Pre-Consultation Business Case (PCBC)
Sheffield Transformational Hubs

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Version control

Rev	Originator	Description	Date
1		First draft	09/06/22

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Acronym	Description
5YFV	**NHS Five Year Forward View**
ARRS	Additional Roles Reimbursement Scheme
BAU	Business as Usual (or Do-Nothing)
BRP	Benefits Realisation Plan
CCG	Clinical Commissioning Group
CIA	Comprehensive Investment Appraisal
CRB	Cash releasing benefit
CSFs	Critical Success Factors
CSU	Commissioning Support Unit
DES	Directed Enhanced Service
DHSC	Department of Health & Social Care
DMBC	Decision Making Business Case
EHIA	Equality Health Impact Assessment
EPRR	Emergency Preparedness, Resilience and Response
FBC	Full Business Case
GIA	Gross Internal Area
GP	General Practice
GPFYFV	GP Five-Year Forward View
HBN	Health Building Notes
HMT	Her Majesty's Treasury
ICB	Integrated Care Board
ICS	Integrated Care System
IG	Improvement Grant
JSNA	Joint Strategic Needs Assessment
LAC	Local Area Committee
LTP	NHS Long-Term Plan
NAPC	National Association of Primary Care
NCRB	Non-cash releasing benefit
NHSE	NHS England
NHSE/I	NHS England and Improvement
NIA	Net Internal Area
OBC	Outline Business Case
OCS	Overview Scrutiny Committee
OPE	One Public Estate
PBC	Programme Business Case
PC	Practical Completion
PCBC	Pre-Consultation Business Case
PCCC	Primary Care Commissioning Committee
PCES	Primary Care Estate Strategy

Acronym	Description
PCN	Primary Care Network
PIDs	Project Initial Documents (PIDs)
PM	Planned Maintenance
PWF	Preferred Way Forward
QIA	Quality Impact Assessment
RIBA	Royal Institute of British Architects
SB	Societal Benefit
SCC	Sheffield City Council
SCCG	Sheffield Clinical Commissioning Group
SHAPE	Strategic Health Asset Planning and Evaluation
SO	Spending Objectives
SOA	Schedule of Accommodation
SOC	Strategic Outline Case
SPEEIC	Strategic Patient Involvement, Experience and Equality Committee
SRO	Senior Responsible Officer
STP	Sustainability & Transformation Plan
SY&B	South Yorkshire & Bassetlaw
UBs	Unmonestiable benefits
VfM	Value for Money

1 Executive Summary

Primary care services in Sheffield face a number of significant challenges. This Pre-Consultation Business Case (PCBC) sets out our journey so far in making the case for transforming the future of local primary and community services in three specific primary care networks (PCNs) (City, SAPA and Foundry). It explains how we have developed what we believe to be a sustainable hub model of care for the future of primary services, and the options for change which we wish to test and consult upon. The document:

- Explains the purpose of the PCBC
- Presents the key features of the local system and the case for change
- Provides proposals for co-locating primary services into hubs; and
- Proposes the next steps for further consultation and implementation.

1.1 Purpose of the PCBC

This PCBC is focussed on primary services across three PCN areas of Sheffield. Specifically, we consider the preferred way forward for primary and community-based care covering our proposals to collocate and expand existing primary and wider community services into hubs. The purpose is to:

- Describe our emerging proposals for service change, and to enable decision makers to decide whether there is a case to launch a public consultation
- To build alignment between the NHS and local authority by describing the case for change and:
    - Demonstrate that all options, benefits, and impact on service users have been considered
    - Demonstrate that the planned consultation will seek the views of patients and members of the public who may potentially be impacted by the proposals.
- To inform the necessary assurance process that our proposals against the government's four tests of service change, and NHS England's fifth test of service change and best practice checks for planning service change and consultation.

This document refers to proposals and indicates changes that will be made to services if those proposals are implemented. However, the CCG has not made any final decisions on:

- Whether to make changes to services in accordance with any of the proposals discussed in this document, or
- How to implement any proposal which is subsequently agreed.

As we have indicated, this document is issued prior to public consultation. No decisions will be made until the views of all stakeholders, including members of the public and our patients have been carefully considered following that consultation. Accordingly, nothing in this document should be interpreted as indicating that the CCG or ICB have made any decision on any of the proposals described in this document.

1.2 The local situation and case for change

To meet the changing demographic demands for care and make sure people's outcomes continue to improve, we must transform the way in which care is provided to ensure people are cared for in the right place and setting.

1.2.1 Proposals

Our proposed model of care is based on the outputs of the 2017 Sheffield Sustainability and Transformation Plan (STP) bid for Wave 4b capital funding to enhance primary care, through wrapping care around patients, and based on their needs. We will deliver this enhanced support through considering proposals focussed on service redesign of colocation of complementary services to primary care within hubs.

Our proposal is to co-locate through relocating primary care services from existing not fit for purpose buildings into new modern hubs. Our proposals are for 5 new hubs, x1 in the City PCN, x2 in the Foundry PCN and x2 in the SAPA PCN.

1.2.2 Hubs/ health centres

Some services need to be delivered on a wider scale than at locality level to maximise efficiency and effectiveness, but on a small enough scale to align to population/place needs. To this end, we will develop hubs also known as health centres in some of the most deprived PCNs of Sheffield: City, SAPA and Foundry. The hubs will for some provide the opportunity for patients to receive care at locations closer to their homes and communities. However, we need to support and put in place appropriate mitigations for those that may be negatively impacted should this be the case if our proposals were to go ahead.

The hubs would also provide physical locations where primary, other PCN wrap-around services and local authority community teams can come together to deliver care side by side and enable discussions on options for ongoing patient care.

The wrap around and local authority teams based out of hubs will identify with a network of general practices, improving the working relationships between primary care and community-based services. Services delivered through the hubs by community teams will interface closely with primary care staff, removing barriers to referrals between teams and allowing swift escalation to the most appropriate clinicians as care needs change.

Our proposed model of care aligns clinical teams from across primary care so they can work collectively to deliver joined up care for patients. It takes a proactive approach to delivering the care that people need, aiming to prevent or identify early deterioration in health status, working with each person and their family or carer to help them help themselves.

1.2.3 Strategic Context

The hub proposal will deliver against current national, regional, and local strategic directions such as the NHS Long Term Plan[1], Five Year Forward View[2], GP Forward View[3], South Yorkshire & Bassetlaw Integrated Care System (SY&B ICS) Five-Year plan[4] and the Sheffield Joint Health and Wellbeing Strategy[5]. Our PCBC informs how our proposals for service change will support towards achievement of the above strategic direction.

1.2.4 Vision

[1] NHS Long Term Plan
[2] Five Year Forward View (england.nhs.uk)
[3] NHS England » General Practice Forward View (GPFV)
[4] Five Year Plan (2019 - 2024) :: SYB ICS
[5] 2 Joint Health Wellbeing Strategy 2019-24.pdf (sheffield.gov.uk)

Our vision is to provide excellent integrated services, to:

- Build on the success so far of regional and local teams integrating services
- Ensure the sustainability of primary care in sheffield
- Help people stay well and support them when they need help
- Enable people to stay at home for as long as possible
- Create hubs for colocation of primary and complementary services.

1.2.5 Our local health needs

The three PCN areas of City, SAPA and Foundry are some of the most deprived across Sheffield. ONS suggests population figures for Sheffield, mid-2019, were 584,853, a figure that has grown significantly in recent years due to large scale housing developments. The population of Sheffield is expected to increase by 9.2% between now and 2040. Based on Council new housing development projections, this may create an additional patient list of circa 20,500 over the next 20 years for these three PCNs.

1.2.6 Current estate

Most of the GP estate across Sheffield is aged with varying levels of backlog maintenance required to bring up to a suitable standard. Detailed 6-Facet information was collected for all 105 GP premises in the city (including those in scope of these proposals). Just 19 (18%) practices had a Gross Internal Area (GIA) over 800m2, the size where wrap-around services are considered viable in practice and an older age profile of our primary care estate (average building age was 53 years).

The existing estate across the **practices in scope of the programme** in some cases do not provide appropriate environments to fully address the current health needs of the local community or for proposed new models of care for the future. **Some of the existing services are currently being provided off-site due to not having any available space in the current buildings**.

The existing estate in terms of functionality and condition is not fit for the future in that:

- The premises GIA (m2) are below the levels to meet the demand of future patient list sizes
- Very little room for expansion on the existing sites
- No space to absorb additional patients or services through demographic change, new models of care or residential developments, and
- The fabric condition of the buildings will require capital expenditure for improvements with 5 years.

The practices in scope of the proposals have a combined building area (GIA) of 5,252 m2 and a total weighted list size (as Jan 2022) of 82,850.

The needs of the patient list this size is met by operating in buildings with occupancy that is already at 100% capacity and utilising space from third party sites.

1.3 Case for Change and our proposals

1.3.1 Case for change

In some of the most deprived areas of Sheffield, particularly across City, SAPA and Foundry PCNs, our review has indicated there is a lack of appropriate primary care accommodation, which will continue to worsen if not acted upon now. This primary care estate issue is likely to increase significantly in the future (i.e., over the next twenty years up to 2040) due to a growing and ageing population and due to future residential developments in the area, people living longer and more complex conditions.

There are **four strategic drivers for change** for these three areas of Sheffield:

- **Lack of primary care estate** – to accommodate likely significant increase in patient list sizes - new residential developments are increasing the population in particular areas of Sheffield, therefore creating increased patients for practices
- **Future service demand** – an ageing population is likely to result in an unprecedented increase in demand for services, creating an increased cost pressure
- **Patient expectations changing** – patients want local health and care services to deliver better quality, more accessible and more co-ordinated healthcare in and out-of-hospital
- **Socio-economic profile of the PCN** – low car ownership / high unemployment – patients not being able to access full services that they require.

1.3.2 Objectives

The project strategic objectives (SOs, i.e., '**what we are seeking to achieve'**) were defined as:

- **SO1 - Building Constraints** - Dispose/reduce not fit for purpose estate driving efficiencies within the system, supporting local regeneration
- **SO2 - Increased Capacity** - Additional primary care capacity required due to forecast population growth / housing developments demand
- **SO3 - Improved Service Integration** - Greater integration of primary care with other complimentary PCN services in a highly accessible location
- **SO4 - Enhanced Scale and Quality** - Additional/new services available, enhancing patient choice and service quality
- **SO5 - Affordable Scheme** - Meets financial tests of capital and revenue availability and affordability, and offers long term value for money
- **SO6 - Improved Early Intervention, Access, and Support** - Embeds wellbeing, prevention, protection, early intervention and enables fair access, considering specific needs of local communities
- **SO7 - Sustainable Workforce** - Supports service delivery and attracts and supports a sustainable workforce, including anticipated technological changes, digital connectivity, and overall system shifts
- **SO8 - Achievable Scheme** - Scheme capable of being delivered within any capital timeframe requirements.

1.3.3 Benefits

In developing the proposal benefits, we have reviewed the SOs and considered how these translated into clearly linked measurable benefits, on the basis that a **benefit is an**

economic measure of the outcome that is expected in return for an investment. We have developed 34 individual benefits with these being categories into unmonetisable or monetisable. Of those that were monetisable, they were used within the economic case options appraisals. A Benefits Realisation Plan (BRP) has been developed to be refined during consultation to assist with identifying benefit baseline position and setting and agreeing a plan for future improvements and how they will be monitored and evaluated.

1.4 Economic case

To assist the economic case options appraisal, several **Critical Success Factors (CSFs)** were developed:

- **CSF 1: Alignment** with the project spending objectives and business needs and any other relevant Council and ICB (or wider i.e., system level) strategies, programmes, and projects.
- **CSF 2: Delivers benefits** – delivers the proposed required benefits
- **CSF 3: Deliverability** within appropriate timescales and with minimal disruption to service delivery
- **CSF 4: Attractive** to the market to deliver
- **CSF 5: Delivers efficiency** savings and affordable to implement.

1.4.1 Options Appraisal

Using the Green Book[6] options framework, a range of possible solutions have been reviewed, developed, and initially appraised by us and the GPs in scope. We used the SOs and the CSFs to appraise each option. This saw any alternative options to doing-nothing (or Business as Usual – BAU), and doing-minimum being developed and appraised.

1.4.2 Initial Site selection

In conjunction with stakeholders, including GPs and CCG the project developed and undertook a site selection exercise for the potential new hub sites. Many potential hub sites were reduced to a shorter list which we scored with GPs to determine an initial preferred way forward site per hub.

1.4.3 Our proposals (the short-list)

The outputs of the options appraisal and initial site selection exercise was a shorter list of proposals and a preferred way forward site per hub upon which enabled us to undertake our pre-consultation engagement prior to any formal consultation. Not all options per project ended up being applicable from the initial short list. We have used a green tick to show those that now still apply and a red cross for those that do not now apply.

Option	Description	Site	C	F1	F2	S1	S2
Do-Nothing (BAU)	No change to existing ('in-scope')* practices in scope of this PCN. **Periodic backlog maintenance is undertaken** as per the latest 6 Facet Surveys.	n/a – practices remain at existing sites	√	√	√	√	√
Do-Minimum	**Extension and or reconfiguration of existing practice(s)** to provide additional future capacity	n/a – practices remain at existing sites	X	√	√	√	√

[6] The Green Book: appraisal and evaluation in central government - GOV.UK (www.gov.uk)

Option	Description	Site	C	F1	F2	S1	S2
Do-Intermediate	**Build a new Hub**, practices in agreement to move in, plus any other agreed existing and new PCN ('wrap around'/third and commercial sector) supporting services and **retain an existing practice.**	Varies per hub (see table below)	X	√	X	√	√
Do-Maximum	**Build a new Hub**, practices in agreement to move in, plus any other agreed existing and new PCN ('wrap around'/third and commercial sector) supporting services.	Varies per hub (see table below)	√	X	√	X	X

C = City Hub, F1 = Foundry Hub 1, F2 = Foundry Hub 2, S1 = SAPA Hub 1, S2 = SAPA Hub 2

1.4.4 Preferred way forward hub locations

The current preferred short list of hub site options that we will consult upon are shown in the table below. These are not final decisions, but enabled us to engage upon, understand buildability and the Council to develop the initial high level cost estimates.

PCN / Hub	Preferred way forward site option
City Hub	No appropriate preferred site identified at this stage
Foundry Hub 1	Land at Spital Street, S3 9LD
Foundry Hub 2	Land at Rushby Street, S4 8GD
SAPA Hub 1	Land at Concord Sports Centre, S5 6AE
SAPA Hub 2	Land at Wordsworth Ave. / Buchanan Rd. junction, S5 8AU

We now propose, subject to this PCBC approval, to consult on these options and preferred way forward hub sites. Using the Department of Health and Social Care Comprehensive Investment Appraisal (CIA) model[7] we have in conjunction with the Council project team, undertaken initial value for money assessment and affordability tests of the proposal options.

The table below indicates both the do-intermediate and do-maximum are better value for money compared to the do-nothing or do-minimum options. Although the do-intermediate and do-maximum options will be more costly due to the need to build new buildings (or refurbish in City Hub case), they are indicating higher financial benefits. The table below is an updated version on the initial SOC estimates following recent practices confirmations if they wished to continue following the initial public engagement exercise in 2022.

[7] Comprehensive Investment Appraisal (CIA) Model and guidance - GOV.UK (www.gov.uk)

Economic Summary (Discounted) - £	City Hub			
Options	0 - Business as Usual	1 - Do-Minimum	2 - Do-Intermediate	3 - Do-Maximum
Incremental costs - total	£0.00	-£2,025,684.64	n/a	-£3,839,724.79
Incremental benefits - total	£0.00	£1,604,068.17	n/a	£19,854,400.03
Risk-adjusted Net Present Social Value	£0.00	-£421,616.47	n/a	£16,014,675.24
Benefit-cost ratio	0.00	0.79	n/a	5.17

Economic Summary (Discounted) - £	SAPA Hub 1			
Options	0 - Business as Usual	1 - Do-Minimum	2 - Do-Intermediate	3 - Do-Maximum
Incremental costs - total	£0.00	-£2,535,658.54	-£14,003,163.30	n/a
Incremental benefits - total	£0.00	£2,912,574.49	£51,406,914.77	n/a
Risk-adjusted Net Present Social Value	£0.00	£376,915.95	£37,403,751.47	n/a
Benefit-cost ratio	0.00	1.15	3.67	n/a

Economic Summary (Discounted) - £	SAPA Hub 2			
Options	0 - Business as Usual	1 - Do-Minimum	2 - Do-Intermediate	3 - Do-Maximum
Incremental costs - total	£0.00	-£2,084,518.38	-£6,192,005.91	n/a
Incremental benefits - total	£0.00	£1,750,153.50	£27,990,509.32	n/a
Risk-adjusted Net Present Social Value	£0.00	-£334,364.88	£21,798,503.41	n/a
Benefit-cost ratio	0.00	0.84	4.52	n/a

Economic Summary (Discounted) - £	Foundry Hub 1			
Options	0 - Business as Usual	1 - Do-Minimum	2 - Do-Intermediate	
Incremental costs - total	£0.00	-£1,742,745.33	-£9,479,759.95	n/a
Incremental benefits - total	£0.00	£2,394,505.59	£24,517,753.36	n/a
Risk-adjusted Net Present Social Value	£0.00	£651,760.26	£15,037,993.41	n/a
Benefit-cost ratio	0.00	1.37	2.59	n/a

Economic Summary (Discounted) - £	Foundry Hub 2			
Options	0 - Business as Usual	1 - Do-Minimum		3 - Do-Maximum
Incremental costs - total	£0.00	-£4,619,782.73	n/a	-£8,164,597.46
Incremental benefits - total	£0.00	£2,727,101.70	n/a	£25,759,303.83
Risk-adjusted Net Present Social Value	£0.00	-£1,892,681.04	n/a	£17,594,706.37
Benefit-cost ratio	0.00	0.59	n/a	3.15

1.4.5 Pre-consultation engagement

We have undertaken pre-consultation engagement on the latest options. The outputs of this are captured in our **Pre-Consultation Engagement Report** (**Appendix 01**). The outputs of this support us to shape our final pre-consultation scheme proposals.

1.4.6 Final pre-consultation scheme proposals

From the pre-consultation engagement process, we learnt more about the impact our proposals will have on patients and on other services. We need to show how we would support patients in the future to access the right service for them and how we would support any other services that would be impacted by our proposal. **Our pre-consultation proposals are shown in the table below.**

Proposal	Hub	Preferred way forward hub site
Build four new primary care hub buildings **(and for the following practices to move into them, disposing of their existing buildings)**	**Foundry Hub 1** – Burngreave Surgery and Sheffield Medical Centre) – with Pitsmoor Surgery remaining and expanding on its existing site	Land at Spital Street, S3 9LD
	Foundry Hub 2 – Page Hall Surgery and Upwell Street	Land at Rushby Street, S4 8GD
	SAPA Hub 1 – Dunninc Road Surgery, Shiregreen Surgery and Firth Park Surgery) – with Norwood Medical Centre Surgery remaining and expanding on its existing site. Elm Lane decided to withdraw from the project.	Land at Concord Sports Centre, S5 6AE
	SAPA Hub 2 – Margetson Surgery, Buchanan Road Surgery and The Healthcare Surgery – with Southey Green remaining at their existing site	Land at Wordsworth Avenue / Buchanan Road Junction, S5 8AU
Refurbish an existing city centre building **(and for the**	**City Hub –** City Practice and Mulberry Practice – Devonshire Green MC and	Site TBC

Proposal	Hub	Preferred way forward hub site
following practices to move into it, disposing of their existing building(s):	Hanover MC decided to withdraw from the project.	

