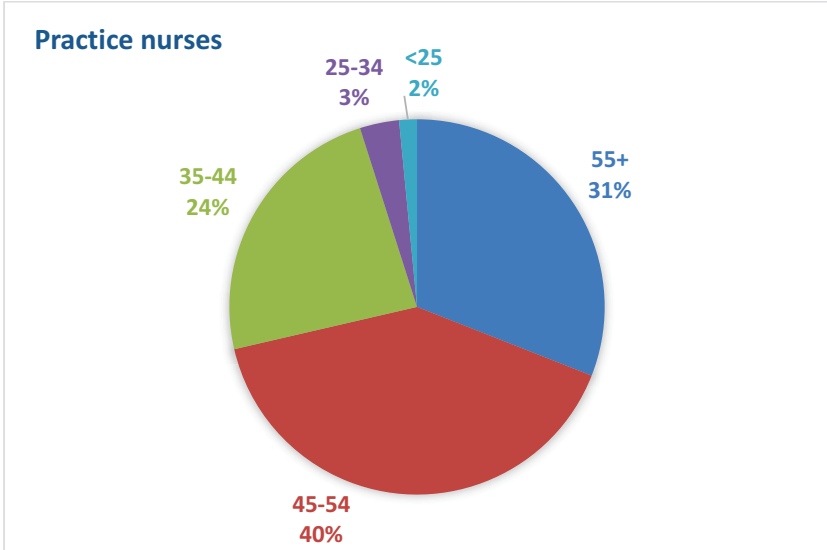
APPENDIX C

Primary care workforce data collected by Health Education Yorkshire and Humber (HEYH) from October-December 2015 (from 71 Sheffield practices) shows that the skill mix in general practice remains 'GP heavy' and reveals a high proportion of the general practice workforce are within 5-10 years of retirement; 17% (55) of GPs, 31% (44) of practice nurses and 34% (54) of practice management staff are age 55 or over:



Age profiles for general practice staff:





APPENDIX D

Development of the strategy – stakeholder engagement

- Three facilitated workshops which focused on the value and values of General Practice and the future structure of Primary Care. A range of stakeholders attended the workshops including representatives from:

Healthwatch; GPs, pharmacists and community nurses working across Sheffield; Local Medical Committee (LMC); Local Pharmaceutical Committee (LPC); Local Optometric Committee (LOC); Royal College of General Practitioners (RCGP); Primary Care Sheffield (PCS); Professional Network Lead for Pharmacy; Sheffield Teaching Hospital Foundation Trust (STHFT); Sheffield Children’s Hospital Foundation Trust (SCHFT); CCG GPs, Clinical Directors, Chief Nurse and nursing staff, Medicines management staff, Locality Managers and Directors; Professor of General Practice, University of Sheffield; NHS England.
- A series of stakeholder engagement and one to one meetings with primary care stakeholders including various GP leaders, Primary Care Sheffield (PCS), City Wide Localities Group (CWLG) and CCG Lead Managers (HR, Communications and Engagement, IT, Medicines Management & Finance), NHSE, Public Health, Sheffield City Council, Healthwatch, Our Healthier Communities and Adult Social Care Scrutiny Committee.
- Presentation and discussion at each Locality Clinical Council.
- The establishment of a Local Delivery Group for Primary Care, responsible for overseeing the implementation of an agreed Primary Care Strategy.

As well as local consultation work, extensive material recently published concerning the future of primary care and the future of general practice has been drawn on to inform the thinking. This includes: The Five Year Forward View (NHSE, 2014); Place-based Systems of Care (The King’s Fund, 2015); The Primary Care Home (National Association of Primary Care, 2015); Stepping Forward (RCGP, 2015); Responsive, safe and sustainable. Towards a new future for general practice (BMA, 2015); The 2022 GP. A Vision for General Practice in the Future NHS (RCGP, 2012).

APPENDIX E

Prime Ministers Challenge Fund – joint working between general practice and community pharmacy

This programme, which is the first and largest of its kind in the UK, has 80 GP practices being provided with pharmacy support (78 by a pharmacist and 2 by technicians). The pharmacists/technicians are working within their local GP practice 1-2 sessions a week, performing a variety of work including; domiciliary visits, reconciliation of hospital discharge and repeat medicines, education, medication reviews and solving ad hoc medication queries. 7,383 provisions of work have been recorded since the project began in October 2015, the majority being reconciling of hospital discharge medicines and medication reviews. In 87% of cases the pharmacists completed the work or resolved the issue without referring to a GP. 95% of the work would have been dealt with by a GP in the pharmacists' absence.

