NHS England

South Yorkshire and Bassetlaw Commissioners
Draft Joint Primary Care Strategy

NHS Sheffield CCG Governing Body meeting

C

6 February 2014

1. Introduction

Primary care is the lynchpin of the health and care system, and acts as the first assessment, onward referral, and follow-up service for the majority of patients with both health and social care needs. As such, we need to protect it, sustain it and develop it to be the best it can be. This (draft) strategy sets out the commitments that the commissioners in South Yorkshire and Bassetlaw are making to achieve this aim over the next five years.

2. How the draft has been developed

Over the summer 2013, NHS England launched a consultation and engagement exercise entitled Call to Action, which had a specific primary care element within it. This exercise continues into 2014, with the bespoke Call to Action – Community Pharmacy phase, due to conclude in the spring. As part of Call to Action, a number of conversations were held with key stakeholders, patients and partners, to understand what the issues are that need to be addressed within primary care services locally. (The engagement report provided at Appendix 1 of the strategy describes the outputs of these conversations, and lists the participants in the exercise.)

It became apparent that the issues being raised in each locality were broadly similar, although with different levels of emphasis. The consensus emerged that the system needed a coherent vision for the future of primary care, to provide a backdrop for all the local strategic intentions and ensure a common identity of aim between NHS England and the CCGs, who jointly are the main commissioners responsible for primary care development.

To this end, the enclosed draft strategy and its appendices have been co-produced by the Area Team and the five CCGs in South Yorkshire and Bassetlaw. All the content of the document represents the joint thinking that has been done by the commissioners, and in the fullness of time will be underpinned by the CCG-specific local strategies, which are currently in development and will reflect the CCGs' respective intentions regarding primary care development locally. These strategies will be published by June 2014, if not before, and web-links will be provided within the regional primary care strategy.

3. Key issues within the document needing more work-up and engagement

- The tasks we need to undertake to translate the objectives into reality, at regional and local level – these will be described in an implementation plan, which is in the process of being worked up jointly between the Area Team and CCGs
- IT and premises; these are recognised as fundamental enablers of the strategy, and a coherent focus on them is a priority for inclusion in the action plan
- Workforce; this needs almost a strategy of its own, and again is priority for inclusion in the action plan, working with Health Education England

- The detailed impact of the national planning guidance needs working through, ie the effect of the CCGs funding of £5 per head to GP practices to support improvements and contribute to the target of 15% reduction in acute admissions; the plans for this are anticipated to form part of the local CCG plans with support and input from NHS England

4. Next steps

The intention is to now seek further feedback and input into this first public draft of the South Yorkshire and Bassetlaw Primary Care Strategy, from stakeholders, providers, and patients. It is not envisaged that formal consultation is required at this stage as the strategy does not represent major service change, rather a strategic direction of travel. It is suggested that the Area Team can conduct engagement via a number of regional mechanisms that were used for initial debate and discussion within the Call to Action exercise last year; and that these mechanisms will be supplemented by local engagement activities taking place within CCGs as part of their local strategic planning processes, with support from the Area Team as and when requested. The following table sets out some preliminary engagement routes that will be pursued to gain feedback on this draft strategy in March and April, subject to CCG Governing Body approval.

Table 1: Engagement Routes March-April 2014

Area	Group
South Yorkshire and Bassetlaw	LMC Strategic Liaison Committee
	LPC Strategic Liaison Committee
	LDC Strategic Liaison Committee
	LOC Strategic Liaison Committee
	SY&B Area Team Staff Briefing - Workshops
	Working Together Programme Board
	Healthwatch Network Meeting
	SY&B Patient Experience Forum
Rotherham	Rotherham CCG Exec Management Team
	Rotherham Health & Wellbeing Board
	Rotherham Healthwatch
Doncaster	Doncaster Health & Wellbeing Board
	Doncaster Health & Wellbeing Board Officers Group
	Doncaster LMC-CCG Joint meeting
	Doncaster Healthwatch
Barnsley	Barnsley Health & Wellbeing Board
	Barnsley Membership Council
	Barnsley Healthwatch
	Barnsley Quality & Patient Safety Group
Sheffield	Sheffield Health and Wellbeing Board
	Joint Health & Wellbeing Strategy Co-ordination Group meeting
	Sheffield CCG Clinical Exec Team
	Sheffield CCG Primary Care Commissioning & Quality Group
	Sheffield Healthwatch
Bassetlaw	Bassetlaw Patient Engagement Group
	Nottingham Health & Well-Being Board
	Bassetlaw CCG Partnership Advisory Forum
	Bassetlaw Healthwatch

It is then proposed that a final version of the strategy is constructed in May, informed by the feedback, and signed off by CCG Governing Bodies and the Area Team in June, for publication.

5. Recommendations

The NHS Sheffield CCG Governing Body is asked to**:**

a) Consider the contents of the draft strategy and the appendices
b) Approve the draft for further engagement
c) Advise on the routes for engagement

Presenter: Steve Hackett, Director of Finance, NHS England

January 2014

PRIMARY CARE STRATEGY

SOUTH YORKSHIRE & BASSETLAW COMMISSIONERS

Working together for high quality, sustainable primary care, now and for future generations

NHS Bassetlaw Clinical Commissioning Group

NHS Barnsley Clinical Commissioning Group

NHS Sheffield Clinical Commissioning Group

NHS Doncaster Clinical Commissioning Group

NHS Rotherham Clinical Commissioning Group

NHS England

Version Number: 0.6

Status: Draft

Amendment History

Version	Date	Amendment History
0.1	26.11.13	First draft for comment from CCG primary care leads
0.2	2.12.13	Comments and output from November stakeholder events included
0.3	16.12.13	Amendments made for consideration at SYB Primary Care Strategy Steering Group 17 Dec
0.4	19.12.13	Amendments made following Steering Group, for consideration internally within CCGs and Area Team during January
0.5	10.01.14	Minimal amendments made to update in accordance with national planning guidance
0.6	27.01.14	Draft to go to CCG Governing Bodies in February

Reviewers

This document must be reviewed by the following:

Name	Date	Version
South Yorkshire & Bassetlaw SMT	3 January 2014	0.4
Barnsley CCG Governing Body	13 Feb 2014	0.6
Bassetlaw CCG Governing Body	11 Feb 2014	0.6
Doncaster CCG Governing Body	20 Feb 2014	0.6
Rotherham CCG Governing Body	5 Feb 2014	0.6
Sheffield CCG Governing Body	6 Feb 2014	0.6

Approval

This document must be approved by the following:

Name	Signature	Title / Responsibility	Date	Version
Eleri de Gilbert		Area Team Director	June 2014	Final
Nick Balac		Chair, NHS Barnsley CCG	June 2014	Final
Steve Kell		Chair NHS Bassetlaw CCG	June 2014	Final
Nick Tupper		Chair, NHS Doncaster CCG	June 2014	Final
Julie Kitlowski		Chair, NHS Rotherham CCG	June 2014	Final
Tim Moorhead		Chair, NHS Sheffield CCG	June 2014	Final

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Introduction

About this document

This strategy is co-produced and co-owned by NHS England, Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG and Sheffield CCG (referred to in the document as the South Yorkshire & Bassetlaw Commissioners). It will set out how these organisations will work together to design and implement sustainable, high quality primary care services that are centred upon the service user and their families. It will describe the key deliverables and priorities over the next 2-5 years, and how they align to the five challenges within the NHS Outcomes Framework:

1. To prevent people from dying prematurely
2. To enhance the quality of life for people with long term conditions
3. To help people recover from episodes of ill health or following injury
4. To ensure that people have a positive experience of care
5. To treat and care for people in a safe environment and protect them from avoidable harm

About Us

NHS England, established on 1 April 2013, holds contracts for their core generic services with each of the four primary care groups (dentistry, pharmacy, optometry and GP practice). The majority of these services are in-hours, nationally designed, and common to all providers within the group. Clinical Commissioning Groups (CCGs) are responsible for commissioning a variety of community-based services that are bespoke to the local population's needs, including out-of-hours services, some of which will be commissioned from primary care providers.

What is primary care?

Primary Care is defined as the first contact of a patient with a healthcare provider, usually a GP, dentist, pharmacist or optician, in a given episode of illness. As such, it has a key role to play in improving health outcomes and reducing health inequalities. Evidence shows that strong and effective primary care services are vital for health economies and for delivering high quality, best value health services and healthy populations. As an indication of the scale of the impact that Primary Care has on the population and their health: GPs and nurses in general practice see over 800,000 people a day; dentists and dental teams see around 250,000 people a day; opticians provide around 12 million NHS sight tests each year; and an estimated 1.2 million people visit a community pharmacy every day.

The Vision and Purpose of South Yorkshire & Bassetlaw Commissioners

Vision: To achieve excellence in commissioning strong, vibrant primary care services, including improvements in quality and patient satisfaction, and reductions in inequalities of access and outcomes.

Purpose: We create the culture and conditions for primary care services and staff to deliver the highest standard of care and ensure that valuable public resources are used effectively to get the best outcomes for individuals, communities and society for now and for future generations.

Case for Change

National Situation

The NHS is facing some critical challenges as it enters its 65th year. These include:

- Increasing demands on services within a tight financial envelope, predominantly due to a growing, ageing population with more complex needs.
- Increasing (yet often under-reported) prevalence of long term conditions, but often under-recorded.
- Overall satisfaction with primary care services remains high, but growing challenges in relation to patient experience of access.
- Inequity in distribution of workforce, and recruitment. Retention and retirement issues are facing GPs and practice nurses in particular.

Local Demographic

In South Yorkshire and Bassetlaw there are some unique challenges posed by the demographic of the population, and therefore the prevalence of certain conditions and the resulting patterns of healthcare activity. The maps at Appendix 1 depict some of these particular issues, where parts of South Yorkshire and Bassetlaw are more challenged than the rest of England.

The data shows that, although the age of the population in South Yorkshire and Bassetlaw is not significantly higher than the England average, the number of people suffering from long-term debilitating illnesses are higher the average, and the number of people dying from cancer, circulatory disease and respiratory disease is also higher. Primary care services have an instrumental part to play in addressing these challenges.

SY&B has seen a steady growth in population, some GP practices have grown significantly in size over a period of time and have responded with increased capacity and skill mix. The area team has a larger proportion of the population aged 20-24 than the national average, and a smaller proportion aged 30-39 than the national average. The first cohort (20-24) are traditionally the group that does not access medical services, but do access dental services and Pharmacies. This offers opportunity to consider whether some basic screening/health advice can be provided by dental contactors with signposting to medical services where appropriate and supports the need to consider further how pharmacies can support delivery of primary care services.

Additionally, there are some specific issues in each CCG locality which are not immediately evident within a regional profile; these include for example particular pockets of deprivation, or dense migrant populations. We need to ensure that the future commissioning of primary care services takes account of local needs as well as regional ones, within each CCG community.

What our Patients tell us

Primary care services are, in the majority of cases, the first port of call in the health system, and therefore of vital importance to patients. The patient experience of these services is fundamental to how they need to be commissioned in the future. This strategy is informed by a number of sources of patient experience, including[1]:

- National patient surveys, including the Annual GP Patient Survey and the Voices Survey
- Results of the online "Call To Action" survey, run by NHS England during September-November 2013
- the intelligence gathered by the Health and Well-Being Boards in South Yorkshire and Bassetlaw when undertaking consultations on their respective strategies in 2013;
- intelligence gathered by CCGs when consulting on their strategic plans in 2013;
- views expressed by patients and the public during bespoke primary care strategy meetings run by SY&B Area Team in autumn 2013

The full report on patient engagement is provided at Appendix 2. For the purpose of this strategy, the intelligence can be summarised into the following key themes:

Access: Throughout the engagement on this strategy, the issue of access to GPs in particular was raised in several fora, and the frequency and consistency of this feedback would suggest there is a problem to be addressed. However there is conflicting data available to commissioners on this issue, and joint work needs to be undertaken by commissioners and service users together, to fully understand the position in each locality and take appropriate action.

Quality: It was widely felt amongst the patients and public that contributed to this strategy that improved quality of care should be a strategic value. Comments focused on reducing need for care services, raising awareness of health issues and the care available, thereby promoting accessibility for all. In addition, the feedback emphasised the value of face-to-face/person centred care, and the need for services to be designed around the patient not the organisation providing them.

Integration: The need for services to become more joined up is widely agreed. People feel they are passed from pillar to post and have to speak to a range of professionals which can be confusing and frustrating. People commented on the fact that health and social care don't share a common language, and this is perpetuated by different systems, funding priorities and work cultures.

Prevention and Personal Responsibility: There was support for encouraging people to take responsibility for their own health and wellbeing and for encouraging healthy lifestyles. Comments emphasised the need to support and guide people to do this, to widen this responsibility beyond individuals and their families, and make sure that the principle of taking personal responsibility for one's health does not result in patients feeling judged for being unwell. It was felt that by building in appropriate time for professionals and equipping them with the right skills, many more people would be able to maintain independency for longer. It is important to consider how primary care services can work together and differently to contribute to this agenda; for example, the potential role of community pharmacies in prevention and early intervention was highlighted by some patients.

Equality: It was recognised that inequality currently exists in primary care; both in terms of outcomes (for example, life expectancies differ not just across the CCGs but within the boroughs also), and in terms of how primary care is commissioned to address equality and

[1] Appendix 2 lists all the mechanisms used to gather patient feedback

diversity, as some services are better than others in recognising cultural differences. With regard to the latter point, it was suggested that better training for staff would help; as well as more support for non-English speaking patients, and improved and more sensitive communication aids and methods in general.