1.5 Financial impact

There are no capital financial impacts for the CCG or ICB. This is because the STP Wave 4b capital will be used to fund any capital works. A financial impact assessment on our revenue consequences of the proposals has been made, based on initial high-level estimates. We are forecasting a potential saving following implementation of the proposals. We have agreement from our governing body for any savings to be ringfenced for things such as future hub financial support and or practice development and to help address health inequalities within the respective PCNs. Such estimates will be refined as proposals are as further considered, particularly following public consultation and the development of the Decision-Making Business Case (DMBC).

1.5.1 Impact assessments

Several impacts assessments have been undertaken on our proposals:

Equality and Health Inequality Impact Assessment (EHIA) –

To inform this PCBC, we undertook comprehensive equality impact analysis for each proposed hub or health centre. See section x for more information.

1.5.2 Assurance

Assurances are in place from both NHS England and Improvement and Her Majesty's Treasury (HMT). HMT approved the Programme Business Case (PBC) in January 2022. This enables access to the STP wave 4b capital to deliver the proposal. However, there are conditions attached which need to be evidenced via the HMT business case process through completion of Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC).

We regularly review proposals with NHS England and Improvement through a checkpoint process called Stage Gate. The next one of these in September where we will provide the latest programme position and re-check on value for money, affordability, and deliverability of our proposals. The outputs of the consultation will be discussed at Stage Gate (subject to ICB approval).

The pre-consultation engagement plan and consultation plan have been presented to and assured by CCG's Strategic Public Involvement, Experience and Equality Committee – a sub committee of our governing body.

1.5.3 Reconfiguration: The Four Tests

Our PCBC has considered the 2010, Government "four tests" for service changes, documented in the Planning, Assuring, and Delivering Service Change for Patients[8]. The tests require any NHS organisations considering a change of service to be able to demonstrate evidence of:

[8] planning-assuring-delivering-service-change-v6-1.pdf (england.nhs.uk)

- Strong public and patient engagement
- Consistency with the current and prospective need for patient choice
- A clear, clinical evidence base
- Support for proposals from clinical commissioners.

The NHS England additional test introduced on 1 April 2017, of any proposal including plans to significantly reduce hospital bed numbers NHS England will expect commissioners to be able to evidence that they can meet one of the three conditions. However, our proposals do not propose to reduce hospital bed numbers.

We believe our proposals meet the above requirements and we would like to progress to consultation to seek feedback to help shape and develop these exciting proposals for Sheffield.

1.6 Next steps: Consultation and Implementation

Our **Consultation Document** (**Appendix 04**) implementation plan considers the requirements for workforce, estates, digital, procurement and finance. Benefits realisation is a key aspect of ensuring we deliver the outcomes and improvements we have planned for. We have performed an initial assessment of risks and mitigations, which are also summarised in this document.

Moving forward we will continue to engage with the public and our consultation implementation plan outlined in this document, sets out a **10-week consultation process, planned to run from Monday 18th July to Monday 12th September 2022.** The outputs from the consultation will be reviewed on a fortnightly basis with a full mid-point review to assess any gaps in demographic and geographic responses and the Consultation implementation plan will then be adjusted accordingly. A full analysis of the consultation outcomes will be undertaken to inform the Full Business Case (FBC) per hub to be considered for decision to proceed by the Integrated Care Board (ICB) Governing Body.

Sheffield City Council has confirmed its willingness to deliver the hub schemes via a Section 2 grant from the NHS England STP Wave 4b Capital to enable the hubs to be developed (subject to the necessary engagement, consultation, legal, financial, and political agreements, and final business case approvals). The Council would own the new build facilities (and refurbished hub in the City Centre) and would lease the premises to health partners in order that the planned hub services can be delivered in modern, fit for purpose facilities, to meet the needs of the local population as set out within this PCBC. This commitment is in principle and is conditional on agreeing overall development/capital values, the finer details of the lease arrangements and full Council approval.

2 Introduction

2.1 Context

This pre-consultation business case (PCBC) outlines the proposals to ensure the sustainability of primary care, in three Primary Care Networks (PCNs) in Sheffield (namely City, SAPA and Foundry PCNs). The purpose of this PCBC is to:

- Describe our emerging proposals for service change, and to enable decision makers to decide whether there is a case to launch a public consultation
- To build alignment between the NHS and local authority by describing the case for change and:-
    - Demonstrate that all options, benefits, and impact on service users have been considered
    - Demonstrate that the planned consultation will seek the views of patients and members of the public who may potentially be impacted by the proposals.
- To inform the necessary assurance process that our proposals against the government's four tests of service change, and NHS England's fifth test of service change and best practice checks for planning service change and consultation.

The aim is to commence public consultation in July 2022 supporting the vision of further integration between primary care and other PCN complementary services within the health, social care, and voluntary sector in new Hubs in the three PCNs (City, SAPA, and Foundry).

2.2 Public consultation

The pre-consultation business case outlines how CCG has ensured that the plans for public consultation meet the government's four tests and the requirements of the NHS England gateway process.

NHS England published 'Planning, assuring, and delivering service change for patients'[9] in March 2018 (along with more recent updates in May 2022[10]) which sets out guidance for NHS bodies with regard to service change. There is no legal definition of service change but broadly it encompasses any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered.

NHS commissioners and providers have duties in relation to public involvement and consultation, and local authority consultation. They should comply with these duties when planning and delivering service change. The public involvement and consultation duties of commissioners are set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs. The range of duties for commissioners and providers covers engagement with the public through to a full public consultation. Public involvement is also often referred to as public engagement. Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the 2013 Regulations") made under s.244 NHS Act 2006.

[9] planning-assuring-delivering-service-change-v6-1.pdf (england.nhs.uk)

[10] B0595_addendum-to-planning-assuring-and-delivering-service-change-for-patients_may-2022.pdf (england.nhs.uk)

All service change should be assured against the government's four tests:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear, clinical evidence base
- Support for proposals from clinical commissioners.

Where appropriate, service change which proposes plans significantly to reduce hospital bed numbers should meet NHS England's fifth test – a test for proposed bed closures. However, this programme is not proposing to reduce hospital bed numbers.

2.3 Background to this proposal

The primary care estate in some of the City, SAPA and Foundry PCNs are not fit to provide modern health and care services. This was confirmed the finding of the 2016 six-facet surveys undertaken by independent surveyors stated that over £750,000 would need to be spent to address backlog maintenance items.

Some practices are housed in old buildings with limited accessibility. This is having an impact on the GPs' ability to recruit and retain staff and to plan for delivery of primary care in the future. GPs are the bedrock of the NHS; they are everyone's first port of call. Ensuring primary care is sustainable and able to support integrated working is crucial. Local GPs need to be equipped to deliver the benefits of integrated working, so they can continue to enhance the existing model of care and further embed services locally.

In December 2017 feasibility studies developed a long list of potential options to improve patient care and outcomes by considering the expansion of the primary care estate for the Primary Care Networks (PCNs) of City, SAPA and Foundry.

NHS Sheffield Clinical Commissioning Group (SCCG) reviewed and developed addendums to these studies to support with their further development. NHSE Project Initiation Documents (PIDs) were subsequently produced by SCCG to further review potential hub plans and capture the latest options in February 2020.

These PIDs were reviewed by NHS England (NHSE) with SCCG, through a temporary forum set-up by NHS England and Improvement (NHSE/I) called a Star Chamber, in February 2020, with subsequent regular regional assurance discussions held since then entitled Stage Gate.

It was agreed, by NHSE and SCCG, that the following Her Majesty's Treasury (HMT) business cases were required to progress this:

- Strategic Outline Case (SOC)
- Outline Business Case (OBC)
- Full Business Case (FBC).

The next step in these three specific areas of Sheffield is to further integrate services with primary care, and we believe the only way to achieve this is by having them all under one roof, co-located in a fit for purpose building.

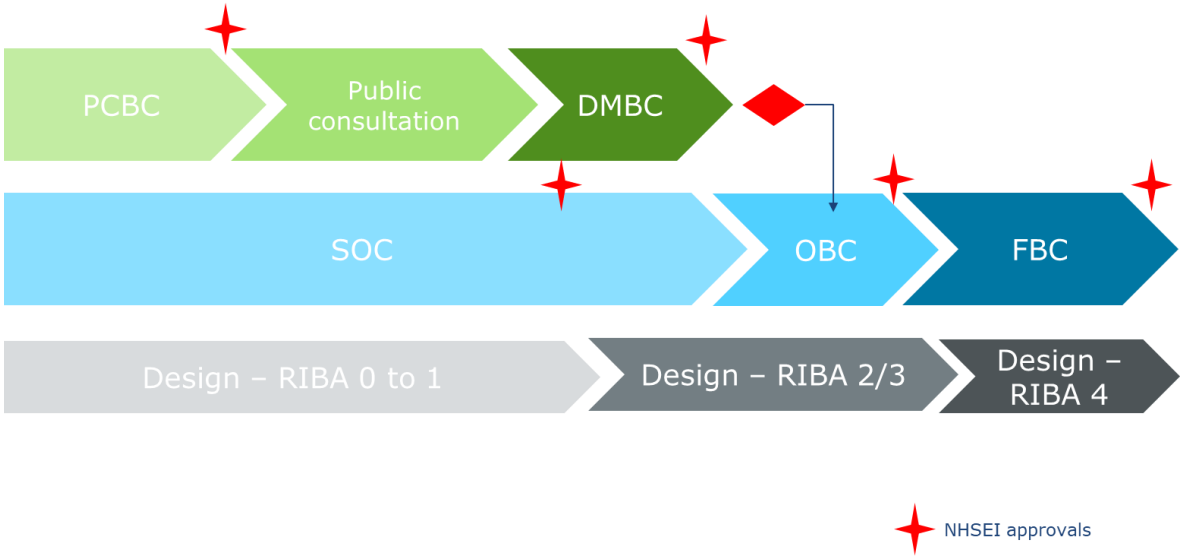
Having those services based in a smaller number of locations would put real focus on prevention, independence and keeping people well and out of hospital - physical and mental health would work alongside social care and the voluntary sector. Everything that is currently available would continue to be available – the same services, delivered through an

enhanced model of care, but in a more modern location with people being able to work better together. Attracting and recruiting doctors, nurses and carers would be vastly improved within an environment in which people want to work.

The previous considerations and more recent SOCs (x1 City, x2 SAPA and x2 Foundry PCNs), to improve care and outcome for patients, via primary care estate expansion, has focused on the development, integration and co-location of services via buildings called **hubs**.

Five SOCs have been developed in 2021 alongside this Pre-Consultation Business Case (PCBC) to support shaping the options for further engagement, consideration, and public consultation. The SOCs are helping shape this PCBC and the proposed subsequent consultation (see figure below).

Figure 1 – Programme milestones



Beyond any public consultation would see the development of a Decision-Making Business Case (DMBC), which enables completion of future HMT business case stages, namely OBC and FBC. Figure 1 shows where possible (project dependant) architects can be commissioned to support options by commencement of their project stages (called the RIBA stages – the Royal Institute of British Architects) [11],:

- Strategic Definition (RIBA 0)
- Preparation and Brief (RIBA 1)
- Concept Design (RIBA 2)
- Spatial Coordination (RIBA 3)
- Technical Design (RIBA 4)

This not only assists with enabling more accurate project option cost estimates but supports with engagement and consultation for stakeholders to consider options from a building perspective.

The OBC and FBC which would typically develop the Preferred Way Forward (PWF) option at SOC stage into a preferred option. Beyond RIBA stage 4, would see a construction stage

[11] https://www.architecture.com/-/media/gathercontent/riba-plan-of-work/additional-documents/ribaplanofwork2013overviewfinalpdf.pdf

(RIBA stage 5) e.g., to potentially expand the primary care estate by building the preferred option on an agreed site.

The preferred option asset(s), upon the Construction stage Practical Completion (PC), would be handed over from the principal contractor to the building owner to allow commencement of commissioning (set-up), followed by subsequent occupation and operation (RIBA 6).

2.4 Our engagement

As part of our commitment to involving people at all stages of our work we have been carrying out pre-consultationengagement on our evolving hub proposals. A **Pre-Consultation Engagement Report** of this engagement is provided in **Appendix 01**.

To reach our target audiences, we used a range of methods. These included:

- Online and paper survey
- Public meetings with a face to face meeting in each hub area and one Zoom meeting.
- People email with comments
- Community outreach via three community groups who undertook on-street interviews, in-situ interviews in GP surgeries and attending community meetings.
- Meetings with stakeholders

Overall, we received feedback from 2,205 people.

The headlines from the engagement are:

Over three-quarters (77%) of people agreed that their GP currently provided a good environment for healthcare. People in SAPA 2 and city centre areas were less likely to agree and over a quarter of them disagreed.

A large majority (76%) of people agreed that more investment is needed in GP services in their area. People in SAPA 2 were most likely to agree (net agree of 88%) and those in the city hub were less likely to agree (net agree of +45%).

Nearly two-thirds (64%) of people told us they were not willing to travel further if it meant they got better care. Overall, there was a net agree of -44% (meaning more people disagreed than agreed). Those on SAPA 2 and Foundry 1 were more likely to agree than those in the other areas were and city residents most likely to disagree.

Overall, there was no agreement from respondents on whether building new GP health centres were a good idea or not, with slightly more people disagreeing than agreeing (net agree of -8%). However, there were differences between areas with SAPA 2 and Foundry 1 areas more than likely to agree than disagree (net agree of +29% and +1% respectively) and city most likely to disagree (net agree of -31%) compared to others and the average.

Overall, 6 in 10 people (61%) said they would not be able to get to their practice if it was further away. In all hub areas, more people agreed that they wouldn't be able to get there than disagreed with city and SAPA1 having the highest percentage of net agree (+43% and +49% respectively) and SAPA 2 having lowest number disagreeing – 32%.

People did want to see other services lo-located in the new health centres. Rapid testing and diagnostics services were rated highest overall, with community mental health also rated highly in each area, particularly in SAPA 2 with two-thirds of people wanting mental health and Foundry 1 (61% rapid testing and diagnostics).

The lowest rated services were interpreting services (8%), spaces for community organisations (9%) in SAPA 1, and group sessions rooms in SAPA 1 (11%) and Foundry 2 (11%).

Overall, the most mentioned theme from the qualitative data was that these proposals were good, but people had significant concerns about the extra distance travel that would be required for some, particularly more vulnerable members of the community, with concerns about the lack of suitable public transport for some proposed locations. In a significant number of responses these concerns were seen as sufficient enough for them to feel that the proposals would not benefit patients and should not proceed.

People felt that the main problem was staff and that either the investment should be made in staff and services instead or would be required to deliver the improved care of these proposals.

People's main concern was about the current availability of appointments with many feeling that having more patients at one site would make appointments harder to get, although some felt that these proposals may help to make appointments more available. Some people shared that they are satisfied with the current service that they receive from their current GP practice. Some suggested that the investment should be spent on improving current premises, whilst others felt that some of the sites included in these proposals were suitable as they are modern, purpose-built buildings.

2.5 Key duties for consideration

In line with the Health and Social Care Act 2012, the CCG is mindful that it must have due regard to:

- Reducing inequalities between patients with respect to their ability to access health services
- Reducing inequalities between patients with respect to outcomes achieved for them by the provision of health services.

As such, consideration has been given to a wide range of information about the CCG's population including issues such as deprivation, ability to access services, demographic trends, and patterns of service use. This evidence has informed the development of our proposals to ensure that local people continue to have access to high quality, safe and sustainable services to meet their needs.

Alongside this, the CCG is keen to ensure we promote integration with a view to securing health services that will:

- Improve the quality of those services
- Reduce inequalities between people with respect to their ability to access those services
- Reduce inequalities between people with respect to the outcomes achieved for them by the provision of those services.

These duties have been considered as part of our process in developing these proposals, supporting clinical and financial sustainability across our local system, and supporting the delivery of a wide range of services within our local community.

To fulfil our public sector equality duty under Section 149 of the Equality Act 2010, the CCG has undertaken an **Equality Impact Assessment (EIA)**. T

his is to ensure that the impact of our proposal is understood and that there is no adverse impact on any group of individuals (of protected characteristics and groups who may be most impacted by health inequality) and to identify actions to mitigate any identified impact where necessary. This is described in more detail in **section 11 ('Impact of the Pre-Consultation Proposals')**.

3 Strategic National Context

3.1 NHS Long-Term Plan (LTP)

The NHS Long Term Plan sets out the vision for the provision of health services over the coming decade. It identifies where and how changes need to be made to keep it in pace with those requiring its services. Part of this focus is on providing more support and a joined-up approach to care at the right time, in the optimal setting.

The Plan aims to achieve this by focusing at a PCN level to support GPs to work more collaboratively in commissioning a range of services to meet the needs of the local population. These newly expanded community health teams will be required under new national standards to provide fast support to people in their own homes as an alternative to hospitalisation, and to ramp up NHS support for people living in care homes. Within five years over 2.5 million more people will benefit from 'social prescribing', a personal health budget, and new support for managing their own health in partnership with patients' groups and the voluntary sector.

The Transformational Hubs will allow more people to receive a wider range of healthcare services in their home and community by becoming a focal point for the PCN. By providing a facility for GPs and other community and healthcare practitioners to work together, in a single facility, care will be more coordinated and tailored to the needs of the individual.

3.2 The Five Year Forward View

The NHS Five Year Forward View (5YFV) published by NHSE (NHSE) in October 2014 set out the government's priorities and a clear direction for the NHS, showing why change was needed and what it would look like. It set out a triple integration agenda, involving greater integration between primary and specialist care; physical and mental health care; and health and social care.

The vision was one of services organised around the needs of patients rather than professional boundaries. As such there was a clear emphasis that delivering the 5YFV vision would require the input of the NHS, local communities, local authorities and employers.

3.3 General Practice Forward View (GPFV)

The 2016 GP Forward View (GPFV) introduced the ambition to establish hubs to offer shared, same-day access and appointments across a group of practices. The objective of this model was to provide additional, and more convenient, capacity to better deal with same-day demand for primary care.

The proposal fits fully with the national strategic direction set out in the NHS Long Term Plan, the NHS Five Year Forward View and General Practice Forward View. It is designed to combine the benefits of primary care at scale and integrated delivery models.

3.4 GP Contracts (2019)

In 2019 GP contracts were updated to reflect the Long-Term Plan as well as respond to current and emerging needs within the health environment. Central to this is how GPs and their contracts respond to the rollout of PCNs across the country. Most notably within this was the drive to increase staffing numbers to meet these new services. In total 22,000 additional staff are expected to be working within primary care by 2024. At an individual surgery level this translates to an average 3 additional healthcare practitioners per surgery.

The proposed transformational hubs will be developed specifically to any new requirements that the PCN creates. By advocating the provision of more services at a

local level and increasing staffing levels of primary care it is essential that the estate is enlarged to support these expanded provisions.

3.5 One Public Estate (OPE)

OPE was established to provide practical, technical support and funding to public sector organisations to deliver ambitious property-focused programmes in collaboration with central government and other public sector partners. This programme will propose how the identified primary care health care improvements will fulfil the objectives of OPE including economic growth, integrated services and generating efficiencies.

The hubs would aim to offer a more integrated, and patient focused approach to health care, made possible by the bringing together geographically disparate services into a coordinated hub, mirroring the OPE objectives.

3.6 Primary Care Networks (PCN)

The CCG has rolled out its PCNs across Sheffield. Refreshing NHS Plans for 2018-19 set out the ambition for CCGs to actively encourage every practice to be part of a local PCN so that these cover the whole country as far as possible by the end of 2018/19.

PCNs contain geographic populations of 30-50,000 patients and consequently around 1,300 have been created across England. They are expected to think about the wider health of their population, taking a proactive approach to managing population health and, from 2020/21, assessing the needs of their local population to identify people who would benefit from targeted, proactive support.