Impact of the project to date:

- Improved joint working, communication and patient care
- More timely resolution of patient problems
- More efficient patient access to advice/treatment
- Improved patient satisfaction and reduction in waste
- Improved patient awareness of pharmacists' skills
- Improved medicines optimisation in vulnerable patient groups
- Improved patient-centred care
- Improved resolution of prescription issues
- Improved patient perception and use of the pharmacy
- Increased signposting to community pharmacy
- Seamless patient care
- Pharmacists learning new skills
- Enhanced role of the Community Pharmacist
- Utilisation of Pharmacist knowledge
- Pharmacist motivation with expanded job role
- GPs sharing their workload
- Pharmacists becoming an integral part of the primary care team
- GP Practices asking for access to their IT system within the Community Pharmacy

APPENDIX F

Changes to primary care contracts 2016/17

The following changes to the primary care contracts have been signalled or are in the process of being negotiated:

General Medical services

Nationally there are minimal changes to the GP contract for 2016/17. The Quality and Outcomes Framework (QOF) will remain the same apart from an adjustment in the value of a QOF point to reflect change in the average list size; the Dementia directed enhanced service (DES) will end on 31st March 2016; the Avoiding Admissions DES will continue in 2016/17, with some minor changes to the service requirements and an increase in the fee for vaccinations and immunisations. Overall, there will be an increase in investment of 3.2%.

General Pharmaceutical services

The Department of Health has proposed changes to the Community Pharmacy Contractual Framework for 2016/17 and beyond. A stakeholder consultation is currently underway, to inform the final details of the plans. The strategy is to develop a clinically focused community pharmacy service, which is better integrated with Primary Care; to increase the role of community pharmacy in delivering clinical services; and to ensure it is better aligned with emerging new models of care. The Department of Health plan to consult on how best to introduce a Pharmacy Integration Fund to help transform community pharmacy.

The proposed contractual changes are currently being consulted on; concerns have been raised about them by the Pharmaceutical Services Negotiating Committee (PSNC). PSNC have published a set of service proposals⁸ that describe how pharmacy services could develop within the context of government drives for efficiency. The proposals include the introduction of a care package, which would see repeat dispensing becoming a default option where medicines are needed on a long-term basis, patient registration at pharmacies, and pharmacies offering enhanced medicines optimisation services. The consultation will continue to be monitored by the CCG.

Community pharmacy welcomes the opportunity to work differently to utilise their clinical and communication skills to improve efficiencies for the NHS, improve patient safety and care and reduce medicines waste.

General Ophthalmic services

There are no proposed changes to the national contract at the moment.

General Dental services

An alternative contract has been piloted in some practices across the country during the last 2 years; this is focused on prevention rather than treatment, as is the case with the current contract. The uptake of the alternative contract has not been as high as anticipated and this calls into question

⁸ Available at: <http://psnc.org.uk/wp-content/uploads/2016/02/PSNC-CPR-service-dev-proposals.pdf>