What Our Stakeholders tell us

Upon consulting with our stakeholders (including local professional committees and Health & Well-Being Boards; see Appendix 2 for full details) upon the vision for primary care during the summer 2013, a number of key messages emerged.

- We need to be ambitious, aspirational, and person-centred
- Our ambitions and improvement agenda must be based on hard data, not perception
- We need to be transparent about the restrictions we face
- The primary care strategy needs to promote prevention and personal responsibility in equal measure
- It is time for a fully-inclusive primary care strategy that does not just concentrate on primary medical care; we need to maximise the potential of the entire system
- Strategic enablers including IT infrastructure, workforce, the national contract, and estates are critical to get right, quickly
- The primary care strategy needs to respond to the Health & Well-Being agendas in
- each patch, and needs full co-commissioner involvement

How the CCGs and Area Team will work together

It is clear from the above feedback that primary care needs to be much more integrated and responsive in the way it provides services, in order to meet the challenges of the future. To support these changes, however, we need to ensure that we commission services in a holistic way, based on the needs of a given locality.

To do this, the SY&B Area Team and the five CCGs have agreed the following principles will characterise their working relationship:

- the need to make decisions which promote patient safety and high quality health care;
- the need to provide services that focus on the needs and experiences of people who use those services and maintain public confidence;
- respect for each organisation's independence,
- openness and transparency between the respective organisations as to when cooperation is and is not considered necessary or appropriate; and
- the need to use resources efficiently, effectively and economically.

Specifically, the CCGs and NHS England South Yorkshire & Bassetlaw Area Team will work together to:

strengthen local clinical leadership and ownership of plans to transform primary care services;

support development of more integrated arrangements for providing primary care and community health services;

ensure continuous strategic fit of CCG and Area Team respective priorities as they evolve

ensure that resources are allocated appropriately between primary care, community health services and hospital services to deliver the health needs of the population,

through optimal application of the commissioning rules and ensuring that commissioning responsibility is clear and duly resourced at all times

Monthly meetings between the Area team and the individual CCGs will allow regular dialogue about the quality of primary care, governed by the agreed Memorandum of Understanding in place between the Area Team and each CCG – see Appendix 3. The outputs of these meetings will inform wider strategic discussion where appropriate, and also feed into the risk management approach detailed below.

Jointly Agreed Objectives

As a direct result of the feedback and information set out above, the following table describes our strategic objectives regarding primary care in South Yorkshire and Bassetlaw, together with how they align to the NHS Outcomes Framework:

Objective	NHS OF
1. Maximise the role of primary care services in the prevention of ill-health and the promotion of personal responsibility for health & well-being, working with the local authorities and CCGs, in recognition of where they can deliver the greatest benefit;	1,2
2. Identify and implement best practice models of patient access across primary care	1,2,3,4,5
3. Align primary care services to support delivery of local commissioning priorities in each community, particularly where SY&B outcomes are poorer than the national average	1,2
4. Working with Health & Well-Being Boards, identify key contributions for primary care to make to the integration agenda, and deliver measurable changes	1,2,3,4,5
5. Development of providers, to facilitate a skilled provider market, configured to deliver challenging commissioning intentions regarding high quality, sustainable, vibrant services	1,2,3,4,5

Through the delivery of the above objectives, we will achieve our vision for strong, vibrant, effective and person-centred primary care services.

Principles of Primary Care

Our principles are to ensure the following:

- Primary care continues to be an effective first point of contact for patients
- There remains a common core offer of high quality, patient-centred primary care
- There is an increasing role in active case management and supporting patients to manage their own care
- Through the use of integrated clinical systems, and through appropriate governance and consent arrangements, summary records are shared to enable the effective management of all registered populations
- Primary care supports the continuous improvement in health outcomes across the five domains of the NHS Outcomes Framework through the use of innovation and technology.
- Primary care is delivered by appropriate services with seamless transition ensuring the optimisation of primary care, assessment and diagnosis, enhanced recovery, reablement and rehabilitation of all scheduled and unscheduled care (seven day services)

- Partnership working is developed by the Local Professional Networks in order that patient experience and clinical leadership drive the commissioning agenda, securing higher quality health services
- A reduction in health inequalities i.e. through health promotion and commissioning services in the right locations with the right skill mix to meet patient needs.

Jointly Agreed Critical Enablers

In order to deliver the above, there are fundamental building-blocks that need to be in place. These are:

- Sustainable, skilled and motivated workforce
- Modern, fit-for-purpose premises
- Responsive and intelligent IT systems
- Fit-for-purpose contracts and transparent commissioning intentions
- Strong governance and support arrangements

Much of the feedback we received when engaging with providers on this strategy revealed the importance of these five themes in creating the environment for high quality care. Below we set out our approach.

Workforce

There is a fundamental need to increase or "free up" capacity in primary care, and review and redesign of the workforce is a crucial part of the solution. There are however a number of risks currently facing the primary care workforce, particularly in general practice, as the age profile of GPs is growing and pockets of primary care in SY&B are not considered attractive areas to work in. Currently, there are a number of issues, including:

- The training route for practice nurses is unclear
- There is insufficient awareness of training opportunities and in some areas a lack of provision for primary care staff
- There is currently a lack of capacity to support training in primary and community care settings
- There is the potential to use even greater skill mix in delivering primary care services through a range of roles and professions

As a result, primary and community care is a key priority in the Health Education England Strategy 2013-2018, which states the following strategic steps will be taken:

- Extension of data collection to provide a more comprehensive analysis of the region's health care workforce
- Sustainable model of primary care training and placements developed in conjunction with the introduction of placement tariffs
- Investment in training to support service transformation and better continuity of care through better multi-disciplinary working across organisational and sector boundaries
- More defined training routes for practice nurses and other primary care staff
- Further assessment of training for primary care staff, its suitability and impact and awareness raising of provision available
- Increase in GP trainees and, where recruitment is difficult, greater skill mix solutions

On our collective behalf, NHS England will lead the work with Health Education England in Yorkshire & Humber to undertake a full stock-take of workforce, including numbers, skill-mix, working practice, risks and opportunities, to understand the baseline position in the region. This intelligence will inform work to address the inequities and variation in provision within

the region currently, as well as future workforce development and planning activity, to be undertaken in conjunction with the CCGs. As a first step, information on nursing and non-clinical capacity within GP practices will be available through the national primary care workforce audit being undertaken over the Autumn 2013 and will be available in early 2014.

We will develop the idea of primary care teams, recognising under the auspices of primary care the community nursing, physiotherapy, mental health, and occupational health functions among others. This concept is key to unlocking the solution to workforce challenges; more integration and joint working is critical.

In addition, we will explore opportunities for overarching accreditation frameworks which allow practitioners to transfer and use their skills across organisational boundaries for the benefit of patients. It is not acceptable that a clinician cannot employ all their relevant skills in treating a patient, just because they are working in a different setting one week as opposed to the next. We need to ensure that clinical governance frameworks are in place, that are strong without being unduly restrictive and negatively impacting on the patient outcome.

Nationally, we will ensure that South Yorkshire and Bassetlaw fully engages with national development opportunities, linking into NHS England and NHS Improving Quality, to avail local providers of the chances to participate in national leadership capability and capacity programmes, as described in NHS England's National Framework for Primary Care (due for publication January 2014).

Premises

NHS England is currently in the process of developing a strategic framework to support joint work with healthcare providers, CCGs, local authorities and other community partners to ensure that local strategies for out-of-hospital care include appropriate strategies for premises development. This will include working with other commissioners, healthcare providers and premises providers (including NHS Property Services Ltd, Community Health Partnerships and LIFT companies) to promote more effective use of current primary care estate, including ways to improve utilisation of current properties through the use of all available commissioning levers.

Primary Care premises need to be assessed for their fitness for purpose, both in terms of delivery of core primary care, and potential to deliver more out-of-hospital services. Finite resources available for capital developments in future mean that we will have to maximise use of existing buildings, with new builds being approved only when all existing resources have been exhausted. A whole system review of current premises stock, including space utilisation and fitness for purpose for the short, medium and longer term, within SY&B will be explored with the multiple partners of CHP, NHSPS, and Health and Well-Being Boards, to provide a baseline from which to start. We will learn from other sites across the country where this has already been done to ensure maximum efficiency.

Information Technology

In order to deliver the aspirations set out in this document, information and the use of electronic means of accessing and transfer of information is key. Slow, unresponsive or out of date systems/software are one of the biggest limiting factors to delivery.

In 2013-14, the responsibility for GP IT systems was devolved to CCGs, who in turn agreed a programme of IT improvements with the W&SYCSU. Priorities for 2013/14 included upgrades to software which would have been unsupported from April 2014 , including the replacement of terminals.

Changes to the GP contract from April 2014 place greater emphasis on electronic solutions being used to communicate with patients, allowing then to book appointments on line, request prescriptions, contact a GP and have access to their shared medical record. Whilst the solution to much of these developments can be found in IT hardware and software, staff within primary care will require support and training in order to put these developments effectively into practice. As a priority in 2014-15, CCGS and the Area Team will work together to agree a joint way forward and ensure that the joint strategic objectives are underpinned by a robust strategy for IT infrastructure development.

Strategic Commissioning Intentions

Primary care is multi-faceted and, following the changes introduced by the Health and Social Care Act 2012, now has multiple commissioners. NHS England holds contracts for their core generic services with each of the four primary care groups (dentistry, pharmacy, optometry and GP practice). The majority of these services are in-hours, nationally designed, and common to all providers within the group. Clinical Commissioning Groups (CCGs) are responsible for commissioning a variety of community-based services that are bespoke to the local population's needs, including out-of-hours services, some of which will be commissioned from primary care providers. To deliver the vision of this strategy, primary care needs to be considered in the round, and the strategic commissioning intentions of the responsible organisations need to be mutually aligned. This section sets out: NHS England's approach to core contracts from 2014-15 onwards; the impact of national commissioning guidance on primary care; and where to find the complementary CCG strategies for the local communities within South Yorkshire and Bassetlaw, which provide the detail on how this strategy's objectives will translate into measurable outcomes for local people.

Commissioning Core Primary Medical Services

An agreement has been reached with GPC on changes to the GMS contract for 2014/15 which support our strategic objectives for primary care, including providing more proactive care for people with more complex health needs, empowering patients and the public, giving parity of esteem to physical and mental health, promoting more consistently high standards of quality, and reducing inequalities. These changes will also be applied through the appropriate mechanisms in PMS and APMS contracts, wherever appropriate. The changes directly relevant to the joint objectives in this strategy (not an exhaustive list) are broadly summarised as follows:

<u>More personal care for older people and those with complex health needs</u>

This will include:

- Named, accountable GP for people aged 75 and over
- New contractual duty to monitor and report on the quality of out-of-hours services
- Reducing unplanned admissions, through:
    - improved practice availability
    - better communication with other clinicians and providers to support decisions relating to hospital transfers or admissions
    - regular risk profiling
    - developing, sharing and regularly reviewing personalised care plans for at-risk patients
    - reviewing and improving discharge processes with local hospitals;
    - internal reviews of unplanned admissions/readmissions.

Empowering patients and the public, through:

- Choice of GP practice; from October 2014, all GP practices will be able to register patients from outside their traditional boundary areas without a duty to provide home visits.
- Friends and Family Test in practices from Dec 2014
- Patient online services; GP practices will be contractually required from April 2014 to have plans in place to promote and offer patients the opportunity to book appointments online, order repeat prescriptions online and gain access to their medical records online
- Extended opening hours; the extended hours enhanced service will be adapted to promote greater innovation in how practices offer extended access.
- Patient participation; the patient participation enhanced service will be adapted to promote greater innovation in how practices seek and act on patient insight and feedback, including the views of patients with mental health needs.

Commissioning Core Dental services

NHS England is progressing plans to commission NHS dental services based on the local oral health needs assessment which will be developed by public health teams in local authorities and will help determine the needs of local populations.

The benefit of NHS England being a single commissioner for all dental services is the ability to plan for and deliver more consistent standards, higher quality services and better health outcomes for patients across the whole of England. A more consistent approach to commissioning and contract management will be implemented in order to deliver these improvements. In addition, by having the oversight and responsibility for commissioning all dental services for the population, the NHS England is able to ensure greater coordination between the different areas of dental care. This offers dentistry a unique opportunity to share excellence across England.

Dental care pathways are being developed to describe consistent national elements, regardless of setting, describing:

- Complexity and procedures across all levels of care, building on work led by the Department of Health
- Consistent clinical competencies for each level of care
- Consistent environment and equipment standards
- Consistent clinical outcomes, quality standards and patient reported outcome measures (PROMS)
- Consistent coding and pricing measures for each care pathway

Our intention is to commission improved dental health outcomes for patients and communities, tackling health inequalities, working within the available resources. We will commission to nationally consistent high standards but with local flexibility so that decisions about services can be made as locally as possible, involving the clinical community, patients and the local population

Commissioning Core General Optometry Services

The Government has made eye health a public health priority not only by supporting the UK Vision Strategy (UKVS) and VISION 2020, but by publishing the first ever Public Health Indicator for eye health to track progress from 1 April 2013.

NHS England will seek to progress eGOS payments, adopting learning from the outcomes of current pilots. We will seek to reduce bureaucracy associated with payment processes, and look to identifying opportunities to achieve efficiencies through economies of scale upon which to take forward service developments. Options will be considered and tested with a wide range of stakeholders before a formal procurement is undertaken.