In June 2020, NHSE/I provided updated advice to PCNs on accommodating additional Multi-Disciplinary Team (MDT) staff appointed under the **'Network Contract Directed Enhanced Service (DES) Contract Specification 2020/21 – PCN Entitlements and Requirements ('the Contract')**. This contract "paves the way for around **seven additional new full-time clinical support staff** for an average PCN in 2020/21. This figure rises to **20 full-time staff by April 2024**. It is predicted that the introduction of these new staff, under the Additional Roles Reimbursement Scheme (ARRS), will transform service delivery for patients, and ease the mounting pressures on existing clinical staff, including GPs and practice nurses.

Practices within a PCN within continue to develop their relationships and will work more collaboratively to provide services that might otherwise not be possible from a standalone surgery through joint commissioning. This has already commenced and roles such as social prescribers are being fulfilled at a PCN level.

This programme aims to set out the case for bringing surgeries into a single central location and providing them with the facilities needed to deliver the wide range of PCN and out of hospital services their community requires.

3.7 Primary Care Home Model

Developed by the National Association of Primary Care (NAPC)[12], the model advocates the colocation of health and social care to provide personalised services better equipped to offer preventative care for the local community.

In the model, health care professionals come together to provide joined-up GP, mental health, social and acute care. It is also providing a formal route for the voluntary sector to provide services. Sitting within the PCN, the mix of services can be refined according to the needs of the local community.

[12] https://napc.co.uk/

The proposal set out the programme aims to achieve these objectives by bringing together GPs and other primary health care professionals in a new purpose-built facility with sufficient space to meet the needs of the local community.

4 Local context

4.1 South Yorkshire & Bassetlaw Integrated Care System (SY&B ICS)

The ICS has set out the following vision within its Five-Year plan (2019-2024):

"Our vision is for everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well for longer".

The ICS has set out the following four key ambitions:

i Developing a population health system

ii Strengthening our foundations

iii Building a sustainable health and care system

iv Broadening and strengthening our partnerships to increase our opportunity

The overarching regional Programme Business Case (PBC), in which these proposals sit, was developed by the ICS, and was approved by Her Majesty's Treasury (HMT) in January 2022. The approval came with several conditions and any proposals will need to work to meet such requirements as we work through consultation and any initial option design and cost estimating developments.

The proposed Hubs in Sheffield will fulfil this vision and ambitions through the provision of a more robust and expanded primary care service that is able to address more of people's needs without referral to hospital and tackling problems at an early stage, near their home, before they are able to develop into more complex medical conditions requiring secondary care intervention.

4.2 Sheffield Joint Health and Wellbeing Strategy (2019-2024)

Sheffield City Council (SCC) has established the Sheffield Joint Health and Wellbeing Strategy (2019-2024) with the vision of facilitating ***"a city that is eventually free from damaging disparities in living conditions and life chances"***. The Strategy is informed by the Joint Strategic Needs Assessment (JSNA) of the health and wellbeing needs of Sheffield, and responds to the needs of residents, but also supports to develop the work led via the ICS.

The overarching ambition of the Health and Wellbeing Board aims to improve the health and wellbeing of residents and reduce health inequalities, and to achieve this a life course approach will be maintained, that is ensuring plans are targeted at critical points throughout life: giving children and young people the best start in life and enabling adults and older people to live well and remain independent. However, the health of residents and communities is also shaped by the conditions in which they live, the extent of social connections, and whether they have stable and supportive work. The Strategy has an approach focused around three area for a health lift as follows:

- **Starting Well** – where we lay the foundations for a healthy life
- **Living Well** – where we ensure people have the opportunity to live a healthy life
- **Ageing Well** – where we consider the factors that help us age healthily throughout our lives.

Whist it is recognised that greater emphasis on prevention may slow growth in demand for health and care services, it is imperative in the current financial climate that the actions agreed are delivered within the respective resource envelopes of the partner organisations.

Delivery of transformational hubs in Sheffield will support the achievement of these aspirations through improved access to primary care and the co-location of primary health services, reducing demand on in-hospital services. Whilst GPs will provide mental health support, it is in the intention of the transformational hubs to work with additional mental health support organisations who would provide access to mental health services in the Hubs. Their co-location would ensure a closer alignment of services tailored to the needs of the individual.

5 Vision

To provide excellent integrated services:

- To build on the success so far of integrating services
- To ensure the sustainability of primary care in Sheffield
- To help people stay well and support them when they need help
- To enable people to stay at home for as long as possible.

As the commissioner primary care for the people of Sheffield, we have an ambition to help people stay well and support them when they need expert help. We believe the best way to support people is to bring services together and integrate them around the needs of individuals, enabling them to stay well and at home for as long as possible.

By bringing the services of general practice, voluntary sector, and community services together we can create more resilient, integrated health and care provision, delivered in modern facilities designed better to meet the needs of service users, their families, and carers. Coming together in one building will enable closer working relationships and co-ordination benefiting patients, their carers and families and staff. This will also support the GP practices who need to ensure that they are able to recruit staff and continue to deliver high quality care to sustain local health provision into the future.

Through STP Wave 4b capital funding we will invest in these local services and the buildings they are delivered in so that local people will receive care that is resilient and sustainable in buildings that are fit for purpose both now and in the foreseeable future. Without these changes, the future of GP services in these areas of Sheffield may not be sustainable over the next decade.

5.1 Plans

Our shared plans include:

- Bringing services together through the creation of a vibrant new hubs
- Supporting sustainable GP services working together with partners to bring services from hospital closer to people's homes, improving communications between services, enhancing 'joined up' working and training the future workforce of doctors and nurses
- Developing new ways of working and new services for the benefit of the local population and extending education of the workforce needed to deliver this care
- Ensuring that local people can access GP and some other services from a new hub
- Housing voluntary sector services in the new hub, linking up a range of community services
- Pooling our resources and facilities so we can better respond to the health and care needs of the people of City, SAPA and Foundry PCNs.

6 Our local health needs

6.1 Location

Sheffield is a UK City in South Yorkshire, England. Both the programme and individual hub projects are located within the Sheffield City boundary (see Figure below).

Within the Sheffield City Boundary, CCG split the primary care estate across 15 areas / neighbourhoods (called Primary Care Networks, PCNs). The three PCNs in scope in the Programme are City Centre PCN, SAPA PCN (was SAPA 5) and Foundry PCN (was North 2).

Figure 2 – Maps identifying Sheffield City Boundary, UK (Source – SCC)

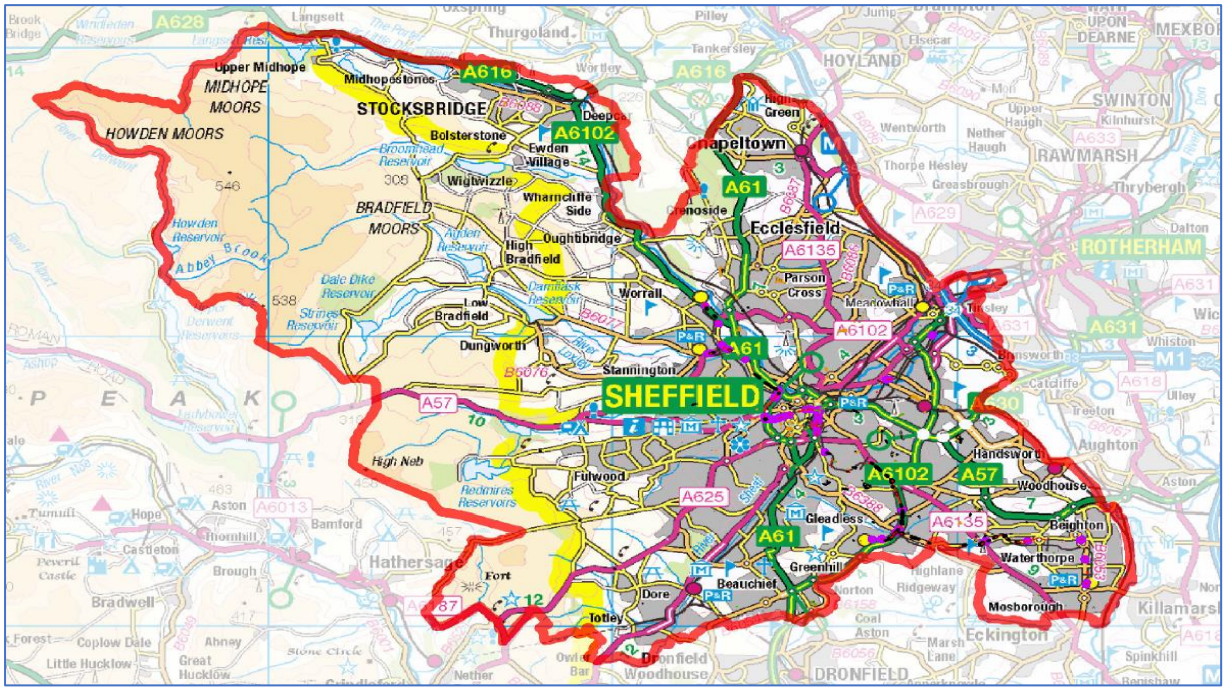
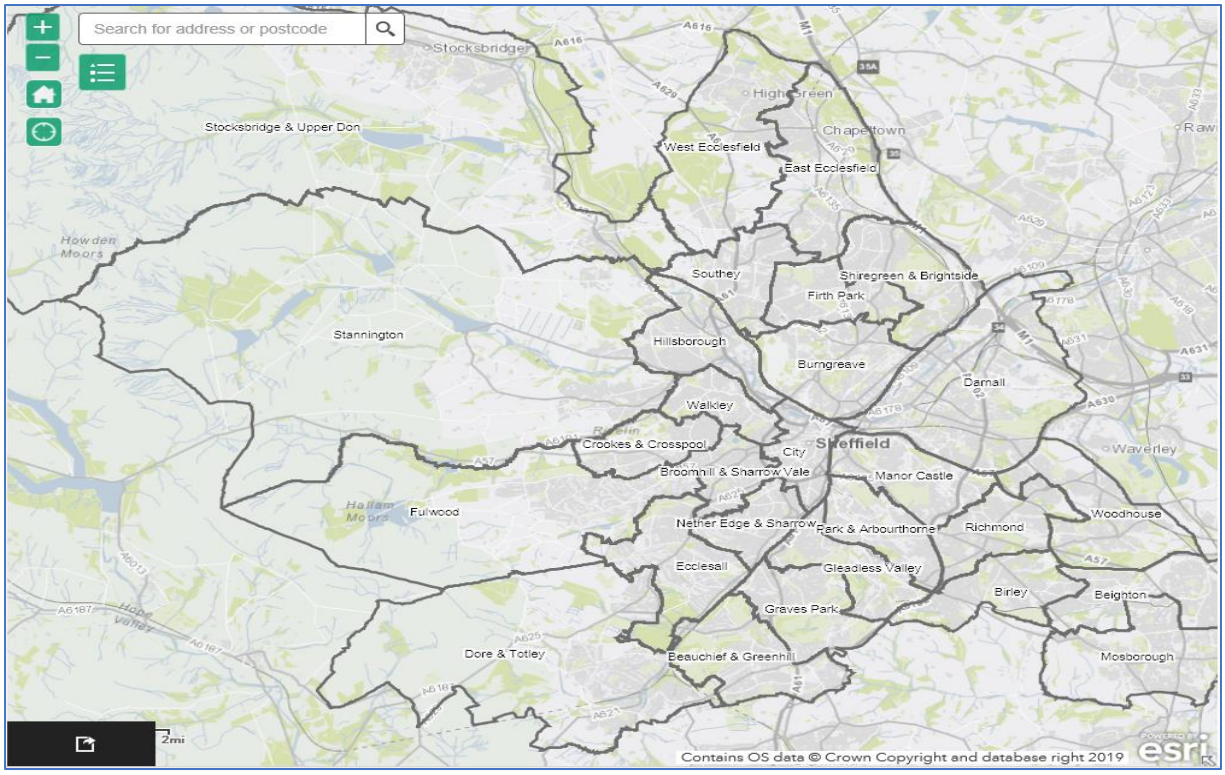


Figure 3 – Sheffield City Boundary showing all GP practice premises (Source – SHAPE)

Sheffield is divided into 28 elected wards. The PCNs do not align directly with the SCC wards (see figure below). The three Transformation Hubs in scope of the ICS Capital Programme (i.e. some practices from the City, SAPA and Foundry PCNs), are situated approximately within the following wards / areas of Sheffield:

- City PCN – 3 practices within the City Centre only (City)
- SAPA PCN – North East Sheffield (Burngreave, Firth Park, Shiregreen & Brightside)
- Foundry PCN – East Sheffield (part of Darnall, parts of Burngreave).

Figure 4 – Sheffield Council Wards Map (Source – Sheffield City Website – OS data)



6.2 Deprivation

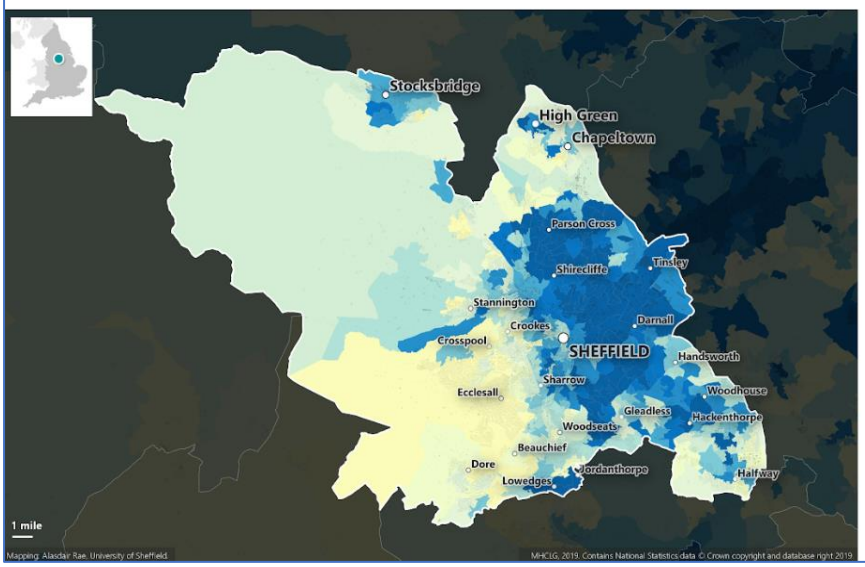
The three PCN areas of City, SAPA and Foundry are some of the most deprived across Sheffield. The figure below provides the deprivation levels across Sheffield as of 2019.

Figure 5 – Sheffield Deprivation 2019

English Indices of Deprivation 2019

Ministry of Housing, Communities & Local Government

SHEFFIELD



Local deprivation profile

% of LSOAs in each national deprivation decile

MORE DEPRIVED

1	23.8%
2	10.4%
3	7.5%
4	6.4%
5	9.0%
6	9.0%
7	7.5%
8	7.8%
9	8.7%
10	9.9%

LESS DEPRIVED

What this map shows

This is a map of Indices of Deprivation 2019 data for **Sheffield**. The colours on the map indicate the deprivation decile of each Lower Layer Super Output Area (LSOA) for England as a whole, and the coloured bars above indicate the proportion of LSOAs in each national deprivation decile. The most deprived areas (decile 1) are shown in blue. It is important to keep in mind that the Indices of Deprivation relate to small areas and do not tell us how deprived, or wealthy, individual people are. LSOAs have an average population of just under 1,700 (as of 2017).

More deprived — Less deprived

Relative level of deprivation

7 Current situation

7.1 Existing and future arrangements

7.1.1 Existing arrangements

SCC and the CCG are committed to ensuring assets are used effectively providing users and staff with flexible working environments in line with modern working practices. The latest Primary Care Estate Strategy (PCES) 2017-2022 reviewed the primary care current estate and identified areas for improvement over that five-year period (2017-2022).

SCC and SCCG both aim to ensure assets are used efficiently, effectively, and that they meet all statutory compliance standards. SCC and SCCG are committed to ensuring the primary care footprint support local areas from a health, social, environmental, and economical perspective but also from an operationally active perspective i.e., sites do not remain inactive/vacant for long periods of time to ensure site safety and value for money.

A review of the existing estate was undertaken during June – July 2020. This involved reviewing information provided by SCCG, particularly the 6 facet surveys. In addition, stakeholder engagement enabled the collation of additional existing and future requirements with GPs and non-GP stakeholders. GPs completed a questionnaire which provided information on current opening hours, patient list sizes, services provided and current ways of working. Follow-up engagement with each GP enabled discussions to focus on both the strategic aspirations and the potential commercial future arrangements. The sections below capture the outputs from this review and engagement phase of the project.

Across Sheffield, where practices are not open (e.g., 'out of hours') for their patients, there is an organisation called Primary Care Sheffield (a GP Collaborative) who provide GP out of hours and extended access services. The Sheffield GP Collaborative are based at the Sheffield Northern General Hospital. Primary Care Sheffield is a GP-led company set up to support Sheffield's general practices.

Primary Care Sheffield operates a few extended access satellite hubs across Sheffield, which operate 6pm-10pm Monday to Friday and 10am-6pm on Saturdays and Sundays. These satellite hubs are based in the following surgeries: Sloan Medical Centre, Woodhouse Health Centre, The Crookes Practice and The Health Care Surgery.

The practices in the original scope of the programme and individual projects are shown in the table below.

Table 1 – Practices in original scope

Project / PCN	Practices in original scope	Practices in the PCN but not in the original scope
City	▪ City Practice ▪ Mulberry Practice ▪ Devonshire Green Medical Centre ▪ Hanover Medical Centre	▪ Crookes Valley MC ▪ Harold Street MC ▪ Porter Brook MC ▪ Upperthorpe MC ▪ Sheffield Hallam University Medical Centre ▪ Steel City Group practice
Foundry	▪ Burngreave Surgery (including branch sites at Herries Road and Cornerstone Surgery) ▪ Sheffield Medical Centre ▪ Pitsmoor Surgery ▪ Page Hall Medical Centre	▪ Wincobank Medical Centre ▪ The Flowers (part of Forge Health group practice)

Project / PCN	Practices in original scope	Practices in the PCN but not in the original scope
	▪ Upwell Street Surgery ▪ Firth Park Surgery ▪ Southey Green Medical Centre	
SAPA	▪ Dunninc Road Surgery ▪ Shiregreen Medical Centre (including branch site at Melrose Surgery) ▪ Elm Lane Surgery ▪ Norwood Medical Centre ▪ Buchanan Road Surgery ▪ The Healthcare Surgery ▪ Margetson Practice*	

*Part of Network North PCN

7.1.2 Demographics, developments, and the current estate

A review of the demographics, developments and the current primary care estate in Sheffield was undertaken in June 2020. The key outputs are provided below. The review covered:

- Demographics
- Developments
- Current estate.

7.1.2.1 *Demographics*

ONS suggests population figures for Sheffield, mid-2019, was 584,853[13], a figure that has grown significantly in recent years due to large scale housing developments.