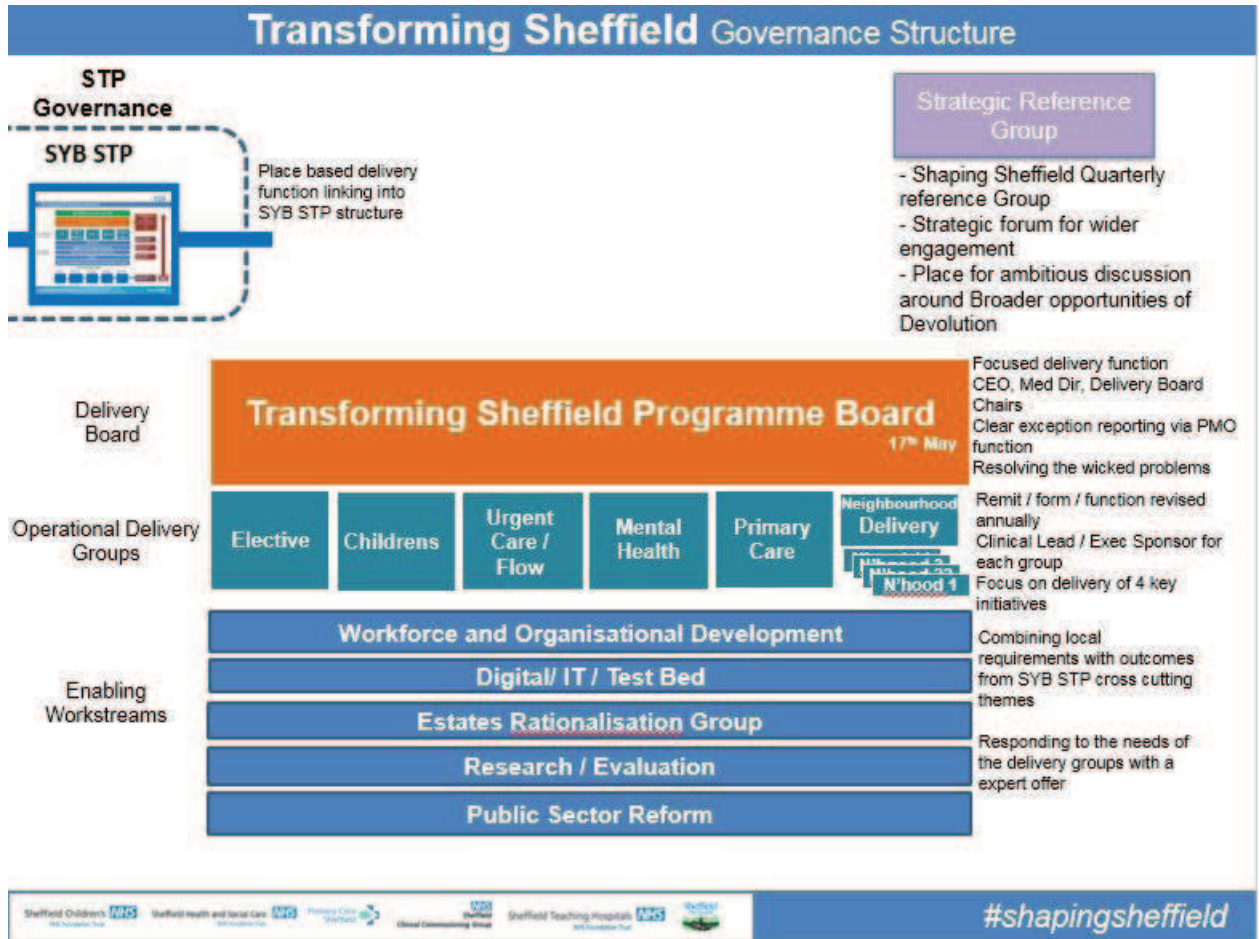
whether the contract will be implemented. This continues to be debated at a national level. Whatever mechanism is eventually used, the direction for general dental services is for more focus on prevention and more complex dental care in a primary care setting rather than on contracting for units of dental activity, as is the case with the current contract.

APPENDIX G

Outcomes Framework – People Keeping Well in their Community						
Function	Risk Stratification	Local Inform & Advise	Asset Based Community Development	Targeted Support	Self-Care – Wellness Planning	Life Navigation
Outcome	Targeting of people (including Carers, children and young people) at moderate to high risk of declining health and wellbeing is informed by comprehensive risk stratification.	People and communities get advice and support locally to make informed choices to improve their health and wellbeing for themselves and/or the person they may care for.	The community has developed a range of support that improves health and wellbeing.	People experiencing poor health, Carers, People with a LTC or at risk of declining wellbeing are supported to engage in activities and access targeted support to improve their health and wellbeing.	People at risk or with long term conditions are actively engaged with effective goal setting to improve health and wellbeing.	People who don't have anyone to help them navigate the health and social care system and daily life issues, are enabled to maximise their choice and control in managing their day to day lives.
Outcome Indicators	<ul style="list-style-type: none"> Wider participation for all targeted activity and resource allocation is supported by comprehensive risk stratification data. 	<ul style="list-style-type: none"> Improved wellbeing (this is Ways to Wellbeing). Improved health literacy in target populations. Increased awareness of and involvement in community activities. Reduced inequalities in access to services. 	<ul style="list-style-type: none"> Improved wellbeing (this is Ways to Wellbeing). Individuals report feeling engaged and in control at local level. Range of activities or services (health and wellbeing) are available and accessible to communities with clear expectations. Local people are those equipped to deliver and deliver or activities. Range and take up of participating opportunities by local people. 	<ul style="list-style-type: none"> Improved wellbeing (this is Ways to Wellbeing). Maintenance and improvement in independence, health and wellbeing is reported by people identified as being moderate to high risk of hospital admission. Improved health literacy in targeted population. Use of community support, resources and activities within target populations. 	<ul style="list-style-type: none"> Improved wellbeing (this is Ways to Wellbeing). Increased uptake of self-care, digital health advice and monitoring by at risk groups. Self-care based on real evidence e.g. structured programmes, self-help groups, peer support. People set and achieve personal goals related to their health and wellbeing. Access to & taking up of individual coaching. 	<ul style="list-style-type: none"> Improved wellbeing (this is Ways to Wellbeing). Recorders in missed appointments (DNA). People report positivity on quality of life and clarity about how to seek help to navigate the health and social care system, and daily life issues.