A Clinical Council for Eye Health Commissioning (CCEHC) has been set up. Membership includes representatives from the Royal College of Ophthalmologists, the College of Optometrists, the Royal College of Nursing, the Royal College of GPs, LOCSU and the Optical Confederation, the Royal National Institute of the Blind, other voluntary sector bodies, Public Health England and the Faculty of Public Health Medicine. The CCEHC aims to give advice and guidance on national clinical issues where required and to support Local Eye Health Networks (LEHNs).

The LEHN Steering Group will have a direct communication channel to the CCEHC to ensure issues identified by the LEHNs are acknowledged and inform the CCEHC's priorities.

Commissioning Core Community Pharmacy Services

The community pharmacy cost of service inquiry carried out by PricewaterhouseCoopers (PwC) was published in July 2011.

Although the DH retains responsibility for medicines supply and reimbursement, NHS England will now play a key role in the discussions with the pharmacy services negotiating committee in relation to future commissioning implications. NHS England will review and refresh additional Pharmacy Local Enhanced Services. Guidance will be published about which pharmacy LESs will continue to be commissioned by NHS England, and what may be further developed to enable community pharmacy to contribute to the objectives of this strategy by:

- providing a range of clinical and public health services that will deliver improved health and consistently high quality;
- playing a stronger role in the management of long term conditions;
- playing a significant role in a new approach to urgent and emergency care and access to general practice;
- providing services that will contribute more to out of hospital care; and
- supporting the delivery of improved efficiencies across a range of services.

NHS England published "A Call To Action – Community Pharmacy" in December 2013, with feedback requested over Jan – March 2014, and the results of this engagement exercise will be fed into the final version of this strategy.

Everyone Counts: Planning For Patients 2014-15 to 2018-19

This guidance sets out the need for bold and ambitious five year strategic plans from NHS commissioners. It describes an approach to deliver transformational change with the first critical steps over the next two years, to achieve the continued ambition to secure sustainable high quality care for all, now and for future generations.

There are some specific highlights of this guidance which relate to primary care and reflect our joint objectives in this strategy, including:

- A growing consensus that primary care needs to play a much stronger role in improving health outcomes, at the heart of a more integrated system of community-based services; and this will mean enabling general practice in particular to work at greater scale and in collaboration with other health and care organisations
- CCGs will support practices in transforming the care of patients aged 75 or older by providing funding for practice plans to do so, at around £5 per head of population for each practice
- During 2014-15 pilots to extend access to general practice will be implemented, to test new flexibilities in how citizens access services, supported by the Prime Minister's £50m challenge fund.

The above list is not exhaustive and the guidance as a whole supports the jointly agreed strategic objectives of this document. The South Yorkshire commissioners will work together to implement the requirements of the guidance, ensuring that the commitments stated above are translated into effective, value-adding services and processes for patients. The individual CCG strategic plans, and the Area Team's operational action plan, will together describe the tasks that will be undertaken to make this a reality. These can be found at the web-links below:

To be inserted by June 2014 – local engagement taking place on these in the interim

- *Insert web-link to Bassetlaw plan*
- *Insert web-link to Barnsley plan*
- *Insert web-link to Doncaster plan*
- *Insert web-link to Rotherham plan*
- *Insert web-link to Sheffield plan*
- *Insert web-link to NHS England SY&B Area Team operational plan/append?*

Governance and support

Core functions of the Area Team

The Area Team has a number of duties to discharge relating to the governance of primary care services, as it is the direct contractor of the core services delivered by each of the four contractor groups. These functions include:

- Responsible Officer and revalidation
- GP appraisal
- Incident reporting
- Performers list management
- Contract management

The Area Team is responsible for commissioning and performance managing Primary Care Contracts and Direct Enhanced Services across all four independent contractor groups,

which includes in excess of 950 contractors. With regard to GPs, the Area Team is also responsible for the Quality & Outcomes Framework and involved in premises issues including Rents and Private Sector Capital Grants.

Performance concerns are managed and investigated by NHS England Area Team for South Yorkshire and Bassetlaw (SY&B) using the NHS England policy & procedure for 'the identification, management and support of primary care performers and contractors whose performance gives cause for concern'.

The joint responsibility for continuous improvement of the quality of primary medical services held by both the CCGs and Area Team is discharged in accordance with the Memoranda of Understanding in place between organisations; see Appendix 3.

Robust decision-making

It is important that interdependencies within the system are considered when making primary care commissioning decisions. As an example, both CCGs and Local Authorities commission Local Enhanced Services (LES) from primary care providers in a number of instances, and there are some decisions that NHS England could make in isolation which would have unintended detrimental consequences, such as those relating to primary care premises for instance. Through the mechanisms in place such as the Health and Well-Being Board Officer Groups, and the regular meetings between the CCGs and Area Team referenced above, commissioners will ensure that key decisions are made with full consideration of the wider impact.

Furthermore, decisions will be evidence-based, and grounded in hard data. Public Health England will support commissioners in sourcing rich, accurate information to use in informing decision-making. Sources of intelligence to draw upon include (not an exhaustive list):

- Contractor performance information
- Quality information, including CQC reports, patient satisfaction reports
- Joint Strategic Needs Assessments from each Local Authority
- Pharmaceutical Health Needs Assessments (Jan 2015)
- Oral Health Needs Assessment (pending)

It is also imperative that decisions are informed by patients' experiences and outcomes, and that appropriate engagement and consultation takes place before significant changes are made. The engagement and consultation strategies of each of the South Yorkshire & Bassetlaw commissioners describe how this commitment will be executed when considering service change, and can be found through the respective organisations' websites.

The following principles will be applied throughout commissioning decisions:

- Service users are at the heart of everything we do, and commissioning decisions are transparent
- Resource is targeted at the area of most need; ring-fencing of resource is kept to a minimum to ensure responsive and evidence-based commissioning
- The focus will be placed on raising the thresholds for quality of care offered to all
- Improvements made are measurable and demonstrable

Critical Success Factors

In order for the vision of this strategy to be delivered, there need to be a number of critical success factors in place;

- The pace of change across all commissioning organisations takes account of the need to avoid destabilising services
- There is proactive engagement across all key stakeholders and professions

- National enablers are mobilised to support local change (contract changes, premises, IT infrastructure)
- Cross-sector accreditation frameworks are in place to allow practitioners to maximise their potential, recognising transferable skills which benefit the patient

Risk Management

As with any strategic objectives, there are risks to delivery. Each of the commissioning organisations involved in the delivery of this strategy have their own robust risk identification and management processes. As a minimum, these ensure that within their organisations all risk management issues are coordinated, managed, monitored and reviewed including

- notifying any strategic risks to the delivery of defined objectives or escalating operational problems
- ensuring that appropriate operational risk registers or logs are maintained and actively managed within their directorate or programme area;
- leading the management of risk by devising short, medium and long-term strategies to tackle identified risk, including the production of any action plans;
- ensuring all staff fulfil their responsibility for risk management by identifying, reporting, monitoring and managing risk

The risks to delivery of this strategy are therefore recognised and embedded within core commissioning processes, and these provide the infrastructure for the detailed local CCG & Area Team action plans referenced above.

Role of primary care in business continuity and emergency planning

The “NHS Commissioning Board Emergency Preparedness Framework 2013” provides the framework for all NHS funded organisations to meet the requirements of the Civil Contingencies Act (2004), the Health and Social Care Act (2012), the NHS standard contracts and the NHS CB EPRR Core Standards (2013), NHS CB Command and Control (2013) and NHS CB Business Continuity Management Framework (2013). This NHS emergency preparedness framework contains principles for effective health emergency planning and business continuity management that apply to:

- all NHS organisations at each level, including NHS England
- providers of NHS funded care;
- clinical commissioning groups (CCGs);
- GPs; and
- other primary and community care organisations

South Yorkshire and Bassetlaw commissioners will work together to ensure that the principles espoused in this framework are developed and maintained across primary care services in SY&B.

Business continuity and surge planning are increasingly under the spotlight in primary care, impact on secondary care, A&E and ambulance services is significant if primary care capacity does not have sufficient flex built in to respond to surges in demand. Whilst there is no mandatory contractual target for primary care, the ability to sustain services where demand increases by 15% would be the minimum expectation. NHS England SY&B Area Team has a primary care surge plan in place which has been issued to contractors and encourages collaborative working of contractors (associations/buddying) as a means of responding to pressures over winter (and in the longer term) to build sufficient flex within the workforce.

Finance and Resources

Finance and Resources for the South Yorkshire and Bassetlaw (SYB) Area team and the CCGs are set down in the planning guidance "Everyone Counts" issued by NHS England.

From 1 April 2014 both the Area team and the CCGs will have 5 year financial plans which will consist of 2 year operational plans and less fluid plans for the further 3 financial years. 2 year allocations will be issued for 2014/2015 and 2015/2016 with broad assumptions for the remaining 3 years of the plan which will give some certainty for planning purposes.

The NHS England planning guidance has given certainty to the following areas with regard to the core primary care contracts held by the Area Team:

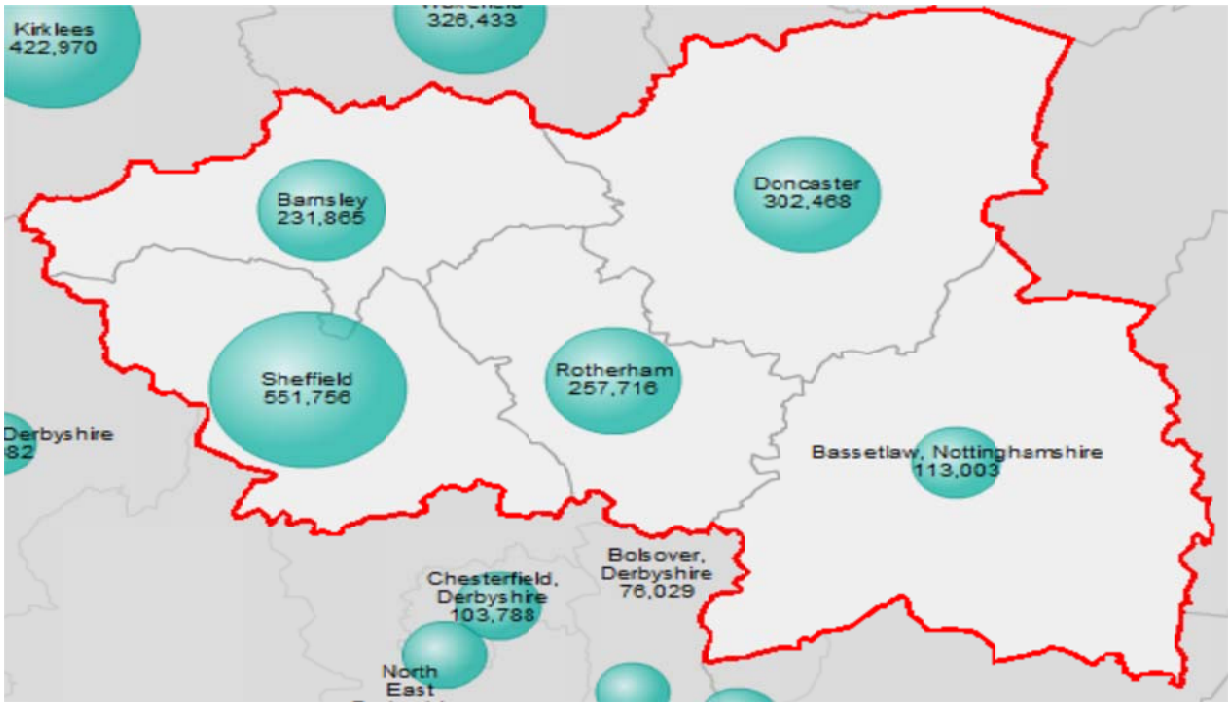
- Growth in allocations funding for 2014/2015 and 2015/2016 at 1.6% and 1.22% respectively
- 1% surplus to be generated
- Minimum 0.5% contingency fund to be held each year
- 2.5% recurrent spend to be held for non-recurrent use in 14/15 and 2% in 15/16

Growth funding received will need to take into account demographic changes to the population of SYB.