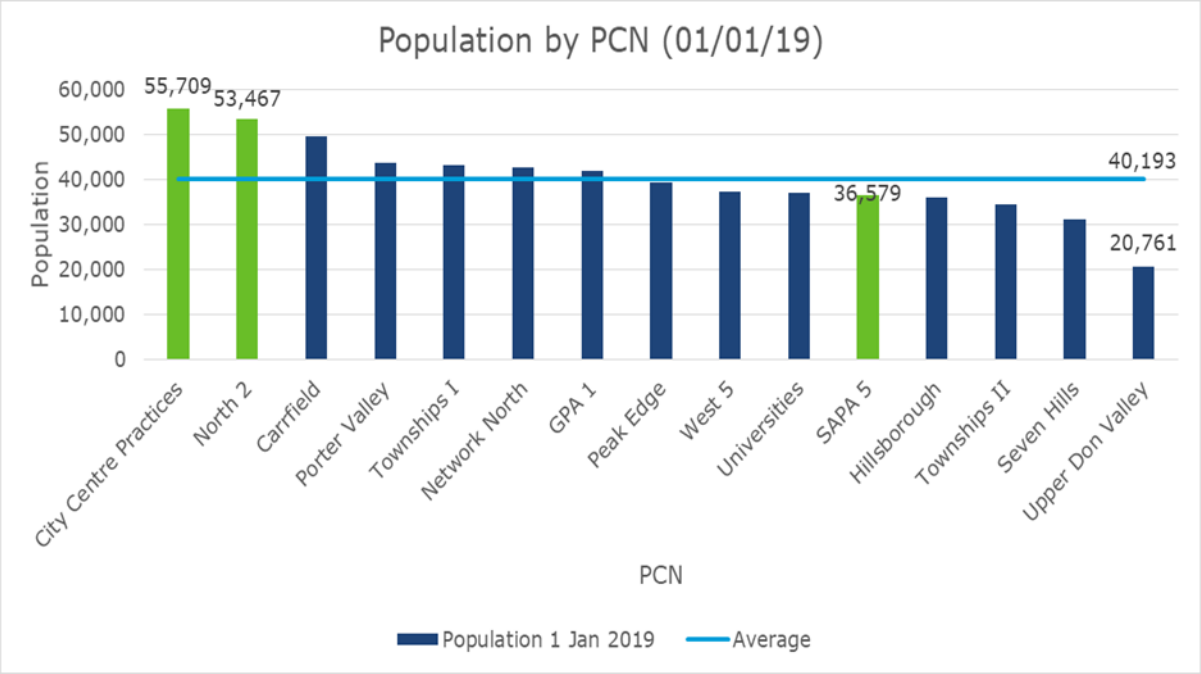
Despite the current geopolitical uncertainty, housing demand is likely to persist, and this can be seen in the new housing sites that are coming online and the maintenance of housing land value.

Using a January 2019 data set provided by the SCCG Primary Care Commissioning Committee (PCCC) report 29 May 2019, the figure below provides the population by PCN across Sheffield.

Figure 6 – Population across the PCN (Source – SCCG[14])

13 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

14 https://www.sheffieldccg.nhs.uk/Downloads/Primary%20Care%20Commissioning%20Committee/2019/MAY%202019/PAPER%20C%20Primary%20Care%20Networks%20Update.pdf



The population of Sheffield is expected to increase by 9.2% between now and 2040[15]. The table below demonstrates this significant increase.

Table 2 – Population change forecast Sheffield from 2018-2040

Year	2018	2025	2030	2035	2040
Population	582,506	596,486	612,214	623,864	636,097
	% change*	2.4%	5.1%	7.1%	9.2%

An SCC supplementary review and examination of key data areas was undertaken by in August 2020 – see **Appendix 02**.

Using numerous sources of insight and information (See Appendix C), we know the following about the people who live in these areas:

15 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2016based

City
Communities: White English, Indian, Bengali, Pakistani, Chinese, Roma, carers, new arrivals (asylum seekers, refugees), students, young people, homeless, isolated people living on own

Languages: English, Punjabi, Urdu, Hindi, Arabic, Romanian, Slovak, Chinese

Top 5 Acorn type descriptions for this PCN:

Acorn type description	%
Educated young people in flats and tenements	24.3
Student flats and halls of residence	17.9
Deprived areas and high-rise flats	10.8
Term-time terraces	6.5
First time buyers in small, modern homes	5.5

Issues raised for area:
- Consider how to reach those with no GP practice – students/asylum seekers/refugees
- Consider how to reach seldom heard groups such as the homeless community
- Mulberry Practice specialises in new arrivals to the city and treats people in a personalised and holistic way. Integrating new arrivals and mainstream patients within the same building should be considered to prevent conflict.

Foundry
Communities: White English, Pakistani, Roma, Slovak, Somali, Yemeni, new arrivals (asylum seekers, refugees).

Languages: English, Arabic, Roma Slovak, Urdu

Top 5 Acorn type descriptions for this PCN:

Acorn type description	%
Poorer families, many children, terraced housing	10.2
Deprived areas and high-rise flats	10.1
High occupancy terraces, culturally diverse family areas	9.2
Young people in small, low cost terraces	8.8
Suburban semis, conventional attitudes	8.6

Issues raised for area/important to note:
- PCN with the highest percentage of patients from an ethnic minority background.
- GPs embedded in communities/neighbourhoods and practices all within walking distance.
- Majority of people don't leave their areas and don't use public transport – practices are on the doorstep/convenient.
- Deprived areas with teen pregnancies/young families/ people don't navigate the system well.
- Need comms on the bigger picture although often these communities don't like change.
- Roma Slovak community are not as familiar with the use of relative time formats such as quarter past, half past. These should be avoided in favour of a digital clock format.
- Some communities don't read in their spoken language.
- Issue of digital exclusion – social media/web/digital can't be accessed.

SAPA
Communities: White English, small dispersed BAME communities

Languages: English

Top 5 Acorn type descriptions for this PCN:

Acorn type description	%

Singles and young families, some receiving benefits	25.7
Poorer families, many children, terraced housing	17.3
Low income large families in social rented semis	11.2
Post-war estates, limited means	9.8
Low income older people in smaller semis	9.4

Issues raised for area:

- High working age population.
- Less densely populated area.
- Residents often shop out of area, so going beyond boundaries of PCN is advised.
- Large Methodist Church following

7.1.2.2 Developments

The SCC local plan and supporting documents captures potential housing developments over a long future forecast i.e., up to 2038. The local plan is currently being reviewed and figures will therefore be refreshed. However, analysis was undertaken by SCC based on current housing development data, to highlight the potential number of new developments potentially occurring 800m around the practices in scope of the projects between now and 2038. Within this there are a large number which are more hypothetical developments. We concentrated on the more certain development and excluded the hypothetical development. This was:

Table 3 – Estimated future additional patients per hub

Project	New developments / homes	Average patient per new dwelling*1	Potential new patients	Adjustment factor*2	Adjusted estimated new patients
City	9,882	1.8	17,788	33%	11,198
Foundry 1	2,157	2.4	5,177	40%	3,106
Foundry 2	2,157	2.4	5,177	40%	3,106
SAPA 1	1,293	2.4	3,104	50%	1,552
SAPA 2	1,293	2.4	3,104	50%	1,552
Total	**16,782**		**34,884**		**20,514**

*1 - based on a 2.4-person average per 'out of centre' new dwelling (and 1.8 per City Centre)
*2 – City % due to presence of many other practices in the PCN, Foundry % due LIFT building taking remaining 20% and SAPA % due to split between the two potential hubs

Whilst other development sites are across Sheffield, they have been excluded as they fell beyond the 800m sample boundary area considered by SCC and those populations will be serviced by other primary care practices within Sheffield.

7.1.2.3 *Current estate for those practices in scope of this Hub Programme*

Most of the GP estate across Sheffield are aged although generally in good condition, with varying levels of backlog maintenance required to bring up to a suitable standard. This is reflective of City, Foundry and SAPA PCNs. The majority of the most recent 6 facet surveys for these practices were completed in July 2016. However, many practices do have space constraints with many not suitable for current primary care needs.

Detailed 6-Facet information was collected for all 105 GP premises. CCG summarised key findings from this showed that across Sheffield there are:

- A high proportion of smaller practices (average list size c6,600)

- A high proportion of physically small practices (average gia of 577m2)
- Just 19 practices with a gia over 800m2, the size where wrap-around services are considered viable in practice
- A high proportion of converted properties
- An older age profile of our primary care estate (average building age is 53 years)
- 71% of practices have less than 0.15 Clinical Rooms per 100 patients (CCG indicated rate)
- LIFT Buildings have low utilisation between 33% and 55% of potential capacity, with 67% of clinical rooms being used below 40% of the potential time (sampled).

Capacity and the existing areas

The existing estate across the **practices in scope of the hub programme** in some cases do not provide appropriate environments to fully address the current health needs of the local community or for proposed new models of care for the future. **Some of the existing services are currently being provided off-site from due to not having any available space in the current buildings**.

The existing estate in terms of functionality and condition is not fit for the future in that:

- The premises GIA (m2) are below the levels to meet the demand of future patient list sizes
- Very little room for expansion on the existing sites
- No space to absorb additional patients or services through demographic change, new models of care or residential developments
- The fabric condition of the buildings will require capital expenditure for improvements with 5 years.

Within all the surgeries, space has become a major limiting factor in their ability to serve their registered patients and meet the needs of a modern primary care system requiring significantly more than the traditional GP consultation rooms. Examining the current clinical space against the current number of patients and against an estimated patient list size in 2040 we can consider the patient per square meter for each of the practices in scope.

The total size of the buildings is set out in the table below. It provides the approximate Net Internal Area (NIA, in m^2) of each surgery which includes all clinical and ancillary space such as training rooms.

Table 4 – Existing Surgery Space/List Size

Project / PCN	Practices	Building area current (NIA)*2	List sizes*1
City	▪ City Practice	▪ 193	▪ 4,160.72
	▪ Mulberry Practice	▪ 202	▪ 3,134.90
	▪ Devonshire Medical Centre*3	▪ 571	▪ 7,689.63
Foundry	▪ Burngreave Surgery*3	▪ 606	▪ 8,150.59
	▪ Sheffield Medical Centre	▪ 171	▪ 2,876.00
	▪ Pitsmoor Surgery	▪ 700	▪ 11,287.38

	▪ Page Hall Medical Centre	▪ 407	▪ 7,600.11
	▪ Upwell Street Surgery	▪ 465	▪ 4,742.47
	▪ Firth Park Surgery	▪ 471	▪ 9,731.17
	▪ Southey Green Medical Centre	▪ 323	▪ 3,101.70
SAPA	▪ Dunninc Road Surgery	▪ 143	▪ 2,383.17
	▪ Shiregreen Medical Centre	▪ 460	▪ 5,841.48
	▪ Elm Lane Surgery	▪ 237	▪ 6,056.72
	▪ Norwood Medical Centre	▪ 479	▪ 9,098.50
	▪ Margetson Practice	▪ 133	▪ 1,017.00
	▪ Buchanan Road Surgery	▪ 498	▪ 4,879.91
	▪ The Healthcare Surgery	▪ 324	▪ 5,409.17
	Total	▪ **5,252**	▪ **82,862.14**

*1 – Based on CCG data 01/01/2022
*2 – Rounded up
*3 – Includes branch sites

The needs of the patient list this size is met by operating in buildings with occupancy that is already at 100% capacity and utilising space from third party sites.

The lack of rooms for the provision of out of hospital services means that in some cases GP consultation rooms are used for these purposes where possible. Whilst this intensive use of space is beneficial, the lack of alternative space for GPs to work from foreshortens any possible gains. Surgeries lack sufficient alternative space for GPs to work beyond a consultation room. As a result, consultation rooms must be used to carry out telephone call appointment consultations with patients when they could be conducted in more cost effective, smaller back of house space, had the space been available.

8 Case for Change and Our Proposals

8.1 Case for change

8.1.1 Rationale

In some of the most deprived areas of Sheffield, particularly across City, SAPA and Foundry PCNs, there is a lack of appropriate primary care accommodation, which will continue to worsen if not acted upon now. This primary care estate issue is likely to increase significantly in the future (i.e., over the next twenty years up to 2040) due to a growing and ageing population due to future residential developments in the area, people living longer and more complex conditions.

The strategic case demonstrates the need to expand the primary care estate in Sheffield to meet such future population growth and future need. This is predicated upon a robust and evidence-based case for change which includes the rationale for why expanding the primary care estate in these areas of Sheffield is required, as well as a clear definition of the benefits and the potential scope for what is to be achieved. It also demonstrates that the development of Transformational Hubs as a potential preferred way forward following previous feasibility studies and NHSE PIDs fits with national, regional, and local policies, local needs, CCG commissioning intentions, strategies, and plans.

Currently there is awarded Government capital funding available for development of the primary care estate in Sheffield for these new Hubs. However, capital funders (namely the Department of Health and Social Care (DHSC) through NHS E&I) as with any public sector investment, require the appropriate level of due diligence in the form of a series of business cases (section 2) to present the case for change, interventions required and that the schemes offer value for money through evidencing and testing the benefits and the costs of the proposed investment(s).

8.1.2 Project objectives

This section outlines the individual project objectives and benefits for investing in the primary care estate in Sheffield by:

- Exploring the need for change
- Alignment to organisational strategic objectives
- Setting out the Spending Objectives (SOs)
- Identifying the benefits
- Developing a Benefits Realisation Plan (BRP).

8.1.3 The need for change

The proposed investment is driven by a need to overcome problems with the existing estate, respond to drivers for change, and opportunities to improve outcomes.

The main reasons causing the need for change are listed in the table below which also describes the likely impact of the status quo continuing as well as highlighting why action is required now through this project:

Table 5 – Main issues causing the need for change

Causes of the need for change	Effect of the cause	Why action now?
Lack of primary care estate to accommodate likely significant increase in patient list sizes	New residential developments are increasing the population in particular areas of Sheffield, therefore creating increased patients for practices	Modifications, remodelling, expanding, or new builds require both time to develop business cases, design and deliver. In addition, the availability of limited capital funding and changing requirements.
Future service demand	An ageing population is likely to result in an unprecedented increase in demand for services, creating an increased cost pressure.	To ensure that the growing demand for different types of services can be met to ensure patients receive the right care and support at the right time in the right place and minimise the associated cost pressures
Patient expectations changing	Patients want local health and care services to deliver better quality, more accessible and more co-ordinated healthcare in and out-of-hospital	To meet patient expectations, new ways of working are needed, and the estate needs to be an enabler for this. However, this requires planning and strategic alignment with other competing priorities.
Socio-economic profile of the PCN – low car ownership / high unemployment	Patients not being able to access full services that they require	If services are housed together, patients are more likely to access required healthcare services and or preventative services

8.1.4 Alignment with SCCG strategic objectives

SCCG has set out several strategic objectives listed in the table below.

Table 6 – SCCG Strategic Objectives

- Reduce the impact of health inequalities on peoples' health and wellbeing through working with Sheffield City Council and partners
- Lead the improvement of quality of care and standards
- Bring care closer to home
- Improve health care sustainability and affordability
- Be a caring employer that values diversity and maximises the potential of our people

Spending objectives (SO)

The SOs outline '**what we are seeking to achieve'** with the programme of projects. They are shown in relation to what is required to overcome the 'effects of the causes of the need for change' highlighted earlier in this section.

The SOs are crucial for making a convincing argument for the proposed investment as set out in this business case. It is important that all objectives deliver tangible results which would assist stakeholders in achieving their respective organisational strategic objectives.

The programme developed the (SMART – specific, measurable, achievable, realistic, and timely) SOs. The programme will work towards, within 5 years completion of its individual Hub projects, the following SO shown in the table below.

Table 7 – Spending objectives (SOs)

SO	Title	Objective
SO1	Building Constraints	Dispose/reduce not fit for purpose estate driving efficiencies within the system, supporting local regeneration
SO2	Increased Capacity	Additional primary care capacity required due to forecast population growth / housing developments demand
SO3	Improved Service Integration	Greater integration of primary care with other complimentary PCN services in a highly accessible location
SO4	Enhanced Scale and Quality	Additional/new services available, enhancing patient choice and service quality
SO5	Affordable Scheme	Meets financial tests of capital and revenue availability and affordability, and offers long term value for money
SO6	Improved Early Intervention, Access, and Support	Embeds wellbeing, prevention, protection, early intervention and enables fair access, considering specific needs of local communities
SO7	Sustainable Workforce	Supports service delivery and attracts and supports a sustainable workforce, including anticipated technological changes, digital connectivity, and overall system shifts
SO8	Achievable Scheme	Scheme capable of being delivered within any capital timeframe requirements

8.1.5 Clinical Strategy and Commissioning Intentions

The proposal seeks to expand the range of services that can be accommodated in primary care buildings to reduce the need to attend hospital. To achieve this SCCG will continue its trend of commissioning services outside of the hospital environment. The current estate lacks the space within surgeries to provide these services whilst continuing to meet requirements of GMS Contracts. As a result, services have been provided in a range of location and building types sourced by providers. Such practices are not conducive to overseeing the interconnected needs of patients, whilst provision of healthcare across a myriad of locations can be confusing for patients and unreliable.

8.1.6 Promoting integrated working between health, social care, and public health

8.1.6.1 *Integrated working*

Several services, including social prescribing are currently provided from the existing surgery estate. However, in some cases particular PCN/ wrap around services can only be provided from surgeries due to a lack of space to accommodate such services. GPs inform that current PCN services and potentially other hospital community type services would view the Hub as a positive step, a real opportunity, to provide services from larger, modern primary care hub facilities. Some PCN surgeries, are clear that they are currently limited in what they can provide on top of existing services because they are curtailed by the estate. Any health/other service providers engaged in the preparation of this SOC were supportive of opportunities to work closer with GPs.

8.1.6.2 *Improved access*

Expanding access to the GMS elements of the building services is limited by the contractual constraints of the contract which provide a limited number of hours. However, it is envisaged that other services could easily expand, and building access in the building model, has been calculated over a 12-hour day (0800 – 2000hrs), including some weekend access (e.g. Saturday mornings between 0800 and 1300hrs), meaning the Hub building being open for 65 hours per week. Currently, the estate typically operates from 0830hrs to 1800hrs 5 days a week with some surgeries providing extended hours being open on Saturday mornings for example.

As expansion of the GMS contract is limited, it is envisaged that activity in the evenings will focus on Extended Hours, Extended Access and those services delivered by visiting healthcare professionals.

The NHS aspiration for 7-day services is possible, but the GMS contract does not require GPs to provide a 7-day service. The surgeries have limited numbers of existing staff and a move towards a 7-day service would only be possible through additional recruitment. The CCG is actively engaged with these surgeries specifically around transitioning them towards a more robust service delivery model. Once complete, it will be possible to investigate increasing the number of operational days.

The role of the programme is to test the overall viability of the proposals and it is not within the remit of this document to drive changes in how surgeries should be managed. However, it does note that increasing service provision across a 7-day working week would allow the proposed Transformational Hubs to operate more intensively and therefore potentially cost less to deliver, as the hub building would be in-use 7 days a week, rather than 5.

Provision of a single site will inevitably reduce the accessibility of services to those who live adjacent to the existing surgeries for those practices in scope. However, it should be noted that older surgeries, where often sited where land or buildings permitted and the robust processes that is being enacted as part of this programme were often not undertaken historically, or if they were, urban areas have often evolved to such an extent that the original considerations are now obsolete. Later sections of this document expand upon this point, quantifying impact of accessibility and ultimately concludes that some patients would be disadvantaged due to a new Hub site being further from their existing surgery, however anyone traveling by public or private transport are likely to be unaffected or benefit from increased accessibility.

8.1.6.3 *Consistency with current and prospective need for patient choice*

Development of new Transformational Hubs in Sheffield would seek to alleviate the current constraints on the primary care estate that to some extent prevent patients being offered a choice over their primary care. Shortfalls in the current estate mean that there are rolling closures of patient lists which prevent patients choosing which surgery they wish to register with. In addition, the under-provision or not optimally configured space within surgeries curtails the number of appointments each surgery can offer despite maximising the potential of the GMS contract. As a result, there can be in some cases perpetual waiting times to get a GP appointment which likely substantially worsen during peak times. These restrictions on the primary care estate increase the risk of patients presenting themselves at A&E or walk-in centres, putting strain across the entire healthcare network.

8.1.6.4 *Clear, clinical evidence base*

The hub space modelling developed as part of the programme is based on Department of Health, Health Building Notes (HBN) 11-01 Facilities for primary care and community

services[16] guidance for the calculation of consultation and treatment rooms. The process has involved calculating the number of appointments per annum needed to satisfy the needs of the patient populations and calculates the number of appropriate rooms needed to meet these needs. Room sizes are also based on this HBN guidance.