APPENDIX H

Proposed model for the Sheffield Transformation Programme



Equality Impact Assessment

Title of policy or service:	Primary Care Strategy		
Name and role of officer/s completing the assessment:	Becky Meadows on behalf of Katrina Cleary		
Date of assessment:	11 May 2016		
Type of EIA completed:	<input checked="" type="checkbox"/> Initial EIA 'Screening'	or	<input type="checkbox"/> 'Full' EIA process
	<i>(select one option - see page 4 for guidance)</i>		

1. Outline

Give a brief summary of your policy or service

- Aims
- Objectives
- Links to other policies, including partners, national or regional

Strategy sets direction for primary care services in Sheffield for next 5-10 years. Purposes of strategy are to:

- Contribute towards improving health and wellbeing of people in Sheffield;
- Ensure primary care services are sustainable and fit for future purpose;
- Establish collaborative working between health, social and voluntary sector across neighbourhoods, extending scope of services provided in a primary and community setting.

Primary care strategy is part of out of hospital plans and sits alongside urgent care and AS&R strategies. Enabling groups for Transforming Sheffield and STP for SY&B will feed into the implementation plans that come out of the primary care strategy – workforce, IT, estates, patient education and engagement and new contracting mechanisms.

Identifying impact:

- **Positive Impact:** will actively promote or improve equality of opportunity;
- **Neutral Impact:** where there are no notable consequences for any group;
- **Negative Impact:** negative or adverse impact causes disadvantage or exclusion. If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures. This may result in a 'full' EIA process.

2. Gathering of Information

This is the core of the analysis; what information do you have that might impact on protected groups, with consideration of the General Equality Duty.

(Please complete each area)	What key impact have you identified?			For impact identified (either positive and or negative) give details below:	What difference will this make?
	Positive Impact	Neutral impact	Negative impact		
Human rights	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Age	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strategy aims to provide better coordinated care for frail elderly	Services will be tailored to needs of individual – less confusion and quicker response times for patients
Carers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neighbourhood working will mean easier access to the right social and voluntary sector services	More support for carers and services tailored better to the people they care for
Disability	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strategy aims to address gap in health outcomes for people with disabilities	Better access to primary care services
Sex	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Race	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strategy aims to improve access to services for all minority groups	Neighbourhood working is more likely to identify and outreach to those who are not currently accessing services
Religion or belief	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strategy aims to improve access to services for all minority groups	Neighbourhood working is more likely to identify and outreach to those who are not currently accessing services
Sexual orientation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Gender reassignment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Pregnancy and	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strategy aims to provide a wider	Easier access to pregnancy and

maternity				range of services closer to home	maternity services
Marriage and civil partnership (only eliminating discrimination)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Other relevant groups	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strategy aims to improve access to services for all minority groups, e.g. refugees, asylum seekers, homeless, drug users	Neighbourhood working is more likely to identify and outreach to those who are not currently accessing services
HR Policies only: Part or Fixed term staff	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		

IMPORTANT NOTE: If any of the above results in ‘**negative**’ impact, a ‘full’ EIA which covers a more in depth analysis on areas/groups impacted must be considered and may need to be carried out.

Having detailed the actions you need to take please transfer them to onto the action plan below.

3. Action plan

Issues/impact identified	Actions required	How will you measure impact/progress	Timescale	Officer responsible
Actions to be identified following approval of strategy and development of implementation plan.				

4. Monitoring, Review and Publication

When will the proposal be reviewed and by whom?	Lead / Reviewing Officer:	Katrina Cleary	Date of next Review:	At sign off of strategy implementation plan

Once completed, this form must be emailed to Elaine Barnes, Equality Manager for sign off: elaine.barnes3@nhs.net.

Elaine Barnes signature:

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