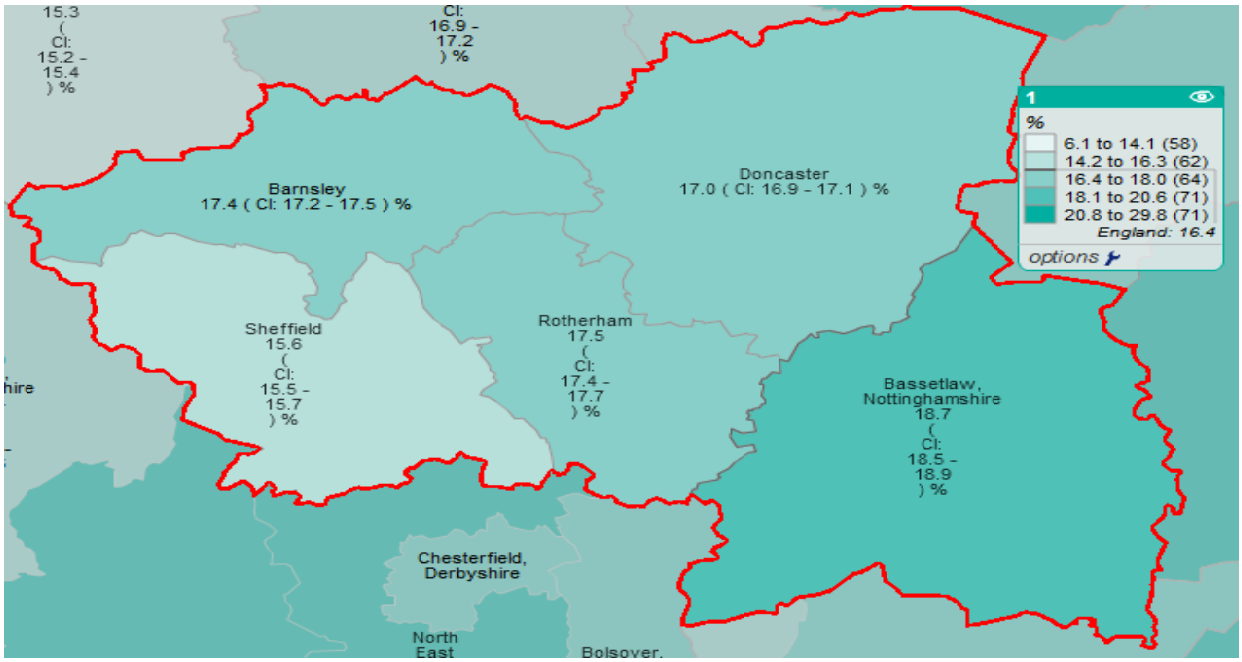
In addition to the above the Primary Care Function will have a QIPP target to deliver recurrent QIPP for each financial year. Discussions around QIPP will need to be in liaison with CCGs if services cross commissioning pathways.

SOUTH YORKSHIRE AND BASSETLAW PRIMARY CARE STRATEGY APPENDIX 1
DEMOGRAPHIC INFORMATION

Local Population



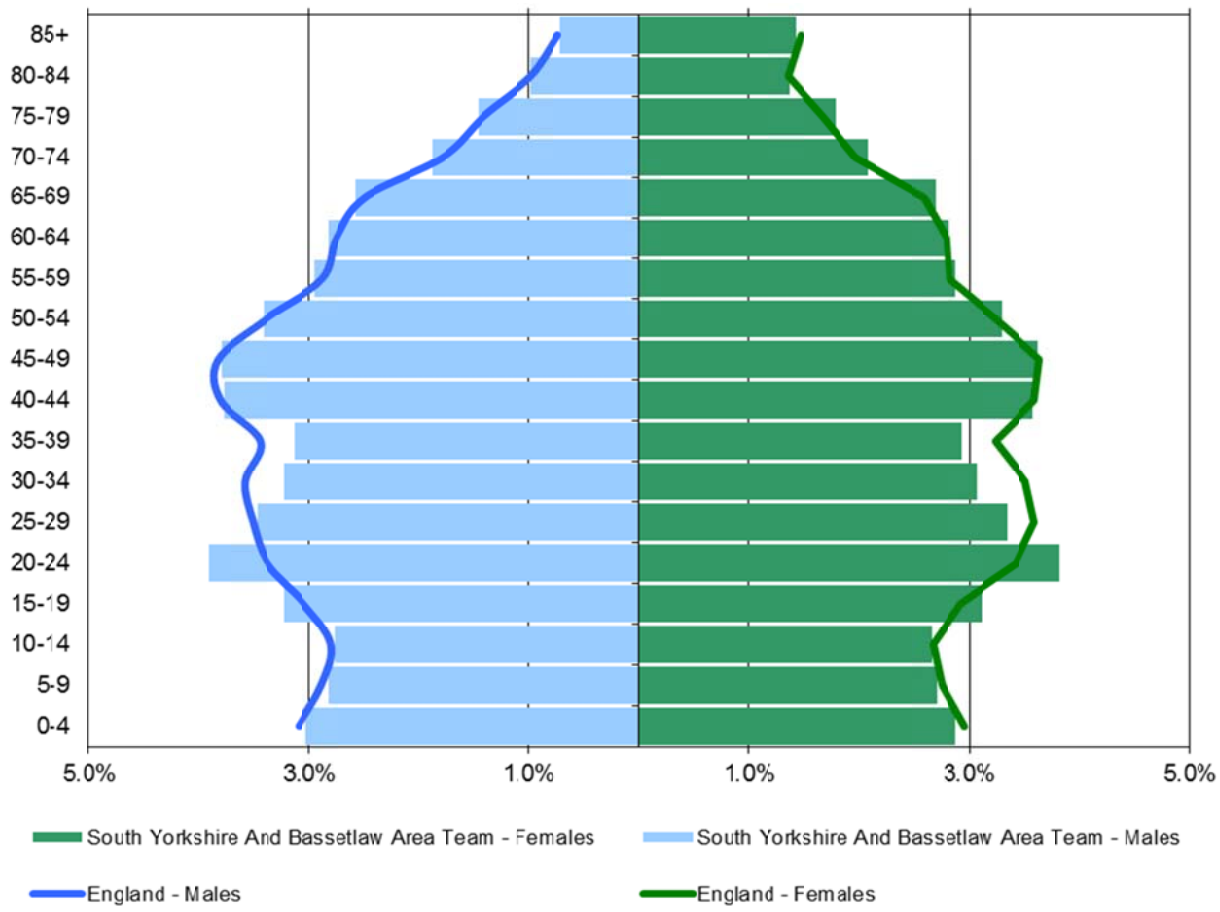
% population over 65 years of age



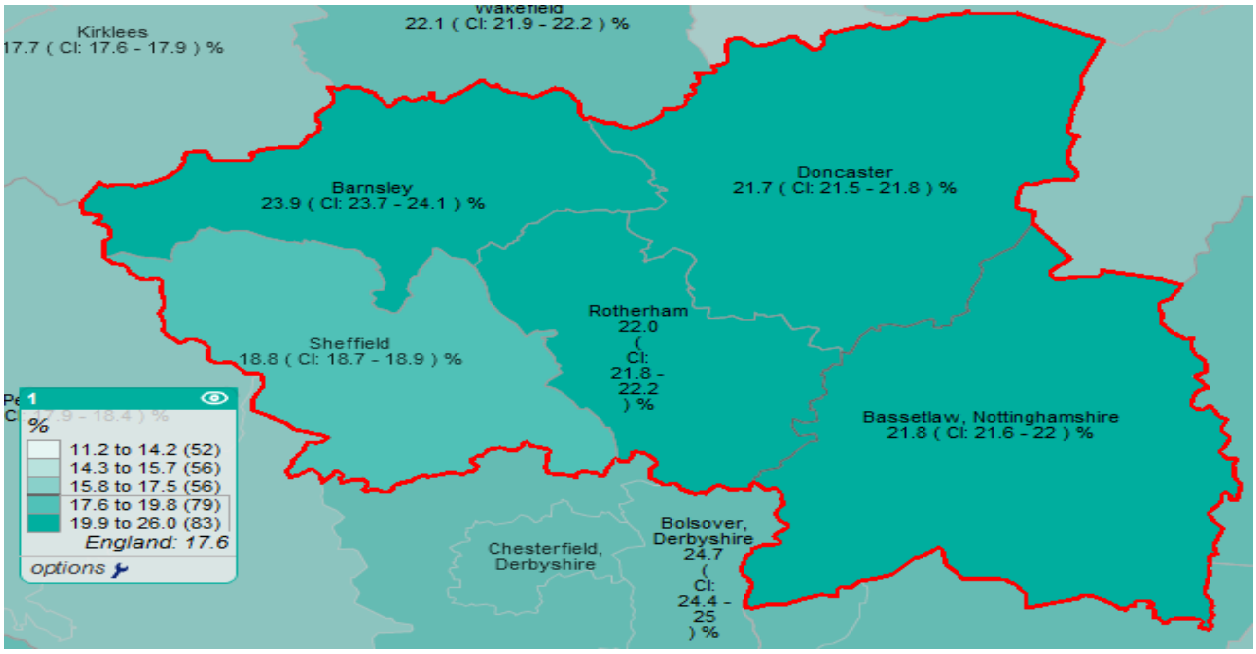
	SY&B	England	England worst	Summary Chart	England Best
Population aged 65+ years (%)	16.8	16.4	29.8		6.1

Registered Population 2012

SOUTH YORKSHIRE AND BASSETLAW PRIMARY CARE STRATEGY APPENDIX 1
DEMOGRAPHIC INFORMATION



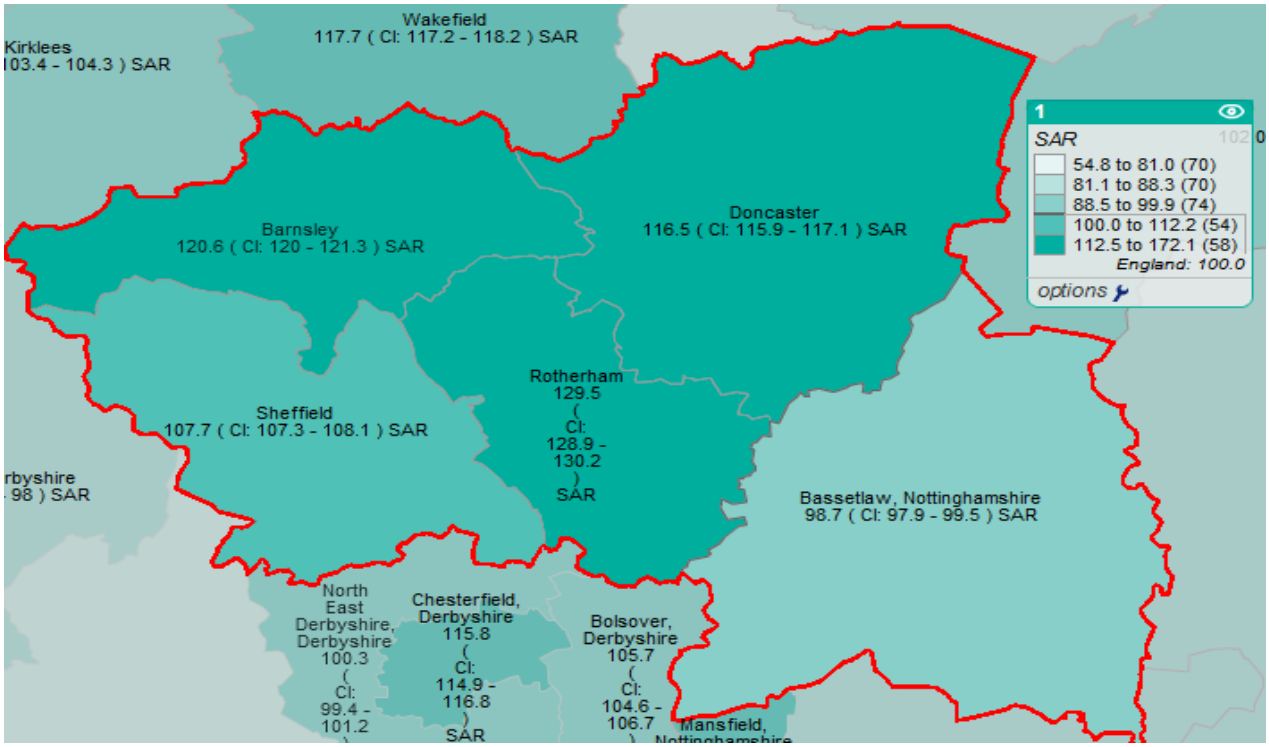
Limiting long term illness or disability (%)



	SY&B	England	England worst	Summary Chart	England Best
Limiting long term illness or disability (%)	21	17.6	26		11.2

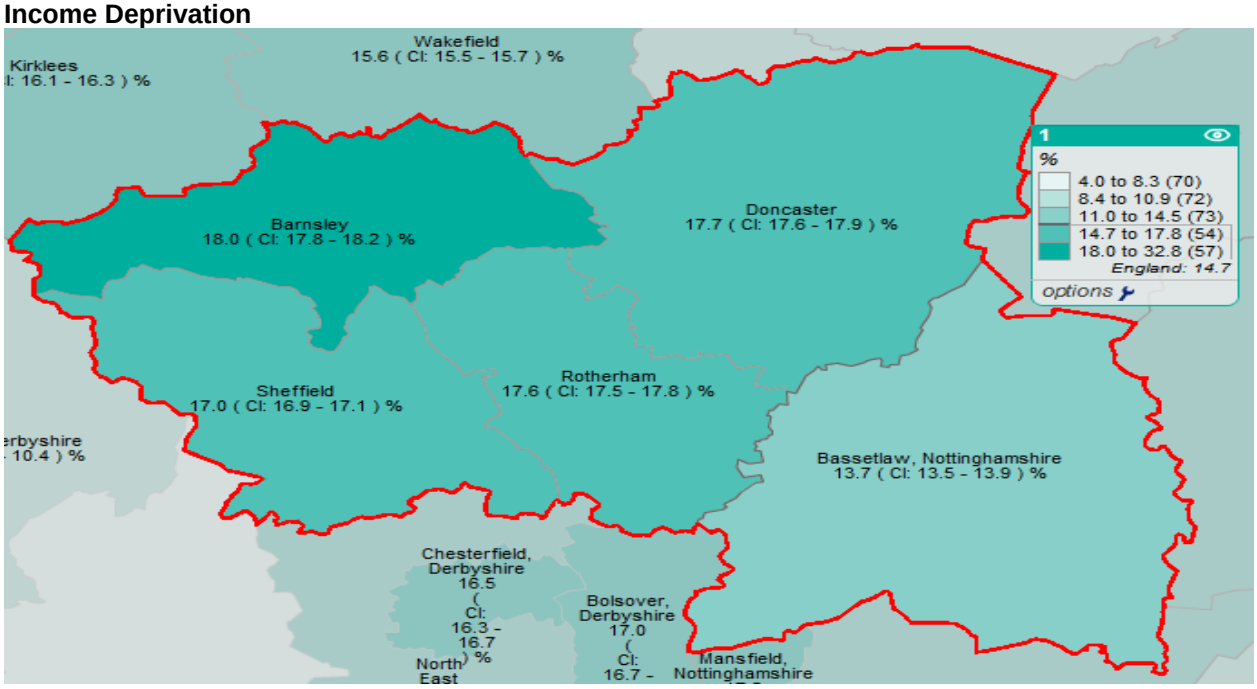
SOUTH YORKSHIRE AND BASSETLAW PRIMARY CARE STRATEGY APPENDIX 1 DEMOGRAPHIC INFORMATION