A healthcare planner has worked with each practice in scope to support them to understand the art of the possible from the potential hubs. This has resulted in the development of a Schedule of Accommodation (SoA) for each potential new hub being considered by specific practices.

8.2 Business needs

The CCG needs to focus on closing any gaps between where we are now (existing arrangements) and where we need to be in the future (business needs). The business needs are highlighted in the table below.

Table 8 – Business needs

Existing arrangement ('current state')	Problems and difficulties associated with existing arrangements	Opportunities for bridging any existing or future gaps ('future state')
Current GP premises too small / incorrectly configured for enhanced primary care provision at scale model	Not able to fully deliver all services required from current premises	Build modern buildings to fully accommodate enhanced primary care provision
An older age primary care estate	Buildings require ongoing / costly maintenance with being / becoming no longer fit for purpose	Moving several practices into a modern new Hub building, significantly reduces primary care estate maintenance issues
Rapidly ageing population, presenting with more complex conditions	Disjointed approach to service provision, exacerbates inequalities in population health	Enhanced and improved collaborative working across health and social and communicate care services
Increasing patient expectations around waiting time for consultation, referral, and treatment	Not able to cope with demand and needs	Support increased capacity in Primary and Community services enabling efficient patient care to alleviate pressures of increasing demand
Weak digital accessibility	Patients not able to access the appropriate technology and technology not in place or not efficiently integrated between primary and community services	Have in place appropriate systems and skills to deliver digital-enabled models of care, together with a more integrated delivery of care using the latest technology

8.2.1 Future requirements

16 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148509/HBN_11-01_Final.pdf

8.2.1.1 *Engagement feedback on capacity requirements*

As part of the preparation of this PCBC and SOC, meetings were held with each GP practice. The availability of space was discussed and in general reported as insufficient for the needs of each surgery.

Part of these discussions included the list of PCN services that are currently undertaken at the surgeries. Surgeries indicated that provision of additional PCN (wrap around) services within a GP surgery environment would help provide a more integrated approach to care and improve patient treatment.

This allowed the project to build up a specification (a Schedule of Accommodation, SoA) for how much space would be needed to consolidate PCN services within the proposed hub buildings per project. Room sizes were led by guidance from HBN 11.01. The appointed healthcare planner developed the SoAs to confirm total space allocations per practice and per hub.

8.2.1.2 *Agreed size and scope*

The combined information from the stakeholder engagement was used to develop the initial building model outputs for any proposed alternative options. The future estate aims to provide a flexible estate to cover circa the next twenty years. It is expected that some PCN services would continue to be provided at the other practice surgeries not included in this study (unless they too are considered for an alternative Hub).

From discussions with GPs, they are in some cases currently facilitating PCN services by using existing GP consultation rooms. This, however, prevents the space from being used by GP to undertake consultations. The proposed mix of consultation, treatment and PCN space reflects an up-to-date special requirement for Sheffield where rooms are used in the most efficient, functionally suitable purpose.

8.3 Project Scope

This covers the potential scope of the hub projects, in terms of the operational capabilities and service changes required to satisfy the identified business needs.

The CCG has considered the potential range of business functions, areas and operations that would be affected by the projects and the key services required to improve organisational capability on a continuum of need, where:

- the **'core'** coverage and services required represent the **'essential'** changes without which the project will not be judged a success
- the **'desirable'** coverage and services required represent the **'additional'** changes which the project can potentially justify on a cost/benefit and thus Value for Money basis
- the **'optional'** coverage and services required represent the **'possible'** changes which the project can potentially justify on a marginal low cost and affordability basis.

This aims to assist in avoiding 'scope creep' during the options appraisal stage of the project and is summarised in the table below.

Table 9 – Business scope and key service requirements

Coverage (Changes)	Core (Essential changes)	Desirable (Additional changes)	Optional (Possible changes)
Potential scope	Improved estate to accommodate primary care provision	Improved estate to accommodate enhanced primary care provision	Improved estate to accommodate other new service provision
Key service requirements	GMS/PMS	PCN	Other health and care services

8.4 Benefits and Risks

This section highlights the main potential benefits and risks.

8.4.1 Identifying the benefits

All stakeholders want to improve services to patients, to build on opportunities to expand services offered, potentially from shared buildings, such as "near patient testing" to reduce need to travel for some tests, introduction of practice-based pharmacists to support medication advice, as well as social prescribing to support wellbeing. Co-location would enable sharing 'back office' working which would release funding to patient-facing staff.

New hubs would enable practices to provide services from a modern building, fit for purpose, with comprehensive disabled access. There are demonstrable benefits of hub models, and scope for further improvements could be jeopardised if we do not act now.

The benefits of a primary and community care hub are:

- Opportunity to co-locate the health, local authority community teams and voluntary sector together with primary care in an easily accessible new buildings and enhance the outcomes of multi-agency working already in other parts of Sheffield
- Greater integration which will improve our ability to support people in their own homes, further reducing hospital admissions and demand on the acute hospital. The main challenges for acute sites are Emergency Department performance and finance. These hub developments would directly contribute to improvement in these areas through a reduction in hospital-based care. Integration of services alongside primary care would deliver further efficiencies and improvement in performance
- Further development of the multi-professional, multi-agency, self-managed team with strength of therapy and nursing leadership in clinical decision making
- Provision of more space so other services can be included on a drop-in basis
- Support the sustainability of primary care with a modern fit-for-purpose building providing a more attractive partnership model without the burden of property ownership
- Improved training opportunities for GPs and other clinical staff with better professional development
- Providing a great place to work, in a bright, modern, and airy environment
- Providing the ability to share services especially back-office functions.

In developing the project benefits the project team reviewed the SOs and sought to consider how these translate into clearly linked measurable benefits, on the basis that a **benefit is an economic measure of the outcome that is expected in return for an investment**.

The key benefits arising from the proposed SOs are set out in the table below.

Table 10 – scheme benefits

Benefit ref	Benefit Category	Benefit description
B1	Reduced GP sickness	GP sickness rates reduced
B2	Reduced Admin sickness	Admin sickness rates reduced
B3	Reduced recruitment costs	Admin recruitment costs reduced
B4	Reduced non-clinical days	GP non-clinical days reduced
B5	Reduced prescriptions	Reduced prescribing costs through close collaboration with pharmacist
B6	Reduced falls	Proactive fall prevention care based on MDT prevention of 3 falls per annum which would have led to hospital admission
B7	Incentivised recruitment	Primary Care Hub identified as contributing to workforce recruitment & retention as they are perceived as attractive workforces and more innovative than traditional models.
B8	Backlog reduction	Decreases backlog requirement per annum
B9	Reduction in complaints	Less staff time spent responding to less complaints - due to the environment and accessibility to appointments
B10	Reduced emergency visits	Reduction in hospital emergency visits (by new Hub emergency support service)
B11	Reduced A&E admissions	Continue to contribute to reduction in A&E admissions
B12	Reduced MH episodes	Primary Care Hub new model of care incorporating social prescribing, reducing mental health crisis episode.
B13	Public/third sector rental of additional space	Lease to Health Trusts, Community/Third Sector groups
B14	Delivers expected Service Quality	will allow services to provide the level of service quality expected
B15	Meets capacity requirements	Assets provide sufficient capacity requirements
B16	Timeliness to deliver by end 2023	Construction and funding can be completed before the end of 2023
B17	Delivers service efficiencies	New arrangement supports to deliver service efficiencies
B18	Capacity for future growth	Assets provide sufficient space for future growth
B19	Co-location with other services	New arrangement supports co-location of complimentary services
B20	Capital avoidance elsewhere	New asset prevents spending money of existing assets

Benefit ref	Benefit Category	Benefit description
B21	Enhanced patient experience	Patient experienced is enhanced
B22	Enhanced accessibility	Accessibility to and within the new asset is enhanced compared to existing
B23	Likelihood of full stakeholder support	All stakeholders have full support
B24	Strategic fit – demand management	New arrangements provide strategic fit - from a demand management perspective
B25	Strategic Fit – Promotes Health & Wellbeing	New arrangements provide strategic fit - promoting/improving health and wellbeing
B26	Strategic Fit – reducing health inequalities	New arrangements provide strategic fit - by reducing health inequalities
B27	Strategic Fit - Primary care at Scale / New Models of Care	New arrangements provide strategic fit - by enabling primary care at scale / new models of care
B28	Rent saving for CCG (Public Sector)	Rent saving for CCG as not reimbursing GPs for (e.g.) 70 years due to capital investment
B29	Avoidance of Planned Maintenance (PM)	PM eradicated as current buildings vacated and disposed of.
B30	Disposal of Public Sector site	Vacation and disposal of Publicly owned Building(s)
B31	Commercial rental of additional space	Lease to Commercial Sector
B32	Travel costs & lost hours	Reduction in travel costs and reduction in lost hours
B33	Crime reduction	Reduction in crime due to reduced premises
B34	Alternatives to Social Care	Users/patients offered social prescribing reducing social care required

The above list of benefits includes some which are 'unmonetisable' benefits. These benefits are used to assist the economic case qualitative (non-financial) appraisal. Any financial related benefits identified, are appraised through the economic case quantitative appraisal. To ensure that all identified benefits that are to be realised through this project, these are developed into a Benefits Realisation Plan (BRP). The BRP is considered further within the management case section.

8.4.2 Risk management arrangements

The project team working on the delivery of this PCBC will maintain a risk register, which is included within the CCG's overall risk management and governance arrangements.

Any risks to the PCBC will be continually updated and refined as our proposed model is being refined and in response to feedback from stakeholders throughout the consultation period and as any other relevant information about the impacts of the final pre-consultation proposal becomes available.

8.5 Our proposals

We reviewed the Case for Change, and this led us to conclude that our proposal should be to consider alternatives to remaining and expanding at all existing practices in scope and to consider finding suitable public sector sites capable of delivery within the programme timescales and that can meet our future population and place needs.

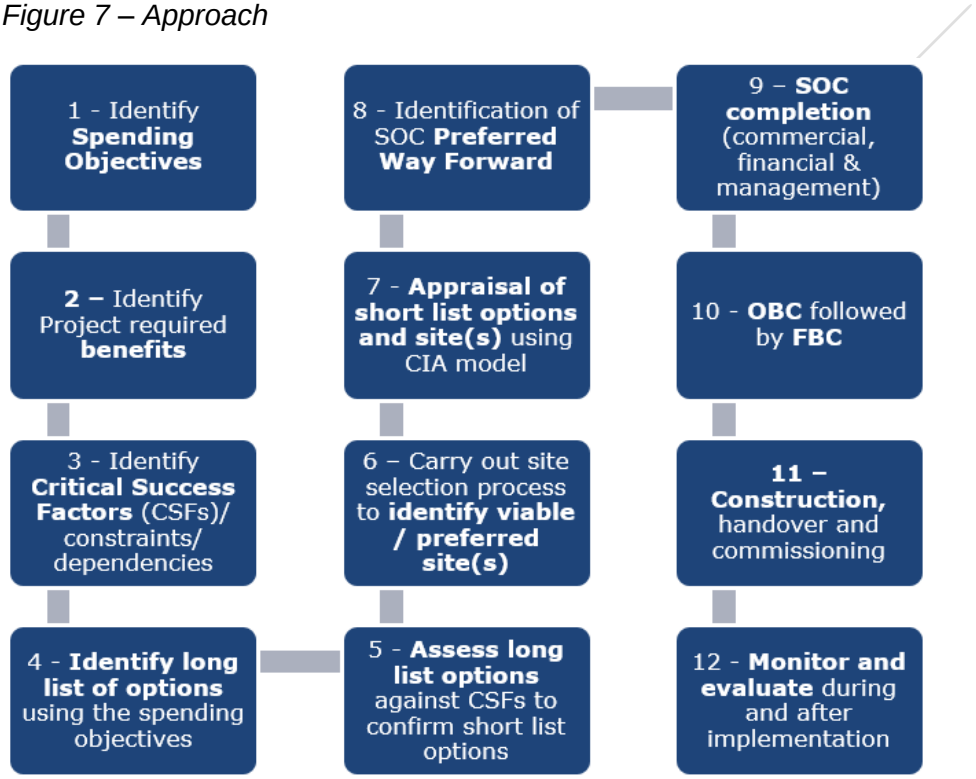
Whatever future options are decided we will take swift action to ensure that patients can continue to see a local GP when they need to, and we will communicate with patients to ensure they know what is happening.

As highlighted in the previous section, prior work was in the form of Feasibility Studies, Addendums to these and NHSE PIDs were undertaken. This work created the initial long list of options in collaboration with GP stakeholders at that time.

8.5.1 Approach to develop the preferred way forward

This PCBC has reviewed and considered outputs from all previous work and considered if the options remain valid today. This has involved engaging with stakeholders to ascertain the latest position. The PCBC has followed steps 1 to 8 in the process shown in the figure below. Steps 1 and 2 were highlighted in the previous section.

Figure 7 – Approach



8.5.2 Identifying the Critical Success Factors (CSFs, step 3)

CSFs relate to the deliverability of the options. They provide a rationale to discard long list options before any detailed review is undertaken. The CSFs were developed using the Green Book guidance[17]. Using the HMT Green Book suggested key CSF areas, the CCG developed specific CSFs for this project. These are shown in the table below.

Table 11 – CSFs and benefits criteria

[17] The Green Book: appraisal and evaluation in central government - GOV.UK (www.gov.uk)

Key CSFs (5 case link)	Broad Description	Benefits Criteria for this project
Strategic Fit and Business Needs *(Strategic)*	How well the option: ▪ Meets agreed SOs related business needs and service requirements ▪ Provides holistic fit and synergy with other strategies, programmes, and projects.	▪ **CSF 1: Alignment** with the project spending objectives and business needs and any other relevant Council and CCG (or wider i.e. system level) strategies, programmes, and projects.
Potential value for money *(Economic)*	How well the option: ▪ Maximises the return on the required spend (benefits optimisation) in terms of economy, efficiency, and effectiveness from both the perspective of the organisation and wider society. ▪ Minimises associated risks.	▪ **CSF 2: Delivers** the proposed required benefits
Potential achievability *(Management)*	How well the option: ▪ Is likely to be delivered in view of the respective organisation's ability to assimilate, adapt, and respond to the required level of change ▪ Matches the level of available skills which are required for successful delivery.	▪ **CSF 3: Deliverability** within appropriate timescales and with minimal disruption to service delivery
Supply-side capacity and capability *(Commercial)*	How well the option: ▪ Matches the ability of the service providers to deliver the required level of services and business functionality ▪ Appeals to the supply-side.	▪ **CSF 4: Attractive** to the market to deliver
Potential affordability *(Financial)*	▪ The project is affordable to the organisation (revenue and capital)	▪ **CSF 5: Delivers** efficiency savings and affordable to implement.

Achieving these CSFs will be a key part of delivering a successful project. All the long list options were assessed against them (see next steps).

8.5.3 Identify long list of options using the spending objectives (step 4) and assessing the long list options against the CSFs to confirm short-list options (step 5)

To support with identifying the long list of options, the individual projects adopted the HMT 'Option Framework Evaluation'. The options framework evaluation, as outlined in HMT Green Book guidance (page 15), provides a systematic approach to identifying and filtering a broad range of options for operational scope, service solutions, implementation timeframes and the funding mechanism for a project.

Several long list high level options were reviewed to develop a shorter list. The long list includes the 'Do nothing' (or otherwise known as the Business as Usual (BAU)) and do-

minimum options, however as part of this process, care was taken to ensure that the options considered reflected an appropriately wide and well-defined range of alternatives.

The development of the long list was undertaken in 2020/21 by assessing the following categories:

- **Scoping options** – The range of potential services to be included within the project
- **Service solution** – How the preferred scope of the project can be delivered
- **Service delivery** – in relation to delivery of the preferred scope and solution
- **Implementation options** – The range of potential delivery timescales
- **Funding options** – The range of potential funding options for the project.

The above categories were assessed against the following assessment criteria:

- **Preferred way forward** – The option that is most likely to optimise public value for money since it best meets the CSFs and the SOs, where advantages far outweigh disadvantages
- **Carry forward** – Options to carry forward for further evaluation on the basis that they adequately meet a range of CSFs and SOs, where advantages outweigh disadvantages
- **Discounted** – carry forward as 'baseline': options that are not feasible but should be carried forward to compare against as a baseline (i.e. the do-nothing/BAU option)
- **Discounted** – Unrealistic options that do not adequately meet the schemes CSFs and SOs, where disadvantages outweigh advantages.

Table 12 – Identification of the long-list

Project	0. Business as Usual (BAU)	1. Do-Minimum	2. Do-Intermediate	3. Do-Maximum
1. Project scope – as outline in the strategic case	1.0 Status quo option. GPs continue to provide existing services only.	1.1 Existing GP practice(s) delivered services only	1.2 Same as 1.1 plus existing and new 'PCN wrap around' services	1.3 Same as 1.2 plus other complimentary services (e.g. Third & Commercial Sector)
	Discounted	Discounted	Carry forward	Preferred Way Forward
2. Project solution – in relation to the preferred scope	2.0 Current services: Backlog maintenance works at existing practice premises/sites	2.1 Extension and or reconfiguration existing premises(s)	2.2 Mix of reconfigure/ expand existing premises and new build Hub	2.3 Build only new Hub, dispose of other sites
	Discounted	Carry forward	Carry forward	Preferred Way Forward
3. Service delivery – in relation to the preferred scope & solution	3.0 In-house delivery	3.1 Local contractor	3.2 National contractor	3.3 International contractor
	Discounted	Preferred way forward	Carry forward	Carry forward
4. Implementation – in relation to preferred scope, solution and method of service delivery	4.0 Phased over 5 years	4.1 Phased over 3 FYs	4.2 Phase over 2 FY's	4.3 Big bang over 1 FY
	Discounted	Discounted	Carry forward	Preferred way forward
5. Funding – in relation to preferred scope, solution and method of service delivery & implementation	5.0 GP cost	5.1 CCG plus GP contribute (e.g. as per PCDs)	5.2 Full 100% Government capital funded	5.3 Mix of public & private funding
	Discounted	Carry Forward	Preferred way forward	Discounted

Using the above options framework enabled the consideration of a possible **72 permutations** (**Appendix X**). These **72 permutations** were grouped into four overarching options per project shown in the table below.

Table 13 – Summary description of long list options

Long-list options	0. Business as Usual (BAU)	1. Do-Minimum	2. Do-Intermediate	3. Do-Maximum
Description	Provide existing services through undertaking of **backlog maintenance of existing practice premises**, using a GP's (in-house) own contractors, phased over 5 financial years through an improvement grant (IG) funded route.	Provide existing services through the **extension and or reconfiguration of existing practice premise(s)**, using a local contractor (or national / international) contractor, over 1 financial year (or phased over 2 or 3) to be fully funded by 100% of the Government grant (or CCG plus GP contributions).	Provide existing services plus additional PCN 'wrap around' services through a **mix of retaining or expanding existing practices and new build Hubs**, using a local (or national / international) contractor, over 1 financial year (or phased over 2) to be fully funded by 100% of the Government grant (or CCG plus GP contributions).	Provide existing services plus additional PCN 'wrap around', third and commercial sector services, through **new build Hubs**, using a local (or national / international) contractor, over 1 financial year (or phased over 2) to be fully funded by 100% of the Government grant (or CCG plus GP contributions).
Initial assessment	Discounted	Discounted	Carry forward	Preferred way forward

As both the BAU and Do-Minimum options from an options framework scope perspective do not meet the project objectives or critical success factors these were discounted. However, although this initial desktop appraisal discounts both option 0 and 1, the capital business case process will require them both to be used for comparison purposes to other alternative options in the SOC, OBC and FBC capital business case economic case appraisal processes.

Within option 2 and 3, the 'alternative options', this is where there are several permutations depending upon the chosen solution, delivery, implementation and funding route chosen. The initial assessment indicates to carry forward the do-intermediate and the do-maximum, with the do-maximum of creating a hub and all moving in being the preferred way forward at this early stage.

Each of the long options, were evaluated, focusing on how well each option meets the project's SOs and CSFs. Based on the long list, an assessment was made about whether it is feasible to carry the option forward in terms of:

- **Green:** assessment indicates **fully** meets SOs and or CSFs
- **Amber:** assessment indicates **partly** meets SOs and or CSFs
- **Red:** assessment indicates **does not** meet.

The results are shown in the table below. This indicates that option 3, do-maximum of providing existing services plus additional PCN 'wrap around', third and commercial sector services, through a new build hub, using either a local (preferred), national or international contractor, over 1 financial year (preferred) and to be fully funded using 100% of the government grant (preferred) would fully meet the SOs and CSFs and is the early preferred way forward at this stage. The tables below show more detail including some additional further commentary/analysis.

Table 14 – Filtering the long-list using the SO & CSFs

Option	0. Business as usual	1. Do-Minimum	2. Intermediate option	3. Do-Maximum
Spending Objectives (SO's)				
SO1: Enables estate efficiencies	Does not meet	Does not meet	Partly meets	Fully meets
SO2: Enables greater primary care capacity	Does not meet	Partly meets	Partly meets	Fully meets
SO3: Enhances service integration	Does not meet	Does not meet	Partly meets	Fully meets
SO4: Enhances patient choice and quality	Does not meet	Partly meets	Fully meets	Fully meets
SO5: Capital and revenue affordable	Partly meets	Partly meets	Partly meets	Fully meets
SO6: Embeds prevention, community needs	Does not meet	Does not meet	Fully meets	Fully meets
SO7: Supports a sustainable workforce	Does not meet	Does not meet	Fully meets	Fully meets
SO8: Scheme capable of being delivered	Does not meet	Fully meets	Fully meets	Fully meets
Critical Success Factors (CSFs)				
CSF1: SOs & business needs	Does not meet	Does not meet	Partly meets	Fully meets
CSF2: Required benefits	Does not meet	Partly meets	Fully meets	Fully meets
CSF3: Deliverability	Does not meet	Does not meet	Partly meets	Fully meets
CSF4: Attractive to market	Partly meets	Partly meets	Fully meets	Fully meets
CSF5: Efficiency	Does not meet	Does not meet	Partly meets	Fully meets
Summary	Discounted	Discounted	Carry Forward	Preferred Way Forward

The outcome / analysis of the SO and CSF filtering is shown in the table below.

Table 15 – Option filtering commentary

Nr	Option	Description	Outcome (at this stage i.e. pre-site selection)
0	Business as Usual (BAU)	No changes to existing GP practices. Buildings continue to present **capacity and configuration issues**, plus future **maintenance issues**.	**Discounted** as it does not deliver against the project SOs, business needs or allow for service relocation. Premises may become costly to maintain as assets become older and go beyond existing life. Existing leaseholds could impact some practices requiring them to seek alternative accommodation. **However, as per HMT guidance, carried forward for comparison to alternative options that make the 'short list'.**
1	Do-Minimum	**Extension and or reconfiguration of existing practice(s)** to provide additional future capacity	**Discounted** as unlikely to be able to meet SOs/project needs, delivery of changes likely to cause major disruption to relocate existing services during reconfiguration / cost of temporary accommodation and unlikely to provide value for money due to higher reconfiguration costs/costs to GPs. However, likely to partially meet benefits and be attractive to some contractors. Other potential issue with this option is that to fully deliver against the project benefits i.e. primary care at scale, the existing reconfigured GP buildings may not provide sufficient space. Also, this option would be an Improvement Grant (IG) route requiring 34% GP capital contribution. **However, as per HMT guidance, carried forward for comparison to alternative options that make the 'short list'.**
2	Do-Intermediate	**Build a new Hub**, practices in agreement to move in, plus any other agreed existing and new PCN ('wrap around'/third and commercial sector) supporting services and **retain an existing practice**	**Carried forward** although it only partly meets the SO's and business needs and required benefits, it appears to fully meets the other CSFs (deliverability, attractive to the market and efficiency). Any new PWF sites, provided following the site selection process, will be able to be delivered without service disruption because it could be a new/adjacent alternative site. Building a new public sector building in central/north/east Sheffield is likely to be attractive to the construction market and with Government capital funding available it could support future revenue savings.
3	Do-Maximum (PWF)	**Build a new Hub**, practices in agreement to move in, plus any other agreed existing and new PCN ('wrap around'/third and commercial sector) supporting services.	**Preferred way forward** as it appears to fully meet all CSFs. Could be delivered without disruption due to it being at new sites/adjacent to existing sites, attractive to the construction market and would provide future revenue savings through use of Government grant to fully pay for capital works. This option is preferred over option 2, because it involves all in scope and in agreement practices moving out of current premises and into a new build Hub providing a bigger building benefitting patients by having as much of their primary care/support services within one building, preventing additional travel. However, some patients would be more negatively impacted than others following the agreement of the preferred way forward site (from the site selection process).

The identified project short list is therefore displayed in the table below. The table below also indicates what the likely site options could be for each option. The Do-Nothing and Do-Minimum would not see any site changes are options are focused solely on improvements at the existing practice sites.

GP stakeholders were involved in the options development process which included confirming the proposed number of hubs per PCN (x1 City hub, x2 hub Foundry and x2 hubs in SAPA) and practices per hub as well as reviewing any required appraisal assessment criteria.

This included specific reviews and discussions as to likely do-minimum changes. With each of the options there could be additional sub-options but at this early stage, most scenarios have been captured into these four short list options.

Table 16 – The Short List

Option	Description	Site options
0. Do-Nothing (BAU)	No change to existing ('in-scope')* practices in scope of this PCN. **Periodic backlog maintenance is undertaken** as per the latest 6 Facet Surveys.	n/a – practices remain at existing sites
1. Do-Minimum	**Extension and or reconfiguration of existing practice(s)** to provide additional future capacity	n/a – practices remain at existing sites
2. Do-Intermediate	**Build a new Hub**, practices in agreement to move in, plus any other agreed existing and new PCN ('wrap around'/third and commercial sector) supporting services and **retain an existing practice.**	Across each of the PCN hub projects the following list the number of potential long list site options City Hub 7 Foundry Hub 1 9 Foundry Hub 2 10 SAPA Hub 1 7 SAPA Hub 2 4 **Grand Total 37** The same site options were applicable for the Do-Maximum option
3. Do-Maximum	**Build a new Hub**, practices in agreement to move in, plus any other agreed existing and new PCN ('wrap around'/third and commercial sector) supporting services.	

**In some cases, this only includes some not all practices in the PCN*

The site selection exercise commenced with the Council upon short list option identification. This highlighted a potential 37 sites in total for consideration (City – 7 site options, Foundry Hub 1 – 9 site options, Foundry Hub 2 – 10 site options, SAPA Hub 1 – 7 site options, SAPA Hub 2 – 4 site options). The focus of the site options was based on the site being in Council ownership but was not essential. Therefore, there were some non-Council owned sites, including some existing GP premises, that would require acquisition should they eventually become preferred sites. The impact of this on the capital budget would need to be factored into this process (if applicable).

8.5.4 Site selection process to identify viable/preferred site(s) (step 6)

In conjunction with stakeholders, including GP, CCG and SCC, the project developed a site selection exercise for the potential new hub site locations.

The initial site searches revealed several potential sites within or near to this in scope areas of Sheffield. As the Transformational Hub projects evolve and are refined through capital business case process (i.e., through to FBC stage – see section 1), the hub potential building area required may increase or decrease following further stakeholder input and

review (although during OBC a design freeze will be sought by the design/Council team for scope change control purposes).

Key factors that were used to identify potential sites included:

- **Size** – is the site foreseeably able to accommodate a building and car park (i.e., aligning to any Local Authority parking standards / guidance)
- **Availability / Surplus to requirements** – is the site vacant, undeveloped, due to be vacated in the foreseeable future
- **Certainty of acquisition** – is it foreseeable that the site could be acquired from the existing owner, or is the existing owner already associated with the Project (e.g., Local Authority or another public sector body)
- **Location and access** – the site is in or around the area of interest in Sheffield and it is foreseeable that the site could be accessed by car and/or on foot.

The process to select a preferred site was discussed and agreed in principle with stakeholders. It provided for a qualitative assessment of all potential sites in the in-scope areas of Sheffield.

An assessment criterion was developed with stakeholders to assess each site. It focused on four key themes: Access, Impact, Functionality and Deliverability. These four themes comprised 8 points of measures.

Each of the 8 measures were individually weighted based on how important the stakeholders believe them to be in ensuring the overall deliverability of the scheme. Those measures which were felt to be essential to deliverability were awarded a higher weighting. Evaluation of each site was based on a scale of 1 to 5:

- 5 – Meets or fulfils expectations, going substantially beyond expectations
- 3 – Meets or fulfils expectations
- 1 – Falls substantially short of expectations, objective still achievable, but with notable compromises.

A score of 0 was also available should a site fail to meet a basic level of the measure. Normally any site that scored 0 for any measure would be removed from further consideration (i.e., classed as not viable).

8.5.5 Discounted sites – Existing

The project first assessed the existing sites. Through interviews held with each surgery and numerical assessments on the space needed to support the Sheffield population it was identified that most of the existing estate in scope was already being used very heavily and that additional clinical space was required.

Internal reorganisation, where possible, has already been undertaken with the surgeries converting back-office space into clinical rooms and utilising hot-desking. Even after maximising the amount of clinical space, the surgeries are unable to provide enough clinical space to meet the future population needs and to deliver primary care at scale.

Expanding the existing surgeries was then reviewed as a means of meeting the clinical space deficit. However, this has by in large been undertaken with all surgeries having been expanded in the last 20 years by permanent or temporary buildings. Such changes now fill

the curtilage of most sites, significantly compromising parking provisions and leaving no future room for expansion.

Further expansion beyond the curtilage of each surgery is possible in some sites although very unlikely at a level needed to meet the space requirements of a new Transformational Hub. This therefore would typically lead practices to considering the purchase of multiple adjacent plots of land with the possibility of higher acquisition costs, thus exposing the project cost pressure on the project capital budget. However, all options were considered.

8.5.5.1 *Discounted sites – Newly identified*

In identifying new viable sites, we used a few guiding principles to help in the identification process:

- The site should be in its respective PCN settlements of Sheffield to avoid increasing travel requirements of patients
- Empty sites are preferable, although developed sites with a use that could foreseeably be relocated are considered
- The buildings will be subject to the normal planning and legal constraints and scrutiny. Therefore, public parks or protected open space has not been considered
- The size of the building is still being considered; however, it will need to be substantially bigger than the existing primary care facilities in this area of Sheffield.

8.5.5.2 *Potential sites*

The remaining viable sites (of which there were 28) were taken forward to be scored. Following site selection and stakeholder discussions a ranking of sites was confirmed. The proposed preferred way forward sites were taken forward for feedback from all stakeholders and following the patient and public engagement exercise. The **Pre-Consultation Engagement Report** capture any site feedback (**Appendix 01**).

The table below indicates the latest outcome following CCG and GP site appraisals, advice from SCC and the more recent public and patient early engagement feedback.

Table 17 – Preferred Way Forward (PWF) hub sites

PCN / Hub	Preferred site options for consideration	Landowner
City Hub	(No appropriate preferred site identified at this stage)	n/a
Foundry Hub 1	Land at Spital Street, S3 9LD	Sheffield City Council
Foundry Hub 2	Land at Rushby Street, S4 8GD	Sheffield City Council
SAPA Hub 1	Land at Concord Sports Centre, S5 6AE	Sheffield City Council
SAPA Hub 2	Land at Wordsworth Ave. / Buchanan Rd., S5 8AU	Sheffield City Council

These sites will be used as the basis for public consultation. Similarly, any previous capital estimates will be refined based on these potential new hub sites.

8.5.6 Final short-list options

After pre-consultation engagement, practices were asked by the CCG to confirm their continued involvement in the programme and individual potential hub projects taking into

account their patients' views as well as their own business analysis. This resulted in some changes to the original scope of the project, with the table below detailing the final short-list options for further appraisals.

Proposal	Hub	Preferred way forward hub site
Build four new primary care hub buildings **(and for the following practices to move into them, disposing of their existing buildings)**	**Foundry Hub 1** – Burngreave Surgery and Sheffield Medical Centre) – with Pitsmoor Surgery remaining and expanding on its existing site	Land at Spital Street, S3 9LD
	Foundry Hub 2 – Page Hall Surgery and Upwell Street	Land at Rushby Street, S4 8GD
	SAPA Hub 1 – Dunninc Road Surgery, Shiregreen Surgery and Firth Park Surgery) – with Norwood Medical Centre Surgery remaining and expanding on its existing site. Elm Lane decided to withdraw from the project.	Land at Concord Sports Centre, S5 6AE
	SAPA Hub 2 – Margetson Surgery, Buchanan Road Surgery and The Healthcare Surgery – with Southey Green remaining at their existing site	Land at Wordsworth Avenue / Buchanan Road Junction, S5 8AU
Refurbish an existing city centre building **(and for the following practices to move into it, disposing of their existing building(s):**	**City Hub –** City Practice and Mulberry Practice – Devonshire Green MC and Hanover MC decided to withdraw from the project.	Site TBC

8.6 Economic appraisal

8.6.1 Appraisal of short-list options and site(s) using the CIA model (Step 7)

8.6.1.1 *Developing the Preferred Way Forward (PWF)*

The DHSC CIA model ('financial appraisal') alongside CCG and GP quality appraisal of the options ('non-financial appraisal') was used to determine the initial preferred way forward options per hub project.

8.6.1.2 *Non-financial appraisal*

Where it was not possible to quantify a benefit from a monetary perspective, these benefits fell into the Unmonestiable benefits (UB) category. The UBs have been separately qualitatively evaluated. This aims to support building upon any previous qualitative appraisals undertaken previously during the original 2017 feasibility studies. **The outputs of the non-financial appraisals indicated the alternative options (the do-intermediate or do-maximum) are indicating qualitatively, better options than the do-nothing or doing-minimum.**

8.6.2 Economic appraisal outcome

For the purposes of this appraisal, the BAU is the baseline position against which all other direct investment costs, such as capital costs, are assumed to be marginal to the implementation of that option. The Benefit Cost Ratio (BCR) has been calculated on this basis and outlined within the table below.

Table 18 – Economic appraisal outcome

Economic Summary (Discounted) - £	City Hub			
Options	0 - Business as Usual	1 - Do-Minimum	2 - Do-Intermediate	3 - Do-Maximum
Incremental costs - total	£0.00	-£2,025,684.64	n/a	-£3,839,724.79
Incremental benefits - total	£0.00	£1,604,068.17	n/a	£19,854,400.03
Risk-adjusted Net Present Social Value	£0.00	-£421,616.47	n/a	£16,014,675.24
Benefit-cost ratio	0.00	0.79	n/a	5.17
Economic Summary (Discounted) - £	SAPA Hub 1			
Options	0 - Business as Usual	1 - Do-Minimum	2 - Do-Intermediate	3 - Do-Maximum
Incremental costs - total	£0.00	-£2,535,658.54	-£14,003,163.30	n/a
Incremental benefits - total	£0.00	£2,912,574.49	£51,406,914.77	n/a
Risk-adjusted Net Present Social Value	£0.00	£376,915.95	£37,403,751.47	n/a
Benefit-cost ratio	0.00	1.15	3.67	n/a
Economic Summary (Discounted) - £	SAPA Hub 2			
Options	0 - Business as Usual	1 - Do-Minimum	2 - Do-Intermediate	3 - Do-Maximum
Incremental costs - total	£0.00	-£2,084,518.38	-£6,192,005.91	n/a
Incremental benefits - total	£0.00	£1,750,153.50	£27,990,509.32	n/a
Risk-adjusted Net Present Social Value	£0.00	-£334,364.88	£21,798,503.41	n/a
Benefit-cost ratio	0.00	0.84	4.52	n/a
Economic Summary (Discounted) - £	Foundry Hub 1			
Options	0 - Business as Usual	1 - Do-Minimum	2 - Do-Intermediate	
Incremental costs - total	£0.00	-£1,742,745.33	-£9,479,759.95	n/a
Incremental benefits - total	£0.00	£2,394,505.59	£24,517,753.36	n/a
Risk-adjusted Net Present Social Value	£0.00	£651,760.26	£15,037,993.41	n/a
Benefit-cost ratio	0.00	1.37	2.59	n/a
Economic Summary (Discounted) - £	Foundry Hub 2			
Options	0 - Business as Usual	1 - Do-Minimum		3 - Do-Maximum
Incremental costs - total	£0.00	-£4,619,782.73	n/a	-£8,164,597.46
Incremental benefits - total	£0.00	£2,727,101.70	n/a	£25,759,303.83
Risk-adjusted Net Present Social Value	£0.00	-£1,892,681.04	n/a	£17,594,706.37
Benefit-cost ratio	0.00	0.59	n/a	3.15

As shown in the table above, in all cases, the alternative options (either Do-Intermediate or Do-Maximum) indicates the **highest BCRs** and are therefore deemed to be the preferred way forward options are this stage. As this are indicating above the MHCLG benchmark of above 2, they are indicating as high (green), and therefore are likely to represent value for money (VfM) for the public sector.

8.7 Sensitivity Analysis

The figures used in the economic appraisals are rarely certain and it is not possible to remove all uncertainties. Sensitivity analysis was used to test the robustness of the appraisal's conclusions to variations in key assumptions, and so determine whether the conclusions of the option appraisal are robust or in any way "sensitive" to assumptions and if this alters the preference ranking of the options.

A series of sensitivities was undertaken with **no change to the PWF in scenarios 1, 2 and 3 shown below.** However, we will re-visit sensitivity during OBC following additional detail on each of the short-listed options.

1. Increase costs by 10%
2. Decrease benefits by 10%
3. Both scenarios above together.

8.8 Funding

The hub alternative options will be funded by NHS England STP Wave 4b Capital. The do-minimum options will follow an Improvement Grant (IG) funding route which would require capital contributions from practices based on the latest Premises Cost Directions (2013).

Therefore, as we have value for money preferred way forward options, preferred way forward sites, supportive stakeholders, capital funding approved in principle by HMT (subject

to future business case development and approval), we have viable schemes upon which to progress to consultation.

9 Pre-consultation engagement

We have undertaken a staged approach to engagement when developing this PCBC:

Table 19 – engagement stages

Stage	Description	Dates
1	Engagement with the health services, in particular GP practices in scope on improving access with our developing PCNs and how best our estate can support current and future patient and population demands and needs	August 2019 to ongoing
2	Pre-Consultation engagement and communications for this PCBC, including the case for change	March – May 2022
3	Formal consultation on proposals (planned subject to approval for the PCBC)	18/07/22 – 12/09/22 (10 weeks)

The key aim of our engagement process, and of stage 2 pre-consultation engagement, was to ensure that a robust and transparent approach was in place that enabled stakeholders to assist us to inform and test the assumptions for this PCBC.

Throughout our pre-consultation engagement, we incorporated the findings from our stakeholder mapping exercise and from the – this is described in more detail in Section 13 (Impact Assessments and **Appendix 03**). This approach ensured that a range of stakeholders was given the opportunity to be involved in the early engagement discussions across the CCG. The approach also included opportunities for engagement targeted at those who have a particular stake in the practices in scope to help inform the PCBC: for example, engagement sessions were conducted with patients in local community settings.

A **Pre-Consultation Engagement Report** is provided in **Appendix 01**. The key themes which have emerged from the surveys, social media comments and discussions at stakeholder meetings and forums during the pre-consultation engagement are summarised in the table below.