Emergency admissions



	SY&B	England	England worst	Summary Chart	England Best
Emergency hospital admissions for all causes (SAR)	114.7	100	172.1		54.8

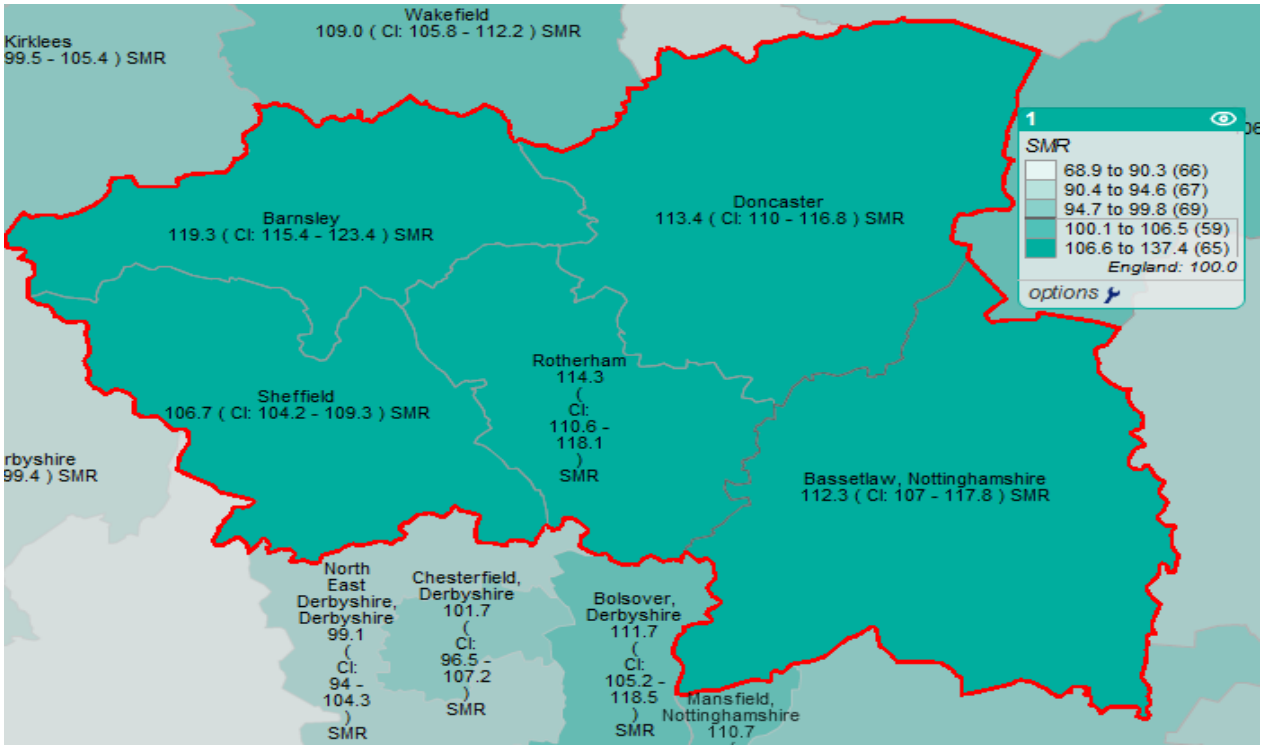
Income Deprivation



	SY&B	England	England worst	Summary Chart	England Best
Income Deprivation (%)	17.2	14.7	32.8		4

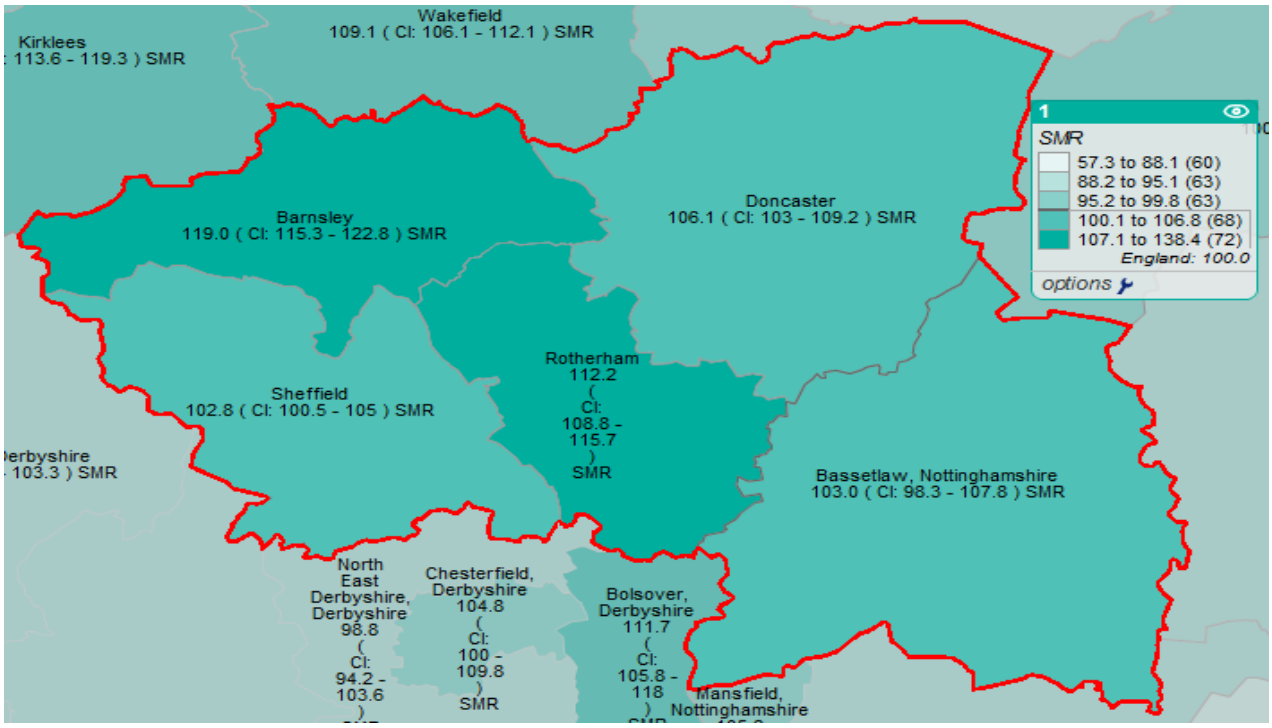
SOUTH YORKSHIRE AND BASSETLAW PRIMARY CARE STRATEGY APPENDIX 1 DEMOGRAPHIC INFORMATION

Deaths from Cancer, all ages



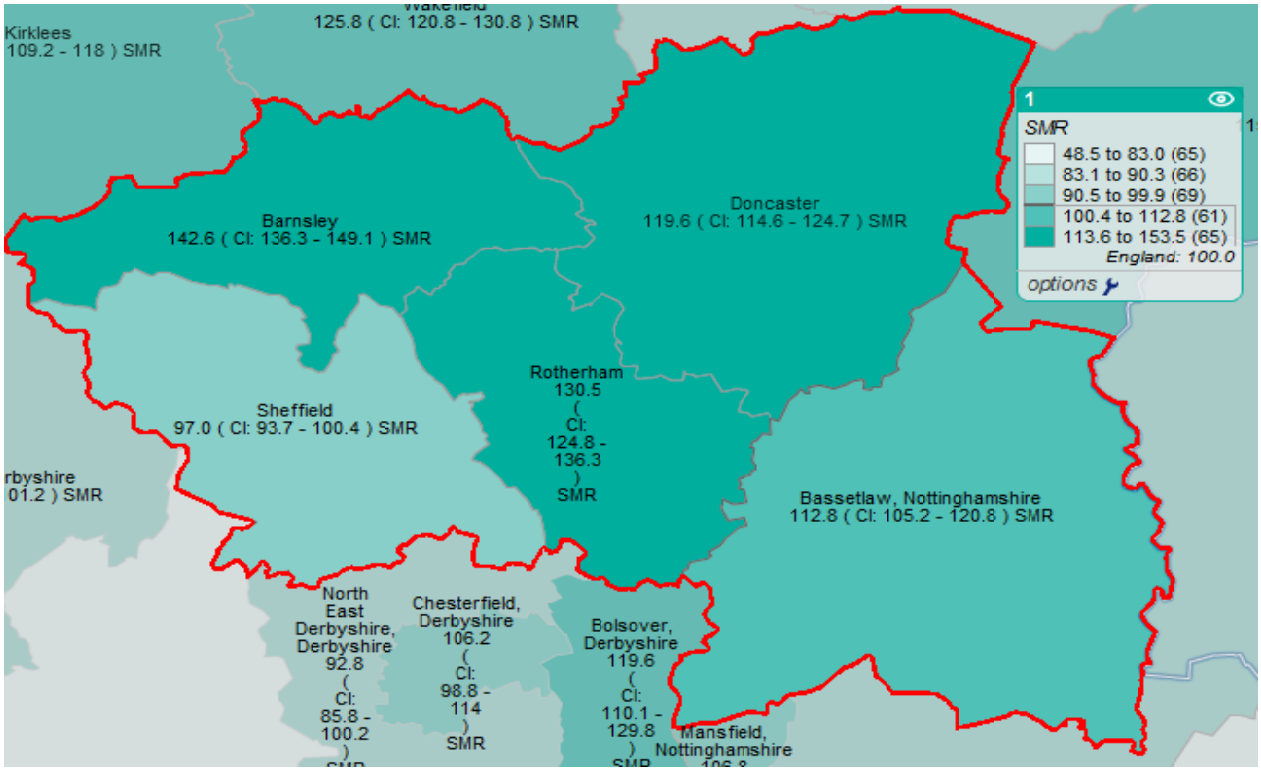
	SY&B	England	England worst	Summary Chart	England Best
Deaths from all cancer, all ages (SMR)	112	100	137.4		68.9

Deaths from Circulatory Disease, all ages



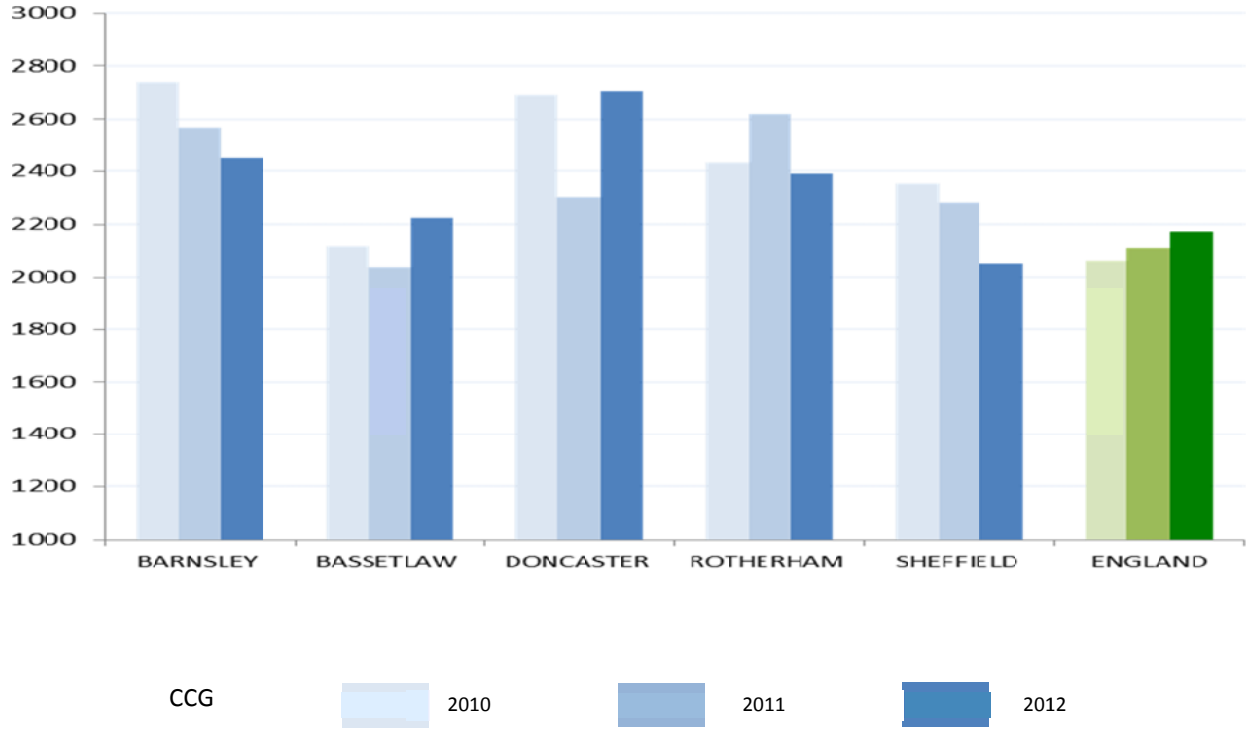
	SY&B	England	England worst	Summary Chart	England Best
Deaths from circulatory disease, all ages (SMR)	107.7	100	138.4		57.3

Deaths from Respiratory Disease, All Ages



	SY&B	England	England worst	Summary Chart	England Best
Deaths from respiratory diseases, all ages (SMR)	116	100	153.5		48.5

The graph below shows the directly standardised rate (DSR) for the potential years of life lost from causes considered amenable to healthcare (PYLL) per 100,000 CCG population. 2010, 2011 and 2012 data is presented for each CCG and for England as a whole. The directly age-standardised rate (DSR) is the rate of events that would occur in a standard population if that population were to experience the age-specific rates of the subject population.