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In addition to the above, the key themes which emerged from engagement with primary care including GPs, practice managers and practice nurses were:

- The importance of seeing the right person at the right stage of a patient's pathway - sometimes it is important for patients to see a clinician early on in their journey
- The importance of access and patients having the right information about services
- The role of community pharmacies and mental health crisis services
- The importance of local support services for homeless patients who use the practices in scope, particularly within the city centre.

A common theme emerging from meetings with GP was that the impact of any changes to patients and service users' needs to be as minimal as possible.

10 Our pre-consultation scheme proposals

10.1 How did we develop our pre-consultation scheme proposals?

Our process for developing the pre-consultation proposal was:

- Finding out what is important to local people - we have been engaging with local practices about the transformation hubs in primary care services since 2018/19. This has also included the recent period of dedicated pre-consultation engagement on the Sheffield Transformational Hubs to inform this PCBC and what other improvements in services we should be exploring. We have done this through meetings with key stakeholder groups, surveys, meetings, community outreach, and social media feedback
- Finding out what is important to local clinicians – we have engaged with our local GP membership through GP locality meetings and to seek feedback on our proposal
- Undertaking reviews of the practice services to better understand who uses the service, how it is used and why - this review was carried out in the 2018/19 through the production of feasibility studies
- Reviewing what other services are available locally – looking at what services have become available since the original STP bid was originally approved
- Modelling the potential impact of the proposal on other services – we have used the data from the feasibilities, national research, and analysis of current GP attendance data to model the likely impact of the proposal on local people and the services they use
- Assuring our proposal by working with NHSE, local clinicians and SAPA and Foundry PCNs (and part of City PCN), who reviewed the capital investment Strategic Outline Case (SOC) proposals. This is outlined in more detail in **Section 14.**

Our pre-consultation engagement process has given us further assurance that changes to the existing GP services in scope are necessary, and that the Case for Change outlined in **Section 8** is valid:

- The GP services used by people to meet their primary care needs is seeing an increasing demand
- Understanding from our practices if they remain on board with the proposals or whether they wish to explore other routes to improve their service delivery. The initial public engagement led to a smaller number of practices deciding to withdraw, with some other practices wishing to expand their existing sites.

10.2 Final pre-consultation scheme proposals

From the pre-consultation engagement process, we learnt more about the impact our proposals will have on patients and on other services. We need to show how we would support patients in the future to access the right service for them and how we would support any other services that would be impacted by our proposal. Our pre-consultation proposal, is therefore now to:

Proposal	Hub	Preferred way forward site
Build four new primary care hub buildings **(and for the following practices to move into them, disposing of their existing buildings)**	**Foundry Hub 1** – Burngreave Surgery and Sheffield Medical Centre) – with Pitsmoor Surgery remaining and expanding on their existing site	Land at Spital Street
	Foundry Hub 2 – Page Hall Surgery and Upwell Street	Land at Rushby Street
	SAPA Hub 1 – Dunninc Road Surgery, Shiregreen Surgery, Firth Park Surgery) – with Norwood Medical Centre Surgery remaining and expanding on their existing site. Elm Lane have decided they do not wish to join this hub.	Land at Concord Sports Centre
	SAPA Hub 2 – Margetson Surgery, Buchanan Road Surgery, The Healthcare Surgery – with Southey Green remaining at their existing site	Land at Buchanan Road/ Wordsworth Junction
Refurbish an existing city centre building **(and for the following practices to move into it, disposing of their existing building(s):**	**City Hub –** City Practice and Mulberry Practice – Devonshire Green MC and Hanover MC do not wish to join this hub.	Site TBC

11 Impact of the pre-consultation final scheme proposals

Those practices following engagement who have decided to withdraw or remain and expand at their existing premises, are excluded from the pre-consultation final proposals. Therefore, the impacts relate only to those moving into a hub.

12 Financial case

12.1 Financial impact of the PCBC scheme proposal

We have considered the financial impact of the PCBC scheme proposals. The financial considerations of the proposals fall into two main areas, capital, and revenue affordability.

12.2 Capital affordability

The CCG is not contributing any capital to the potential new hubs. The funding to deliver the proposals would come from NHS England, via the STP Wave 4b capital grant (£36m), of which the proposed hub schemes was granted £33.9m[18]. However, this has a national spend time constraint, and must be spent by December 2023. The following is therefore focused on CCG/ICB future revenue impacts.

Capital affordability is being reviewed by SCC, who are leading on the design and build workstream of the proposals. SCC will produce cost estimates which will be continuously refined as the consultation and designs are developed with public, patients, and other stakeholders. Early indications are that the schemes require further certainty over design information and proposed site survey information to confirm affordability. This is being developed alongside the consultation and updates are planned to be fed into the consultation process.

12.3 Revenue affordability

The purpose of this section is to outline the potential impact of the proposal on CCG finances and to show that the proposal is affordable. The principal driver for this business case is not to achieve financial savings, and if this proposal were to deliver any savings, we would look at reinvesting released funds in other services that support local people.

The early indication from the Council is that the hubs could cost in the region of £180/sqm to run per hub on an annual basis. Using the Health care planner developed draft schedule of accommodations, we have estimated potential reimbursable impacts. A key difference from current business as usual to the proposal of hubs, is due to the NHSE STP wave 4b capital, this supports for a long rent-free period within the new hub buildings for the NHS occupiers.

We have agreed via our governing body that any savings from cash releasing savings (in particular from rent savings) will be ring fenced and reinvested within the PCNs in scope, to help address significant health inequalities locally. We have also agreed to ensure that our practices will not be significantly financially disadvantaged by moving into a hub and we will work with them to support this change. We are considering as part of our service change proposals to support practices with financial support based on potential new costs, they may face from moving into a bigger and new building. However, the final details on this needs to be reviewed further with our practices. For the purposes of PCBC, we have estimated an initial contribution of 40% to support assessing initial financial revenue impacts.

We have considered our financial recurring revenue impacts at this stage, based on our estimations. We have examined our existing current reimbursables against potential future reimbursables, covering for the hub proposals and for those potentially remaining and or extending their existing premises. Reimbursables cover rent, rates, water, and clinical waste. This is indicating at this stage an annual saving of £140,000.

[18] Microsoft Word - C WAVE 4 CAPITAL ALLOCATIONS FOR PRIMARY CARE (sheffieldccg.nhs.uk)

Table 20 – Financial recurring revenue estimate impact of the proposals

Recurring revenue	Total (£pa)
Current reimbursables[*1]	£970,000
Future reimbursables[*2]	£530,000
Sub-total	**-£440,000**
New ICB financial support to GPs[*2]	-£300,000
Net impact (savings)/cost	**£140,000**

*1 – Excluding any original in scope PCN practices that have withdrawn (see table 5)
*2 – Estimates

There will be non-recurrent which we will need to review with each practice as we progress each project. A non-exhaustive list of the type of estimated non-recurrent revenue costs are shown in the table below.

Table 21 – Non-recurrent revenue costs

Non-recurring revenue	Total (£pa)
Project Fees	TBC
Exiting GP Freehold Premises Related Costs	TBC
Exiting GP Leasehold Premises Related Costs	TBC
Removals	TBC

12.3.1 Sensitivity analysis

We undertook some initial high-level revenue sensitivity analysis. We did this by fixing all other factors other than the (not confirmed) 40% financial support to practices for moving into a hub. We found that the breakeven point, where the above £140,000 saving, reduces to £0, is by supporting each practice annually with 58% financial support with their estimated new service charge at £180/sqm. There are still many variables in place at this early project stage, but this gives us some confidence of the sensitivity of the financial support percentage. The reason there is still uncertainty at this early stage is because there is currently no design information for the new hubs. Therefore, the new costs to run the building from the Council is based on benchmarks only, which is the estimated £180/sqm. This will be refined as the design information and tenant requirements become clearer as the projects develop.

12.3.2 Financial Assumptions

From an ICS (commissioner) perspective, the financial analysis has been focused on revenue (not capital), and cover the following assumptions:

- Reimbursables will continue to be in the new hubs for rates, water, clinical waste
- Future reimbursables and ICB financial support are estimates
- For those practices remaining and or extending existing sites, they would also continue to receive their reimbursables as per current arrangement with agreed uplift as Premises Cost Directions (2013)
- We assume from discussions that due to initial early discussions with the Council that because the NHS is contributing the whole of the capital investment to build the new assets, that there will be no rent for life of building for health tenants, and we have therefore assumed no rent reimbursables from commissioner to GP

- We assume a starting estimating of £180/sqm from the Council as a baseline on which to estimate potential new future reimbursables
- We assume 5% inflation on Council building running costs between now and then the hub buildings could open
- We are assuming an estimated growth in practice list size based on Council estimated housing developments up to 2040
- We have assumed a working estimated draft 40% for new GP financial support for those practices moving into a hub.

12.4 Transitional costs and how will they be funded

As nothing would close before any proposed future alternative arrangement is available, there will therefore be no double running. There will however be some transitional revenue costs. These costs will need to be developed once the consultation has completed and we know final decisions. Potential transitional costs include things like costs to support GP with exiting existing premises / lease arrangements, removals costs and equipment. Where any value for money is required, we will work with our local District Valuer (DV) to support us.

Those practice who are considering remaining and extending alongside a proposed hub development, may require some double running and or transitional costs. This needs to be developed with the practices.

12.5 Workforce & activity models and cost

We have worked with health sector and local authority community services over the last two years to engage on workforce and activity data. This has included consideration of practices current estate information and the type and quantity of services they provide. This cover things like number of appointments per week, per role, etc.

Our health care planner has met with each practice in scope to review their data and develop initial schedules of accommodation to understand the potential scale of the hubs. This drives both the capital and revenue costs impacts.

We will work with practices to develop their workforce and service plans to support a smooth and planned transition into a new hub.

12.6 Workforce plan and implications for future

All services would 'lift and shift' from their current locations and there will be no change to workforce numbers. However, we do anticipate the integration and co-location of services in a new build will increase our ability to recruit and retain staff.

12.7

12.8 Equality Impact Assessment (EIA)

Four EIAs (**Appendix 03**) has been undertaken while developing this PCBC covering the proposed closure of several practices within the hub projects. These assessments have been reviewed following the conclusion of the pre-consultation engagement and are attached in **Appendix 01**.

The EIAs looked at the potential impacts on different sections of the local population, including the protected characteristics as laid down in the Equality Act 2010.

The overall thematic equality analysis is shown below.

This pre-consultation equality impact assessment of a proposal is to relocate GP Practices to up to five hubs linked to the Foundry, SAPA5 and City Centre Primary Care Networks.

The main issue impacting equality is that combining several surgeries in one hub requires more people to travel over a larger distance to see a GP or access GP service. This will impact patient groups who don't drive and need to rely on public transport, taxis or lifts from carers/relatives/friends. Public transport represents barriers such as travel time, reliability, accessibility, potentially a hostile environment for people at risk of discrimination and increased costs.

This distance to travel increases the larger the area the surgeries are spread out over. The more surgeries combine into one hub and the larger the area the surgeries are spread out over, the more people will be affected. People with specific protected characteristics that impact their ability to travel, have communication barriers, need to see a GP more regularly or are less inclined to visit a GP will be negatively impacted by the consolidation of surgeries into a hub.

Those most affected will be older patients, carers and primary carers of children. Disabled people, and other marginalised communities who will need public transport and don't speak English, will struggle to navigate the transport system. The changes could cause confusion and lead to increased stress and anxiety for people who are already facing multiple pressures.

Any mitigating factors that can be put into place to make it less costly and less time consuming for people to travel to the hub (e.g., free transport / taxis, travel training) require system collaboration on already pressurised services, and need to be guaranteed for the lifetime of the building - which is unlikely to be the case. It is unclear how psychological factors that make people less inclined to visit a GP, which may be exacerbated if the distance/travel is seen as an additional barrier, can be mitigated.

Patients may decide to register with another local GP rather than see their existing GP. However, whether this option is available to patients will be influenced by (a) patients' catchment areas and (b) the availability of other local GPs. Patients moving to a local GP may negatively impact the workload of these practices, which may lead to longer waiting times and ultimately worse patient outcomes.

Consolidation of several surgeries into a hub will reduce choice of GP for people who have issues traveling over a longer distance, whether this be for mobility, cost, time or reluctance reasons. The positives that a modern fully accessible building brings will not come into play if travel to the hub discourages many of the patient groups who would benefit from them.

For people with protected characteristics impacting their health needs, such as a disability, long-term health condition or advanced age, it may be more important to continue seeing the

GP/nurses who know their medical history and with whom they have built a relationship. Even if other local GPs are in theory available to them, reducing their choice of GP is putting them at a disadvantage.

A key theme coming from pre-consultation engagement is of concern about already strained GP services undergoing major change, and the benefits of the change not being clear, or strong enough to outweigh many people's concerns about the negative impacts.

While the CCG has prioritised equality, diversity and inclusion in the project development process, including the pre-consultation engagement, issues raised about the process include the need for clearer information, not everyone having online access, and the proposals needing clearer support from GPs in involved practices.

A key concern is the time scale of the proposed project – with a deadline of completion by December 2023. This reduces the time to engage with patients who will be adversely affected or who have concerns. It also reduces time to co-produce solutions and accessible design.

Diagram Key positive and negative impacts

New hub leads to short travel distance for patients	New hub leads to longer(er/ish) travel distance for patients
Positives from the new building being accessible **dominant** – positives for many categories of patients (& carers) eg • Disabled people • People with long-term health conditions • Older people • People needing frequent check-ups, etc.	**Negatives** from increased travel distance **dominant** – impact on many categories of patients (& carers) • Disabled people • People with long-term health conditions • Older people • People needing frequent check-ups, etc. • Lone parents • Economically stretched And knock-on effect that people may feel they have no choice but to switch to a different, more local GP – if there are local options they can register with.
Positives from a larger hub – based on "economies of scale" and levelling up	**Negatives from a larger hub – more "impersonal"**
• Interpretation services may be more easy/economical to provide if there is more need all concentrated in one location • Access to a wider range of services • Quiet / prayer room • Potential for community services to access rooms / meeting space	• More likely to feel less personal – building design can overcome this to some degree, esp. if co-designed with patients/community • Larger hub can feel intimidating/exposing, esp. for specific patient groups, eg. people with learning disabilities, dementia, mental health issues, LGB + & transgender people, introverted people etc.
Negative impact from change / disruption	
• Relocation is likely to result in extra strain / pressure on GPs and practice staff • Decrease in the number of local GP practices 'on the doorstep' • Potential disruption or confusion for patients • Stress to those who will be negatively impacted • Stress of participating in consultation process to those who do not agree with the changes	

For **Foundry 1,** positive impact should be dominant for patients of Burngreave – Cornerstone Branch and Sheffield Medical Centre as distances are very small. However, Church of Scotland EDI Assessment. August 2021 4 for patients of Herries Road Surgery, the likely increased travel distance leads to negative impact. If Melrose Surgery is closed patients need to register with a different GP this can lead to a negative impact for many categories of patients (& carers): disabled people, people, with long-term health conditions, older people, people needing frequent check-ups, etc.

For **Foundry 2**, positive impact should be dominant as distances from Margetson Surgery, Buchanan Road and The Health Care Surgery to the proposed hub at Buchanan Road are small.

For **SAPA 1,** negative impact likely to be dominant, particularly for patients of Dunninc Road, which is the furthest from Concord. Especially impacted are patients living North and North-West of Shiregreen Medical Centre. The straight distance from Dunninc Rd surgery to the proposed new hub at Concord is 1mile.

For **SAPA 2,** the distances are relatively short (+- 0.6m). Least impacted are the patients registered at Health Care Surgery given that the proposed SAPA hub 2 is relatively close (approx 0.2 miles from Healthcare surgery). These patients will benefit from the new hub. Patients to the South of Health Care surgery also have two local surgeries as an option (Wadsley Bridge Medical Centre and Southey Green Medical Centre). For patients of

Buchanan Road surgery, the situation is similar, however with a distance of approx. 0.6 miles to the proposed SAPA hub 2, and Southey Green Medical Centre and Elm Lane Surgery as fairly local alternatives. Especially impacted are patients living North, North-East and East of Margetson surgery as that is a large area where there are no local alternatives (Ecclesfield group Practice is over one mile to the North)

Table 22 – Summary of the EIA for the PCBC

Race	• Accessible information to communities • Good interpretation service or Prescence in hubs
Sex	• A dedicated minibus for hubs and or provision of bus routes and affordable bus travel
Gender reassignment	
Age	• Provision of home visits • A dedicated minibus for hubs and or provision of bus routes and affordable bus travel
Religion and belief	
Disability	• Provision of home visits • Reassurance / information given to people with learning difficulties (e.g. Autism) and people with learning disabilities • Travel training for disabled people (Council training service already over-stretched)
Sexual Orientation	
Marriage or civil partnership	
Pregnancy and maternity	
Social deprivation	• A dedicated minibus for hubs and or provision of bus routes and affordable bus travel
Transient population (e.g. visitors)	
Community cohesion	
Overall	• Levelling up of accessible communications in hubs • Levelling up of EDI skills for all hub staff • An independent evaluation of impact once changes have been made, if proposals go ahead • Involve communities in the design to overcome feelings of bigger space being impersonal. • Have community/ volunteers as meeters and greeters

Our pre-consultation engagement helped us to refine the EIA and define the work we will do to support patients in the future to access the right services for them. As part of our proposal we have developed a wide-ranging communications and engagement programme, which would include the principles of social marketing, to support our patient population to make the right choices for their healthcare.

-

12.9 Travel Impact

One of the principal impacts of closing practices is on travel and the accessibility of other services available locally. As part of initial reviews into the impact on practices and patients on relocations, studies into travel times and distances from each current site to all short-listed site options were undertaken. Shown in the table below are the distances and travel times, via various modes of transport, from current sites to the current Preferred Way Forward (PWF) sites. Practices that have elected to withdraw from consideration within hubs are marked in grey.

These studies have not involved specialist transport consultancy and so are to be regarded as indicative only.

See full list of practices maps (Appendix X)

Table 23 – Indicative travel times from existing surgery to Preferred Way Forward (PWF) Hub sites

Site option:	Notional location: Fargate					
	Distance (miles)	Walking (mins)	Driving (mins)	Cycling (mins)	Bus Stop (mins)	Parking Spc. (proposed)
City Hub						
Mulberry Practice	0.1-1.9	2	10	1	0 (High St HS4)	TBC
City Practice	0.1-1.9	2	10	1		
Devonshire Green Medical Centre	0.5-1.2	9	6	2		
Hanover Medical Centre	0.6-1.9	17	8	5		

Add shape map here with marker for PWF site

Site option:	Sheffield Medical Centre + neighbouring land (Spital St)					
	Distance (miles)	Walking (mins)	Driving (mins)	Cycling (mins)	Bus Stop (mins)	Parking Spc. (proposed)
Foundry Hub 1						
Sheffield Medical Centre	0	0	0	0	2 (Spital Hill)	64
Cornerstone Surgery	0.2	4	2	1		
Burngreave Surgery	0.2	4	2	1		
Pitsmoor Surgery	0.8	17	4	7		

Add shape map here with marker for PWF site

Site option:	Rushby Street					
	Distance (miles)	Walking (mins)	Driving (mins)	Cycling (mins)	Bus (mins)	Parking Spc. (proposed)
Foundry Hub 2						
Page Hall Medical Centre	1.2	21	4	9	2 (Norwood Road)	96
Upwell Street Surgery	1.2	31	6	13		
Herries Road Surgery	1.2	20	3	7		

Add shape map here with marker for PWF site

Site option:	Concord Sports Centre					
	Distance (miles)	Walking (mins)	Driving (mins)	Cycling (mins)	Bus (mins)	Parking Spc. (proposed)
SAPA Hub 1						
Dunninc Road	1.2	26	5	10	0 (Shiregreen Lane / Jacobs Drive)	140
Shiregreen Medical Centre	0.6	11	2	5		
Firth Park	1	15	5	5		
Norwood Medical Centre	1.9	35	5	12		
Barnsley Road Surgery	1.2	19	3	5		
Elm Lane	1.2	19	3	5		

Add shape map here with marker for PWF site

Site option:	Wordsworth Ave / Buchanan Rd					
	Distance (miles)	Walking (mins)	Driving (mins)	Cycling (mins)	Bus (mins)*	Parking Spc. (proposed)
SAPA Hub 2						
Margetson Practice	0.6	11	2	3	2 (Wordsworth Av. / Deerlands Av.)	92
Buchanan Road	0.6	12	2	2		
The Health Care Surgery	0.5	10	2	2		
Southey Green Medical Centre	0.6	15	2	4		

Add shape map here with marker for PWF site

Further, more in-depth transport studies will need to be undertaken as part of the capital business case process (SOC, OBC, FBC). These will include the impact on 'blue light' emergency services and typical routes, and any other key public services.