SOUTH YORKSHIRE AND BASSETLAW PRIMARY CARE STRATEGY APPENDIX 2 STAKEHOLDER, PATIENT & PUBLIC ENGAGEMENT REPORT

In order to gather patient, public and professional views of Primary Care Services we have utilised existing data as well as sought out feedback from a range of individuals and groups across South Yorkshire and Bassetlaw. CCGs, Health and Wellbeing Boards and Local Professional Committees were consulted from the outset in order to understand how they would advise we engage with the local health and care community and as such there has not been a standardised approach taken across all CCG areas. Engagement activities were organised in collaboration with these groups. This engagement process is broken down by 3 stages of strategy development. The following table provides a summary of the groups consulted and the way in which we gathered feedback –

Patients, the Public and VCS (Voluntary and Community Sector)		Commissioners and Providers of Health and Care Services
STAGE 1 - Developing the Primary Care Vision - June-September 2013		
Practice Surveys - Two practices were randomly selected from each CCG area and there patient surveys and audits reviewed for common themes		LMC Strategic Liaison Committee
		LPC Strategic Liaison Committee
		LDC Strategic Liaison Committee
		LOC Strategic Liaison Committee
		Bassetlaw CCG Strategic Commissioning Lead
The GP Patient Survey 2012 – 13 – Key question response rates were compared across each CCG area in South Yorkshire and Bassetlaw alongside the England averages.		Sheffield H&WBB Strategic Development Meeting
		Sheffield CCG Clinical Exec Team
		Barnsley H&WBB
		Rotherham CCG Exec Management Team
		Rotherham H&WBB
The VOICES national bereavement survey to assess experiences of care in the last three months of life for adults who died in England between November 2010 and June 2011		Doncaster H&WBB Officers Group
		Doncaster H&WBB
		Strategic Clinical Lead & Commissioning Lead Doncaster CCG
		SY&B Area Team Staff Briefing - Workshops
		South Yorkshire Commissioners Group (SYCOM)
STAGE 2 - Primary Care Strategy Development - October 2013 to February 2014		
Health and Wellbeing Strategy consultation responses from each CCG area reviewed for relevant health/care themes		Sheffield PLT - Stall
		Sheffield CCG & SYB AT Commissioning Pathways meeting
		Sheffield H&WBB Time Out
Healthwatch Network Meeting		Sheffield CCG & SY&B AT Primary Care Quality meeting
		Sheffield CCG Governing Body
		Doncaster H&WBB Officers Group

Sheffield CCG General Public Meeting – Stall		Doncaster CCG Strategy Group
		Doncaster LMC-CCG Strategy group
		Doncaster Target Events x2 - Stall
Sheffield Healthwatch Public Open Day – Survey Circulated		Doncaster CCG Strategic Commissioning Group-
		Doncaster H&WBB
		Doncaster CCG Governing Body
The Yorkshire Cancer Network Cancer User Partnership group – Survey Circulated		Rotherham PLT workshop session – Workshop + Survey
		Rotherham CCG Governing Body
		Barnsley Membership Council – Workshop
North East Yorkshire and Humber Clinical Alliance – Survey Circulated		Barnsley Quality & Patient Safety Group
		Barnsley CCG Governing Body
		Bassetlaw PLT session – Stall
Bassetlaw Patient Engagement group –Survey circulated		Bassetlaw CCG Partnership Advisory Forum
		Bassetlaw CCG Governing Body
		Commissioner "Working Together" Workshop
Bassetlaw Healthwatch Coffee Morning – Stall		Provider Primary Care Workshop
		CCG-AT PC Strategy Steering Group – periodic meetings set up throughout the strategy development process.
		SY&B AT Senior Management Team
STAGE 3 – Feedback on Draft Primary Care Strategy – March 2014 – April 2014		
Mechanisms to be determined following CCG sign-off of the draft strategy		SY&B & 5 LMCs Co-hosted Workshop 27/02/14

Key

- Existing survey/consultation data
- Stall
- Workshop
- Survey
- Meeting

PLT – Protected Learning Time
CCG – Clinical Commissioning Group
LMC – Local Medical Committee
LOC – Local Optical Committee
LDC – Local Dental Committee
LPC - Local Pharmaceutical Committee
H&WBB – Health and Wellbeing Board
AT – Area Team
PC – Primary Care
SY&B – South Yorkshire and Bassetlaw

SOUTH YORKSHIRE AND BASSETLAW PRIMARY CARE STRATEGY APPENDIX 2 STAKEHOLDER, PATIENT & PUBLIC ENGAGEMENT REPORT

Patient, Public, Voluntary and Community Sector Feedback

Practice Surveys

Two practices were randomly selected from each CCG area and their patient surveys and audits reviewed for common themes. Please note this relates to a small sample particularly when the information is drawn from the comments section –

- Lack of satisfaction with phone access - Solutions included changes in shift patterns and an automated telephone system, additional switchboards/phone lines.
- Opening Times – While the majority were happy with the opening times suggestions of extending opening times included early/late appointments and weekends for those that work full time. However, for 1 of the surgeries 25% of responders weren't even aware there were extended hours.
- Booking Appointments - Responses were mixed but key issues were around getting appointments with a preferred GP and the timeframe to get an appointment being too long although this reduced when willing to see any doctor. On the day appointments do not fit in with those that work. For some the need to call back for appointment availability was an issue and there was support for online booking although it was noted that this does not necessarily include all available appointments. One practice referenced that online booking was not feasible as it can lead to the wrong type of appointment for the patient's needs and that it resulted in some patients making back up appointments. Another practice stated that GPs made their own follow up appointments or suggested patients do so at the reception desk before leaving the surgery. Telephone consultations were cited as good practice in managing waiting times. Some found patients were not aware of the types of appointment available.
- Length of appointment time – In Sheffield late running appointments were referenced as causing parking fines. For a specific practice 3 minute appointment schemes weren't seen as realistic and 10 minute same day appointments weren't known about and/or had not been made available to responders.
- Telephone consultations – Generally responses were positive for those using the service but for some there was still the preference for face to face appointments with the doctor. For one practice many hadn't used this service and of those that had some stated they found it difficult. The ring-back function was seen as problematic when working or needing a family member on the phone at the same time. The nurse triage service at one practice received good feedback as most patients received a call back within the next hour.
- Information – Many respondents felt they had the information needed to make decisions about treatment. In some practices there was reference to the lack of written information regarding management of health problems, how to make compliments and complaints, health check reminders feedback was generally positive. There was recognition from a couple of practices that there is greater opportunity for education around self-care and the development of care management plans.
- Accessibility – Issues were raised regarding parking, public transport and push chair access although this varies across practices.
- Staff – While the majority were positive about staff some comments referenced reception staff, nurses and doctors as lacking interpersonal skills. Some associated this with their lack of available time. Privacy issues, under-staffing and concerns around support staff deciding the type of appointment required when lacking the expertise were also highlighted.
- System issues – these were different in different surgeries but included the need to explain to the receptionist what the problem is, communication between the practice and the hospital, difficulties accessing services outside the surgery and a lack of awareness that they have some degree of choice as to where they are seen when referred.

The GP Patient Survey 2012 – 13

Key question response rates were compared across each CCG area in South Yorkshire and Bassetlaw alongside the England averages. The survey had a much larger sample size and so the results were considered in relation to the practice audits in order to give the information greater context.

- While England reports 22% of responders found calling not very easy or not at all easy, the lowest negative responses were found within Bassetlaw at 12% and the highest Sheffield at 25%.
- Between 12 and 18% of patients across the CCGs said that their surgery is not open at times convenient to them, and the majority of these patients went on to say that additional opening times needed to be on a Saturday or after 6.30pm.
- Between 1% and 5% of patients across the CCG areas currently book their appointments online; however, the percentage of people that would like to be able to do this ranged from 21% in Bassetlaw to 31% in Sheffield.
- The types of appointment people want appear to be very similarly proportioned to the type of appointments they get. Seeing a GP at the surgery is the most popular option followed by seeing a nurse at the surgery. Based on the individual practice surveys it may be that there is not sufficient information regarding options like telephone consultation and the type of issues that it would be most appropriate for.
- The preferred compared to the actual waiting time for those that got an appointment suggested –
    - Those wanting the same day were consistently higher in number than those getting the same day
    - The number of those wanting the next working day and getting an appointment the next working day were quite similar
    - Those getting an appointment a few days later were consistently higher than those wanting an appointment a few days later
    - Those getting an appointment a week or more later were consistently higher than those wanting an appointment a far week or more later
    - Around 15% didn't have a specific day in mind

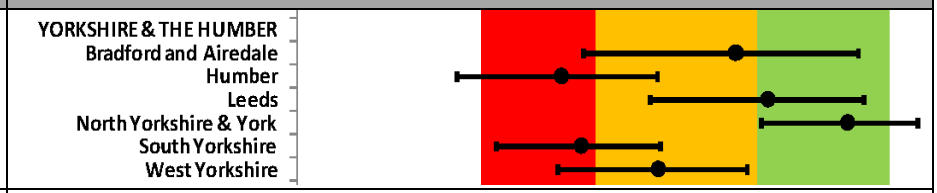
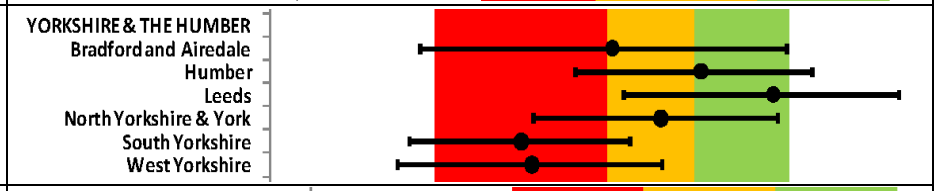
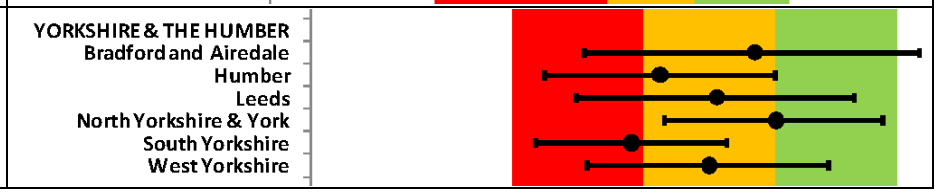
  This is relatively consistent with the practice level data although the practice surveys greater emphasis on waiting times being around 2 weeks.
- The proportion of responders finding the appointment not very convenient or not convenient at all ranged from 6-8%. In this situation the majority stated they would still utilise the surgery by taking the appointment offered, getting an appointment on a different day, having a consultation over the phone or contacting the surgery another time. These actions account for between 73.7% in Sheffield and 81.3% in Bassetlaw. Those that go to A&E or a walk-in centre range from 6% in Barnsley to 15% in Rotherham, those who chose not to see or speak to anyone came to between 8% in Bassetlaw and 14% in Doncaster and those who go to see a pharmacist range from 0% in Bassetlaw to 3% in 3 of the other CCGs.
- Those stating very good or fairly good for the overall experience of booking an appointment range from 72% in Sheffield to 81% in Bassetlaw. Those stating fairly or very poor range from 7% in Bassetlaw and 13% in Sheffield.
- A 5-15min wait was most common across all practices ranging from 54-59% of responders, then more than 15 minutes ranged from 20-29%. While the majority of people feel they don't normally have to wait too long there were still a relatively large number stating they have to wait a bit too long.
- Those with a medical condition were asked whether during the previous 6 months they had enough support from local services or organisations to help manage their long term condition. Those saying yes definitely or to some extent in relation to support from local services to manage their long term health conditions ranged from 65% in Rotherham to 71% in Bassetlaw. Those stating no ranged from 10% - 13%. 91%-93% of all responders stated they were either fairly or very confident about managing their own health.
- Between 87% and 89% of responders stating they found the receptionist very or fairly helpful

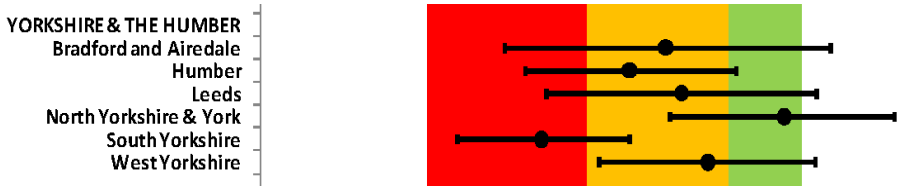
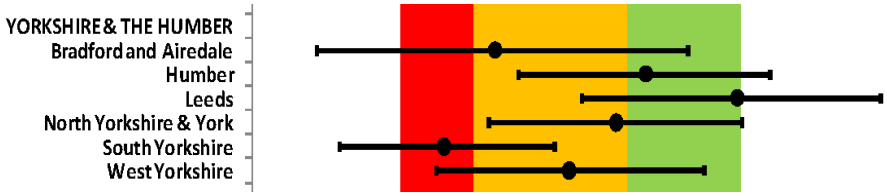
- GPs listening skills rated good or very good ranged from 87%-89%. Of those saying poor or very poor this ranges from 1%-4%. Explanation of tests and treatment ranged between 83% and 85% stating good or very good. Of those saying poor or very poor this ranges from 2%-4%. Ratings of GPs involving you in decisions ranged from 74% in Doncaster and 79% in Bassetlaw. Those stating poor or very poor ranged from 2% - 5%. With regards to GPs treating you with Care and concern, stating good or very good ranged from 83% to 86%. Those stating poor or very poor were between 2% and 5%. Confidence and trust in GP where responders stated yes or yes to some extent ranged from 93% to 95%. 3%-5% stated no, not at all.
- Nurse's listening skills rated good or very good ranged from 79% at Sheffield and 85% at Doncaster. Of those saying poor or very poor this ranges from 1%-2%. Explanation of tests and treatment ranged between 77% at Sheffield and 83% in Doncaster stating good or very good. Of those saying poor or very poor this was only 1%. Ratings of Nurse's involving you in decisions ranged from 67% in Sheffield and 74% in Doncaster. Those stating poor or very poor were only 1%. With regards to Nurse's treating you with care and concern, stating good or very good ranged from 78% in Sheffield to 84% in Doncaster. Those stating poor or very poor ranged from 1% -2 %. Confidence and trust in Nurses where responders stated yes or yes to some extent ranged from 85% to 90%. 1%-3% stated no, not at all.
- Between 23% and 26% of patients felt they could be overheard in the reception area and were not happy about it.
- Knowing how to contact out of hours GPs ranged from 57% in Rotherham - 63% in Doncaster. Between 11% in Barnsley and 17% in Doncaster have tried to contact the out of hours GP service within the last 6 months. Of those that had tried to call the service between 79% in Sheffield and 88% in Doncaster found it very or fairly easy. Between 19% in Doncaster and 31% in Sheffield said the care from the out of hours service took too long. Confidence and Trust in the out of hours clinicians scored between 77% in Barnsley and 86% in Doncaster when stating yes definitely or to some extent. Between 68% in Sheffield and 81% in Doncaster stated their overall experience was either very good or fairly good.

The VOICES national bereavement survey

This survey was intended to assess experiences of care in the last three months of life for adults who died in England between November 2010 and June 2011.

The following data notes the areas where South Yorkshire were one of the lowest scoring 20 per cent of PCT Clusters. Comparison with national figures suggests experiences of community care including GPs showing dignity and respect are in the bottom quintile.

	%	LCL	UCL	
D.3. Dignity & Respect shown Always: GPs	66.2	61.4	70.7	
D.4. Dignity & Respect shown Always: Care Home	52.3	44.7	59.7	
P.3: Patient had enough choice about	47.1	42.0	52.2	

where died by PCT Clusters				
S.5: Has respondent talked to anyone since patient's death by PCT Clusters	11.8	9.3	14.8	
Q.3. Overall quality of care Excellent: District & Community Nurses	38.5	33.0	44.3	
Q.5. Overall quality of care Excellent: Care Home	38.0	31.0	45.6	

Health and Wellbeing Strategy consultation responses

Each Health and Wellbeing Board provided access to the consultation feedback they gathered as part of their development of their local Health and Wellbeing Strategy. Some of the responses include health and social care professional feedback as well due to the way the consultation process was undertaken. Again much of this feedback is taken from individuals so while the summary consists of a range of feedback some are taken from one person's viewpoint.

Independence/ Lifestyle/ Prevention/ Early Intervention –

- Generally people were supportive of individuals having greater responsibility for their own health, enabling independence and co-production of care although there were some caveats.
- Need direct, clear advice, information, signposting and support in order to promote informed decision making, increase awareness of good health and prevention, recognition of individual responsibility for own health in partnership with services, offer support groups and raise awareness of what is available through universal services.
- Children need support to achieve rather than maintain independence.
- Prevention to target higher risk populations e.g. smoking cessation for those with mental health problems.
- Recognition of the role played by community pharmacy in prevention and early intervention
- Suggestion that people may lack self awareness around lifestyle behaviours, so although they may know what services are available they do not realise they need to use it.
- Suggest consideration was needed as to how we are going to shift resources and how we measure the impact.
- Training staff so they know all the services that are available to patients.

- In relation to independence some comments focused on the fact that not everyone can be independent and that some would seek to be "inter-dependent" on each other, to not consider someone dependent when they still need some help, the focus should be on supporting or enabling independence.
- Focus tends to be on older people, there needs to be consideration given to all age groups. It was suggested that to increase independence we need to understand the barriers to it and promote a culture change.
- Stated the need for self-management toolkits
- Concerns regarding the increased burden on carers, the potential to compound social isolation issues particularly for the vulnerable elderly, that some may not be capable of managing their own health, that it could be perceived as a tactic to cut services, that it should be about ownership of your own health rather than making people feel responsible and judged for being unwell, that resources and other barriers may prevent people managing their own health.

Quality

- Supporting the populations health and care needs requires collective action, including from the public.
- Value for money within the choices offered
- Where projects work they need to be continued despite the financial climate.
- We need to learn from and build on research based good practice as well as a proactive approach to innovation.
- Need to consider how we measure quality of care.
- Specific focus on areas like improving quality of life for those with long term conditions, early intervention, taking account of people's concerns and anxieties, service accessibility, person centred, being treated with dignity and respect, support for families and carers, getting the right kind of care and treatment for you and your family.
- It was queried whether standards for GP practices and other services would be published for the public and that clear benchmarks for people's experiences need to be established.

Equality/ Fairness

- Equality gaps referenced within the borough, the greatest health inequalities and inequalities against the national average.
- Suggestion that services should be targeted to need and another highlighting that fair provision does not mean everyone is treated equally.
- One comment highlighted the independence focus tends to be on older people and that there needs to be consideration given to all age groups.
- One area broke down responses by particular equality groups –
    - People with disabilities – felt spoken down to by health professionals, felt self-conscious waiting at 'drop in' clinics meaning they need to wait for regular appointments, lack of awareness of what services are available to them.
    - Older People – Can be more flexible on appointment times, large proportion always want to see preferred doctor although in practice this is rare. Some responders stated that they never receive an annual review of their medication, and so a lot of waste is created, because once prescribed, it cannot be recycled and they get some medication they don't need anymore.
    - LGBT – They felt they were victims of health inequalities, due to the way they feel persecuted in society, leading to more of them having problems with addictions, especially drugs and alcohol, leading to health problems. They were also concerned that their sexual health needs are not always dealt within the most professional manner.
    - BME responses - Better training for staff in cultural differences so individual needs can be met. Language is always a barrier – lack of support to understand people where English is not their first language. This community would like better advice and guidance as they

often find what is available confusing and hard to understand, because there is still lots of abbreviations and jargon in literature.

- Deaf People responses - Findings tend to focus around the issue of communication and negative experiences with services and front- line staff lacking in deaf awareness and a frustration that things are not improving. The findings point to communications being a recurring issue especially where a service user's language is other than written English. Concerns revolved around access to medical appointments and not being able to access a sign language interpreter. The lack of information in accessible formats e.g. British Sign Language and Braille was common throughout.

Integration

- Support for integration which should include the third sector, should not be at the expense of specialisms, should result in a joined up pathway between hospital and the community and noted the need for data sharing, communication and that GPs can refer and signpost patients.
- It was highlighted that health and social care don't share a common language as well as different systems, funding priorities and work cultures. This makes it very difficult for professionals to work together without having the basics in place.

Condition/pathway specific priorities

- Specific reference was given to dementia, dental health, mental health, carers, obesity, teenage pregnancy, end of life care, children with SEND, eating disorders, sexual health, domestic abuse and improving the wellbeing of people with sensory impairment. Mental health was the most dominant element of health care referenced.

Accessing Healthcare

- Access to services was a consistently raised issue including opening hours and waiting times for GP appointments, and access to secondary care specialist services.
- One area performing a survey found many people hadn't heard of 111 and some thought it had ceased as it was considered unworkable.

Meetings, stalls and surveys

- Patient centred care with particular reference to holistic care (Medical Vs Social Model). Suggestion that pills are thrown at patients to treat symptoms rather than investigating and addressing the actual problems or why there care had needed to be escalated. Should look at a person's health on a longitudinal basis from birth to death rather than just condition/pathway specific.
- Inequalities between services and areas particularly in relation to levels of deprivation. One individual noted that the added complexity of disability means people are less likely to be able to be cared for close to home even when it is not clinically necessary.
- Concerns raised regarding the incremental privatisation of services and that the focus will be more on the bottom line rather than patient care.
- Query regarding the geographical coverage of CCGs and how that number of practices within the area can be fully supported.
- Perception that the attitude is you will get what your given (Healthcare professional perspective on this predominantly that care should be based on what patients need, not what they want).
- Assessments yielding different results when done by different professionals – lack of consistency attributed to lack of time given to assess a person as a whole.
- Isolation and the need for community support key area of concern although lack of funding to this sector.
- Need to work with Local Authorities.

- The term 'Ageing Population' makes it sound like it is the fault of older people that we are facing these challenges to the health service.
- Issues with access – opening hours, making appointments, particularly when you are unable to book in advance, waiting times. One individual stated they are re-directed to A&E or walk in centres when requesting emergency appointment. Difficulty getting onward referral. Want improved access with more convenient times, shorter waiting times and different ways of booking e.g. electronically. One suggestion was that once a patient did not attend their appointments 3 times that there were restriction put on how far in advance they could book appointments rather than penalising everyone by not allowing advanced booking. Some support for separate approaches to access depending on whether the patient is requiring care for acute or chronic/long term conditions in general practice.
- Staff attitudes – The public aren't robots, some receptionist behaviour referenced. Want to be listened to, respected, treated like human beings.
- Cost of prescriptions, dental and ophthalmology services. Need to be more affordable (other primary care services also referenced as expensive)
- Strategic planning seems like tokenism and people aren't kept in the loop regarding major decisions
- Lack of networking between providers leading to duplication of effort and mixed messages. Need joined up coordinated approach particularly ensuring improved, secure information sharing of patient records through IT records and/or patient held records. Suggestion for central coordination at the point of delivery and the need to develop robust inter-organisational policies that have the confidence to fully address data sharing arrangements.
- Want consistency in the doctor/nurse you see.
- Access to telephone advice, annual check-ups, practices having facility to deliver minor/routine surgical practices.
- People inappropriately accessing services, we need to be telling them this.
- Encouraging self-management through advice, providing exercises, screening, preventative activities/education particularly in schools, PR/Marketing, leaflets, posters. Highlighted that this isn't appropriate for everyone, that this needs to take account of the impact on carers and that information/guidance materials can be extremely costly.
- Personal health records held by patients and updated with each appointment
- One patient group proposed all patients have a care plan or contract of care incorporating approaches to healthy living
- Responses regarding the use of technology to improve outcomes included text messaging, use of Internet, intranet in work places, email, online booking/enquiries, live help, interaction, skype, and social media. Further comments referred to the benefits of electronic info in increasing text size for the partially sighted, the reduction in time/cost demands compared to printed correspondence and convenience for those that work. However, noted that electronic methods are not appropriate for everyone and aren't overly reliable when it is dependent on how frequently people check their emails.
- It was suggested that the relationships between GPs and the voluntary and community sector (VCS) needs to be strengthened, noting that this will require development of VCS services as well as increasing GP awareness of the services available and how to access them in order to signpost patients.
- One individual posited that GPs have a negative attitude towards advocates.
- 2 individuals noted their lack of trust in out of hours services.
- Access to primary and secondary dentistry raised. It was suggested there should be better preventative care for those that are disabled.
- The cost of people who do not attend appointments and the impact on demand.
- Suggestion by a few responders that public engagement can be strengthened.
- Repeat prescriptions were referenced by a few individuals around pharmacies not having their prescriptions in stock leading to multiple visits and that people should be able to pick up their prescriptions at their usual surgery.

- Improved community based support for those with long term conditions. Incorporates the roll out of personal health budgets.
- Suggestion that management tiers leads to inefficiencies.
- One individual queried whether in encouraging better use of pharmacy we would be ensuring they are physically accessible, including the consulting room and whether they would offer home visits?