If sites are confirmed, consultations with local bus companies serving these areas would take place to improve transport services where populations are impacted.

12.10 Impact on local public services

how the proposed changes impact on local government services and the response of local government.

There will be provision for SCC workspace within the Hub buildings. Hot desks within a shared office environment will enable cross-disciplinary working.

There are no current public services take place within the current GP premises are facing closure.

12.11 Data Protection Impact Assessment?

After consultation with the Information Governance Management team at xxx (the CSU) the following has been concluded:

- There would be no changes to what data was processed nor how it would be processed
- No new or different organisations and/or providers would be involved in accessing and/or sharing patient information
- No new data processing systems would be utilised.

No further DPIA is, therefore, required.

Integrated Impact Assessment

Is this a specific study or a combination of the above?

13 Assurance

13.1 NHS England and Improvement

NHSE&I have supported the development of the proposals through several ways including through regular virtual gateway review meetings called Stage Gate. In addition, the regional NHSE&I team have reviewed the initial SOC information to support shaping and developing the proposals within this PCBC. This has saw the review of the proposals against the NHSE&I business case checklist for capital projects.

Letters of support have been provided by key stakeholders to indicate their continued support and involvement in the continued consideration of our proposals. These cover for the CCG, GPs, and the Council.

13.1.1 NHS Gateway Reviews

During and at the end of each milestone, a series of **NHS gateway reviews** have been held called 'stage gate'. These reviews have included the regional ICS team requesting documentation, reviewing, and providing assurance for this project.

13.1.2 HMT

The overarching regional Programme Business Case (PBC), in which these proposals have been developed from, was approved by Her Majesty's Treasury (HMT) in January 2022 with confirmation letter received in March 2022. The approval came with several conditions and the programme and individual projects will work to meet such requirements as we work through consultation and initial option design and cost estimating development.

13.2 Reconfiguration: The Four Tests

In 2010, the Government introduced the "four tests" for service changes. The tests require any NHS organisations considering a change of service to be able to demonstrate evidence of:

- strong public and patient engagement
- consistency with the current and prospective need for patient choice
- a clear, clinical evidence base
- support for proposals from clinical commissioners.

A further test was introduced in 2017 that covers any proposals that significantly reduce hospital bed numbers. This test does not apply to this PCBC.

Table 24 – NHS Four Tests

Test	Meeting the tests
Strong public and patient engagement	Extensive public engagement on the proposals to understand what matters most to local people when using services – we have used the outcomes of this feedback to shape our plans for Primary Care Services in scope, and we have also considered the views while developing this PCBC Regular communications with our stakeholder GPs via virtual and some face-to-face meetings Pre-consultation engagement and communications programme Jan to May 2022

Test	Meeting the tests
Consistency with the current and prospective need for patient choice	The proposal supports patient choice by promoting other alternative services, such as social prescribing, physiotherapy, community pharmacy etc. The current configuration of services means that patients are often seen in an inappropriate place or by not by the right professional, which means that patients need to be often referred to other services. The proposal aims to reduce handoffs. People would get the right care in the right place, the first time.
A clear, clinical evidence base	The proposal is aligned to the national and Sheffield-wide model of care. The proposal was generated based on national, local, and regional requirements Common themes from the engagement to date were identified and used to formulate this proposal and the case for change Ongoing discussions and engagement with NHS England to review and assure the appropriateness of the proposal. The outcomes of this review are outlined in this section. GP members and the CCG Governing Body have been part of our engagement programme that has informed this proposal. Our proposal will see a continuation and expansion of existing primary care services with enhanced provision, this change is considered clinically viable.
Support for proposals from clinical commissioners	There is a GP clinical lead as part of the team developing these proposal Regular communications with our member GPs via locality meetings to ensure full awareness of proposals and enable any feedback to shape the proposal Specific engagement with practices to ensure any issues have been addressed

14 Proposed consultation principles

In undertaking any engagement and consultation, the CCG will adopt a transparent, best practice approach based on several key principles.

In line with the 'Working with people and communities' section of the Integrated Care System (ICS) design framework and NHS Sheffield CCG's Communication and Engagement Strategy, the following principles will be followed in the preparation and undertaking of all involvement activity with people and communities for Primary Care Capital Estates projects.

- Meet all equality and involvement statutory duties as detailed in the Public Sector Equality Duty of the Equality Act 2010 and section 14Z2 of the Health and Social Care Act 2012.
- Put the voices of people and communities at the centre of plans. Take them on the journey with you.
- Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.
- Understand your community's needs, experience and aspirations for health and care, using ongoing involvement to find out if change is having the desired effect.
- Build relationships with excluded groups, especially those affected by inequalities. Take time to involve seldom groups, those experiencing the greatest health inequalities, and the most vulnerable people.
- Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.
- Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
- Use community development approaches that empower people and communities, making connections to social action.
- Co-produce and redesign services in partnership with people and communities.
- Learn from what works and build on the assets of all partners – networks, relationships, activity in local places.
- Engagement will be an ongoing process, not a one-off exercise.

The above principles can be applied in practice using the list below.

What good looks like

- Making full use of existing insights from local and national data sources, and from place, neighbourhood, and practice-level engagement to inform activity and decision making.
- Building trust with clear, regular and accessible communications with the public.
- Being open and clear about the reasons, scope and limitations of the involvement activity from the start.
- Maintaining proactive and systematic dialogue with public representatives, such as councillors and MPs.
- Maintaining governance arrangements through the Strategic Patient Involvement, Experience, and Equality Committee to ensure all involvement activity is appropriate, proportionate, and meets statutory duties.
- Working with primary care networks and local area committees to work with people and communities, avoiding duplication and overload for the public.
- Supporting local VCSE organisations by identifying funding and having early conversations with them to allow them to plan their workload effectively.
- Approaching external groups; not depending on them coming to you.
- Putting resources into involving people with the greatest health needs and those in the poorest health.
- Recognising and utilising the unique skills and experience of the public within the project e.g. involving the public in accessibility and transport audits of premises or designs.
- Using accessible formats and a range of activities to ensure equality of opportunity.
- Building long term, sustainable links with communities to maintain a dialogue beyond the project.

We will continue to engage with key stakeholders to:

- review data, evidence, and feedback from the pre-consultation engagement
- share information about local patient demand analysis together
- develop a shared understanding of the wide range of services that are available and the national context.

Consideration of consultation with the wider NHS workforce

Consultation plan to enable reaching all stakeholders, including the hard-to-reach groups. Also being clear on use of in-person and digital options for consultation

Link to Consultation Plan

14.1 Outline of the consultation process

We have a detailed communications and consultation plan.

The consultation aims to ensure:

- Ensure the public voice is heard
- Ensure the public shape the final plans
- Ensure the public provides sufficient insight into the impact the plans may have on local people and patients

The engagement of this programme is split into 3 phases.

- Pre-consultation engagement – March 2022 to May 2022
- Consultation – July 2022 to September 2022
- Post-consultation – November 2022 and continues until after health centres have been built and practices relocate

The timeline below shows the planned engagement and consultation activity for the programme.

The milestones from the timeline above are shown in the table below.

Milestone	Date
Consultation starts	18 July 2022
Consultation end	25 September 2022
Consultation report shared with a subcommittee of ICB with oversight of equality and engagement	TBC
Consultation report shared with Scrutiny committee	TBC
A final decision by ICB	TBC

- The responses to the consultation process will be independently analysed and a report will be published outlining how we have considered these in coming to our decision.

To ensure a robust consultation, we want it to be far reaching, so have a comprehensive communications plan to ensure those potentially affected and those interested know about the plans and have an opportunity to be heard.

The methods we will use will differ for audiences. We will use a blanket approach for everyone and a targeted approach for key stakeholders and seldom heard communities.

Channels include:

- Through community organisations – trained volunteers asking for feedback
- Face to face drop-ins in community venues and groups (e.g., Local community orgs/venues)
- Text messages from GP practices to all patients who have a telephone number registered
- Letters from GP Practices for those without mobiles
- Posters in GP practices, pharmacies, and community venues
- Videos created by community organisations and key community influencers (Imams, GPs, other community leaders)
- WhatsApp groups - Using community groups existing groups to share messages / survey link / videos
- Community radio stations – e.g., Link FM
- Community newsletters
- Dedicated webpage to the programme including all documents and FAQs to respond to common enquiries and concerns
- Social media – CCG, council, practices, and community groups
- Broadcast and print media
- Local area committees
- Advertisements in local areas

14.2 Consultation Plan –

A consultation will be carried out with affected patients and communities on the impact that any proposals would have on them or who their advocate for and seek s on alternative options to spending £37 million. Due to time restrictions with the pre-election period and the time required to build the sites, the consultation period will be 10 weeks. The impacts of this reduced period have been negated by the inclusion of a robust pre-consultation engagement period and targeted community approach.

Appropriate timescales for consideration and approval have been built into the timeline to ensure that CCG's primary care commissioning committee or successor ICB committee have sufficient time to scrutinise the feedback received from the consultation before a decision is made.

The findings of the consultation will be shared with Health Scrutiny Sub Committee so they can make a formal response knowing the views of the public and patients.

We'll use multiple channels and methods to reach our target audiences (see in the consultation plan in appendix x).

1. Documents and materials

To ensure that people can make a considered response to the consultation, they must have access to all the relevant information. NHS Sheffield CCG and the ICB are committed to being transparent throughout the process and will publish the following documents on the CCG/ ICB websites:

- Pre-consultation business case
- Summary consultation document
- Quality and equality impact assessments for each site

2. Readers' panel

A readers' panel will be set up to proof and sense check the consultation document and other materials such as surveys, leaflets, and posters. This is to help ensure the information being shared is understood, clear, free from jargon, the tone is right, and structure and layout are accessible, and helping pre-empts potential issues and questions.

3. Survey

An online survey will be the key method for collating responses. The survey will be translated into the main community languages as well as Easy Read.

Paper copies will also be made available within GP practices and for community organisations.

4. Independent telephone and face to face survey

During the consultation phase, an independent social research company will be commissioned to gain a representative sample of 1,000 people per hub via a telephone or face to face survey.

5. Community conversations

Community organisations are being funded to support the distribution of messages and gain feedback from communities to ensure people with the greatest health needs and underrepresented voices are heard.

The methods used by the community organisations will be tailored to the needs of the communities, and they will use their knowledge and expertise of working in these organisations to create culturally appropriate tools to reach as many people as possible.

6. Public meetings

The importance of a two way dialogue between the public and representatives of the programme is recognised. There will be a minimum of two public meetings per hub, held in a community venue, and publicised at least 3 weeks in advance. We will also host at least two public meetings on Zoom for people who struggle to get to a venue (daytime and evening). We propose to have meetings at the start of the consultation and towards the end. Representatives from GP practices and ICB will attend to give an overview of the plan and answer questions from the public.

The questions and comments made will be recorded and fed into consultation analysis.

Interpreters will be available at the meetings.

There will also be programme representation at relevant Local Area Committees (LACs) to give briefings, invite questions and comments, and signpost people to the survey. This will give another opportunity for a two way dialogue.

We will also attend other people's meetings to talk to people about the consultation and organise more meeting where needed or requested.

7. Other methods of feedback

The survey will be encouraged as the main route for feedback due to the ability to equality monitor and gain comparable data, however, it is recognised that some individuals may not be able to feedback in this way, therefore other methods will be available and promoted including:

- Freepost postal address
- Email address
- Conversation with community organisations

Any petitions will be received and reflected on, but these have limited value in understanding the impact on communities, so other methods will be encouraged to the originators of these petitions.

15 Management case

15.1 Project management

We are working with the Council and have set-up joint governance arrangements which has identified the strategy, framework and outline plans required for successful delivery of our proposals using a robust project management methodology.

The governance arrangements in place allow us and the Council to manage the development of the overarching programme and the individual project that sits within the programme.

This PCBC will go to the CCG Governing Body and Overview and Scrutiny Committee (OSC) to consider if the proposals constitute a substantial variation to services and should therefore be subject to public consultation. If so, then this process will begin in July 2022. Beyond consultation, a Decision-Making Business Case (DMBC) will be produced and re-seek approval of the governing body and OSC.

Both the CCG and Council have identified Senior Responsible Officer (SROs) for the proposals:

- CCG – Director of Finance
- Council – Director of Resources.

The SROs are responsible for ensuring that the programme and its projects meets its objectives and delivers on any agreed benefits. The SROs are senior managers in their respective organisation. The SRO(s) carry out key duties on behalf of a Programme or Project Board. Specific tasks include:

- Monitoring and managing the progress of the Programme and Projects
- Acting as the point of contact for the partner stakeholders, providing a direct link to the Programme Board
- Overseeing the appointment of external advisors.

15.1.1 Benefit realisation plan (BRP)

The BRP sets out the anticipated benefits which could be realised because of the proposals. Some initial modelling has been undertaken, which has led to a list of benefits and some initial positive outputs that could be delivered from delivering the proposals. The initial BRP capture this and includes the following information:

- Confirmation of the benefits that are expected to arise from the project
- Who is likely to benefit from the expected benefits
- Who is accountable for delivering the expected benefits
- Confirmation of the alignment of the identified benefits to the project SOs
- Identify the measure/indicators that will be used to assess whether the expected benefits are realised
- Set out the timescales for delivery of the expected benefits
- Establish the baseline measure for each expected benefit
- Set the target measure for each expected benefit, to be achieved through implementation of the project

- Identification of the benefit type e.g. cash releasing benefit (CRB), non-cash releasing benefit (NCRB), societal benefit (SB), unmonetised benefit (UB)
- Where identified as either a CRBs, NCRBs or SBs the data and assumptions used to quantify the benefit and how many years over the investment period the benefit is likely to be achieved / realised
- Where identified as a UB, which short-listed option that applies to.

The BRP will be updated as both the consultation feedback is analysed and the project teams undertake further reviews to refine and develop.

15.1.2 Resource plan

Both CCG and Council have appointed project/delivery teams to support and lead on delivering the projects. The project teams will follow a delivery programme, using individual project progress report and a programme report to manage progress, risks, and issues.

Areas such as digital, information governance, workforce, change management, these areas will be developing should proposals progress following consultation. Such specific areas of work or workstreams, will have a specific CCG or Council lead. This role will develop a workstream plan and implement to support to hit programme and project milestones.

The management and processes of programme communication and engagement is captured within the engagement and communication plan **(Appendix 01).**

15.2 Organisation readiness

15.2.1 Risk management arrangements

The project team working on the delivery of this PCBC will maintain a risk register, which is included within the CCG's overall risk management and governance arrangements.

Any potential negative impacts have clear evidence of mitigating actions planned or to be undertaken to ensure effective Emergency Preparedness, Resilience and Response (EPRR) is maintained.

Any risks to the PCBC will be continually updated and refined as our proposed model is being refined and in response to feedback from stakeholders throughout the consultation period and as any other relevant information about the impacts of the final pre-consultation proposal becomes available.

15.2.2 Monitoring and evaluation of impacts of the pre-consultation proposals

Through targeted conversations with local people and activity and performance data, we will continually monitor and evaluate patient experience and the quality of the services that form part of this proposal. In addition, we will monitor that we are undertaking actions as indicated through our impact assessments.

15.2.3 Process for decision-making following close of the consultation

Subject to scrutiny, review, and approval of the PCBC by the CCG's Governing Body, we will formally consult with the public on these proposals and with a wider community and those who have a stake in the GP practices in scope. We will also consult with OSC and ensure we meet any requirements of this scrutiny process.

Following the close of the formal consultation, the CCG (or ICB) will establish a panel that will review all the available evidence and any new and relevant information received during the consultation period to inform the final decision on the proposal.

15.2.4 Next steps

The high-level project milestones for the proposal support to **identify our indicative implementation timescales** and are shown in the table below. The initial **consultation document** (**Appendix 05**) for the proposal options has been developed to test deliverability and make clear our plans for consultation.

Table 25 – High-level project milestones

Milestones	Date
Engagement with stakeholders, continuous evidence gathering	Ongoing
Final PCBC submitted to the CCG Governing Body for approval	23/06/22
Formal consultation on the final pre-consultation proposal (subject to the approval by the Governing Body)	15/07/22
Engagement and consultation with the OSC Review Board	Ongoing
Evaluation of the consultation outcomes	Xx/xx/22
OSC meeting to receive OSC Review Board report for submission to the CCG Governing Body	Xx/xx/22
Final proposal submitted to CCG Governing Body	Xx/xx/22
Final decision by CCG/ICB Governing Body submitted to OSC	Xx/xx/22
Implementation of the PCBC proposal (subject to the outcomes of the consultation; final approval by the GB and OSC)	Xx/xx/22

The **high-level implementation plan supports to test the proposal is implementable**. The programme governance is in place so that should different proposals and options need to be implemented decisions can be acted upon quickly to assist programme delivery targets.

16 Conclusion and recommendations

This PCBC outlines the process by which we have reviewed the existing services that currently serve the needs of people who use the practices in scope of this proposal. It describes the national and local context within which we are commissioning services. We have asked local people and clinicians what is important to them about their primary care services. This feedback has informed this PCBC.

We have considered the recommendations of NHS England, national research, and our impact assessments (quality, equality, and health inequality, digital and privacy) and the previous feasibilities into who uses the current services in scope, how and why they use it.

The conclusion from this wide range of insight and evidence is that our current primary care services in most cases are not fit for purpose we therefore propose to consider alternative estates provision via developing hubs (i.e., co-locating practices into the same buildings).

Our analysis and impact assessments have highlighted that implementation of this proposal could cause some confusion in the initial stages of any potential change. We plan to address this in the following ways:

- **Continuing to ask local people how we can best support them** - we would establish targeted conversations (potentially through the establishment of a local people's reference group) to inform our understanding of patient experience during the implementation of any changes and to support us in ongoing monitoring and evaluation of the enhanced range of services in the community
- **Clearly communicate about changes, existing services, new services and how to access them** – we would implement communications to make people aware of the changes, including targeted information.

If this PCBC proposal is supported by the CCG Governing Body and OSC consider that the proposal constitutes a substantial variation to services and should therefore be subject to public consultation, then this process will begin in July 2022.

It is anticipated that during this time there will be further opportunity to gather information, evidence and stakeholder feedback that will enable the CCG/ICB Governing Body to make an informed decision on the proposal in the best interests of local people.

17 Appendices

17.1 Appendix 01 – Pre-consultation engagement report (Lucy)

17.2 Appendix 02 – SCC population/deprivation supplementary review

17.3 Appendix 03 – Long-List of Options

17.4 Appendix 04 – Equality and Health Inequality Impact Assessments (EHIA) (Lucy)

17.5 Appendix 05 – Consultation Document (Lucy)

17.6 Appendix 06 – Engagement and Communication Plan (Lucy)

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