Key themes

- Booking appointments and access to general practice – These issues are cited through every approach utilised to gathering views. Solutions and good practice seem to be around offering the right options for how appointments can be booked, the type of appointment available and what other services could address the patient's health needs. There also needs to be improved awareness of these options. Currently there appears to be much variability around what is offered and/or what people are aware is on offer.
- Prevention, independence and support for co-production of care – Feedback suggested support for this principle but that more could be done within primary care to facilitate.
- Inappropriate access – some responders noted that people were inappropriately accessing primary care but also noted that this could be due to social isolation, which lacks public service support/investment.
- Quality – the general focus seems to be around how quality is measured and reported, that practices should be evidence based and that they should be value for money, although there was some suggestion of organisations putting finances before the needs of the patient. It was also suggested that care needs to be holistic, looking towards a social model of care.
- Equality and inconsistency – Focus was around variability between professionals, within boroughs, compared to other CCGs, specific forms of health inequalities and compared to the national averages.
- Integration and collaboration – Much of the feedback highlighted the need for care sectors, services and professionals to work together, noting the need for joined up care, communication and information sharing.
- Perception of staff – this was variable and while the VOICES survey suggests 33.8% of responders didn't feel the GP treated those at the end of life with dignity and respect and many of the individual comments raised issues, the GP survey seems far more positive.
- Out of hours services – The GP Survey and comments received suggests there are issues around awareness of how to access these services and that confidence and trust is lower than for practice based GPs.
- Choice – GP survey feedback and comments received suggest for some patients where they have trust in a particular service or professional they are willing to go further distances or wait longer, although this appears to be dependent on the circumstances. Equally in the case of one individual their lack of faith in the out of hours doctor's assessment meant they went to A&E.

Health and Care Professionals feedback

- Feedback received has explored what patient preference and responsibility –
  - Some suggested that we need to start providing care when and where the patient wants it but the majority of professional responses taken highlighted the need for education, signposting and people taking responsibility for their own care. Taking responsibility was referenced in relation to prevention, self management and accessing the right type of service.
  - It was queried by one responder how much of a consumerist approach we could take with the Primary Care strategy in light of the existing constraints e.g. resources, contractual.
  - A workshop discussion explored the view that there is an assumption from patients that all Primary Care professionals are competent and therefore patient judgement of them is based on more superficial elements like communication. It was suggested that people go to the GP with expectations of what they want and they are dissatisfied if they don't get it. It was hypothetically posed whether in situations where patient needs differ from patient wishes should the GP be focused on getting good patient feedback by giving them what they want or focusing on how to address the patient health needs? People get to know GPs and who will give them what they want this incentivises giving patients what they want. Equally while giving choice is cited as good practice it is not necessarily improving outcomes and professionals have a clinical responsibility.
- It was suggested by some GP respondents that the increasing dissatisfaction of patients with access to services is due to their increasing expectations of what should be provided.
- As the general practice is free at the point of use it was suggested that it is often not valued by patients, an example was provided where requesting a refundable deposit for family vaccinations prevented further non-attendances.
- With regards to the role of pharmacies and the opportunity for extending their remit in patient care views were varied. Some felt it was inappropriate others felt there were opportunities there and that we need to find the right balance with the wider health and care system.
- Some comments referenced the need to ensure services are equipped to deal with language, cultural and social issues that face changing and diverse populations.
- Several respondents highlighted the need to acknowledge the long standing health inequalities and funding inequalities that exist and to reduce such inequalities without destabilising services.
- In relation to signposting feedback focused on the role of pharmacies, A&E, issues with 111 not effectively implementing protocols, opportunities for the initial point of contact to be a triage arrangement so patients go to the right type of service and getting the right type of appointment first time. Suggestion that people should be told then and there when they have gone to the wrong service for their needs.
- Many responders referenced communication as an issue across professions and organisations, highlighting the need to be supported by an integrated IT and Information Strategy. It was suggested that other Primary Care professionals should have access to nhs.net accounts as a further line of communication with General Practice. There was an emphasis on the lack of effective information sharing between community and secondary care. It was suggested that developments in Primary Care should facilitate the delivery of integrated care.
- Issues around access to services were predominantly from the public. Provider responses when referencing this focused more on the benefits of having different ways to arrange appointments and different types of appointments although these were not always effectively utilised.
- Some provider responses highlighted that patient pathways were hampered by contractual mechanisms, funding flows and arbitrary referral processes that are not in patient's best interests. It was suggested there was an 'uneven playing field' due to the different types of contract in place which contributes to inequalities. It was noted that this may be improved by

increased standardisation across practices and intimated that the lack of consistency between services creates complexity and risk. In order to increase the uniformity in pathways particular reference was given to the utilisation of Locally Enhanced Services (LES) to facilitate this and CCGs having designated responsibility for Directed Enhanced Services (DES). Other contributors to the consultation have suggested that practices need to be responsive to the needs of their population, noting that one size doesn't fit all. One GP stated that in order to be responsive to patient needs you need to understand the population and up-scaling practices may mean this is lost.

- One responder highlighted the benefits of professionals taking personal responsibility and accountability for patient outcomes, citing the American system as an example where patients choose their GP.
- It was suggested that quality measures need to be transparent, fair, be made publicly available and that this data can be utilised to produce comparative reports which motivate change and improvement. It was suggestion by one group of professionals that CCGs should have greater control over what is included within QOF.
- One responder noted the need to achieve critical mass for services and functions to ensure the best use of the resources available.
- With regards to workload, workforce, expertise and skill concerns were raised around the recruitment and retention of GPs and Practice Nurses although the scale of these concerns differs across areas. Frontline professionals emphasised the significant workload pressures, especially Practice Nurses and GPs. Some responders felt this resulted in a 'fire-fighting' approach to their role rather than planning and working towards an aspirational model of care. One responder stated that some General Practice staff are unable to access NHS training even when they offer to pay for it making it harder to access training and potentially resulting in variability in staff skill/knowledge base. Some respondents stated they were in favour of joint training and learning events with other professions, particularly between GPs and pharmacists. It was suggested that minimum professional standards thresholds should be increased and that professionals should have to evidence annual improvement in standards. In light of the increasing demand on services it was queried what General Practices were doing to compensate for this and/or what elements of their role they were needing to drop?
- Investment and the need to ensure value for money in light of finite resources was a consistent theme with particular concerns around the funding of 7 day services and meeting the requirements of the NHS constitution. It was suggested there needs to be greater flex in the system to ensure resources go to where they are most needed and that resources should be moved from secondary to primary care.
- It was highlighted by many respondents that we need to join up the strategic direction of primary care between NHS England, the CCGs and Health and Wellbeing Boards. It was noted that this requires a joined up approach and the need to engage Primary Care into the wider system. Some references were made to CCG strategic intentions where they request NHS England's commitment so that the services they commission are also incorporated within plans. One CCG suggested there were opportunities for a jointly agreed approach to locally commissioned services where planned developments incorporate services commissioned by NHS England. An extension of this was to suggest that some of NHS England's responsibilities and budgets could be included within CCG integrated commissioning arrangement, so that the CCGs can commission integrated care that includes primary care services or that there may be an opportunity for pooled budgets around specific pathways.
- With regards to areas of joint interest/responsibility it was suggested we explore how to work seamlessly across organisations, particular reference was made to areas such as primary care premises, workforce development (workforce plans as well as training and development) and maximising the use of modern technology.
- It was noted that there needs to be more supportive, positive relationships with all Primary Care contractor groups and commissioners with specific reference to them knowing where to

go when things go wrong. Rotherham GPs in particular highlighted that NHS England does not currently effectively engage with them.

- It was highlighted that the Primary Care Strategy needs to be underpinned by robust intelligence.
- One responder emphasised the need to link the contract with the strategy to reinforce the areas where our hands are tied and not to raise expectations as to what we can realistically do to change things.
- Premises as a strategic enabler were referenced noting Practices can be limited in what they can take on due to the premises in which they work as well as the workforce limitations.
- Some GPs noted low morale amongst GPs and the potential that this will result in disengagement and/or reduction in the hours they work as their responsibilities increase. Some stated the constant changes are part of the problem and that expectations of what can be provided are unrealistic. It was posited that the continuing top-down changes are due to political groups wanting to make their mark and that this needs to cease if we are to get on with improving the NHS.
- It was suggested by one responder that a “responding to market testing strategy” should be developed which offers business planning and support to mitigate against potential risk of providers investing substantially only to have the service commissioned for a short period and then it folds. It was emphasised that solutions and service developments need to promote sustainability.
- It was proposed by a range of individuals and groups that practices may benefit from the clustering of GPs in order to share expertise, bulk purchasing, developing separate approaches to chronic condition management and the rapid reaction side of service, that a central booking system could be established, that federations of GPs could be instituted (potentially linking these with pharmacies), that CCGs could have a greater role in commissioning Primary Care and that patients should have access to any GP practices they choose.
- In Rotherham a vote of the greatest barriers and enablers to Primary Care were –
    - Barriers – Capacity (26.73%), leadership (21.78%) and the contract (22.77%)
    - Enablers – Contract (24.44%) and leadership (22.22%)

Memorandum of Understanding between NHS England South Yorkshire and Bassetlaw Area Team (SY&B AT) and The CCG; Improving Quality in Primary Medical Services

INTRODUCTION

High quality primary care is integral to the success of the local healthcare system. Within the new commissioning arrangements, it is imperative that roles and responsibilities of the respective commissioners are clearly understood in order for it to be achieved. The DH publication "Functions of Clinical Commissioning Groups" (June 2012) makes the statement below;

The NHS CB will have statutory responsibility for commissioning primary care services, but CCGs will have a statutory duty to assist and support the NHS CB in securing continuous improvement in the quality of primary medical services.

This Memorandum of Understanding (MoU) sets out the framework for the working relationship between South Yorkshire and Bassetlaw Area Team (SY&B AT) and The CCG, with regard to improving quality in general practice, on an ongoing basis. The framework set out in this MoU takes account of the distinct and unique relationship between the two organisations, and details ways in which SY&B AT and The CCG will work together and alongside one another in delivering their respective functions. The MoU is intended to communicate clearly and unambiguously that SY&B AT and The CCG will work together where relevant and appropriate to do so.
Although this MOU is concerned primarily with general practice, the other primary care contractor groups are equally as important and ways of working with dentist, optometrists and pharmacists will be developed as part of the wider primary care strategy, which will be co-produced by the CCG and the Area Team.

Principles of cooperation

SY&B AT and The CCG have agreed that their working relationship will be characterised by the following principles:

(i) the need to make decisions which promote patient safety and high quality health care;

(ii) the need to provide services that focus on the needs and experiences of people who use those services and maintain public confidence;

(iii) respect for each organisation's independence,

(iv) openness and transparency between the two organisations as to when cooperation is and is not considered necessary or appropriate; and

(v) the need to use resources efficiently, effectively and economically.

SY&B AT and The CCG will work in an open and transparent fashion, acknowledge each other's respective responsibilities, and will take these into account when working together.

Information sharing

Where it is necessary to share patient identifiable data, SY&B AT and The CCG will ensure that such data is shared and processed in accordance with the requirements of the Data Protection Act 1998.

SY&B AT and The CCG will apply adequate and appropriate security measures to confidential information that they receive in accordance with "Confidentiality NHS Code of Practice" (2003) requirements Additionally, the two organisations will share information sensitively in accordance with the need to maintain organisational integrity; for The CCG as a member organisation with a duty to serve its members, and for SY&B AT as part of a national body with national operating procedures.

SY&B AT and The CCG recognise each organisation's responsibilities under the Freedom of Information Act 2000. If either organisation receives a "Freedom of Information" request for information that it obtained from the other organisation, they will consult the other organisation prior to making a decision on disclosure.

In relation to "press and publications" where activity will have a direct impact for one another, SY&B AT and The CCG will seek to ensure that they involve each other in the development of planned announcements, including sharing drafts of their proposals and publications as early as possible:

(i) drafts of any planned publications with specific implications for either organisation approximately 72 hours before they are released to the media wherever this is possible; and

(ii) drafts of any press releases with specific implications for either organisation approximately 24 hours before they are released to the media wherever this is possible.

SY&B AT and The CCG will respect the confidentiality of any documents shared in advance of publication and will not act in any way that would cause the content of those documents to be made public ahead of the planned publication date.

Communication

As the direct commissioners of primary care contractors, the Area Team will be communicating with practices on a regular basis, regarding several issues (contractual, performance, developmental, for information only, etc). As a minimum, when planning a blanket communication on any issue to practices, the Area Team will provide a "heads-up" to the named CCG contact (see Key Contacts table), in advance of sending to practices, so that any implications for the CCG or CCG-commissioned services can be understood and planned for. The Area Team will also provide this to the LMCs, to make them aware and prepared for any practice feedback they may directly receive as a result of the communication.

Working together to achieve quality improvement

The Area team will not only be concerned with the contract compliance of poorly performing practices, but will also be involved in ensuring unwarranted variation is reducing and quality is improving, as it is with safeguarding patient safety etc. As such, the model described here is one which embraces open, collaborative and engaging relationships between practices, CCG and the AT.

What this means is that practices will contribute, with the CCG leads and the AT, to work out together, drawing from factual intelligence and other sources of internal and external information, what a practice quality improvement plan will include, what the development needs may be and how practices can be best supported to make those improvements. This could include programme objectives, interventions, sharing best practice, milestones, supporting information/evidence, funding estimates (if appropriate), cost-sharing arrangements and actions to be taken if progress exceeds or falls short of expectations at specified review points.

It is not for the Area Team to determine how the CCG leads should discharge their quality improvement activity with their practices as they will ultimately be measured on their clinical

outcomes, but the AT will need to oversee progress in order to discharge its own responsibilities as contract manager.

Managing poor performance

Recognising that data alone is not indication of poor service provision, the AT primary care managers will use a collection of information including national data (clinical indicators, quality outcome standards, appraisals, complaints etc) and local intelligence (including conferring with stakeholders) in order to assess and mitigate any potential risk to service provision and patient safety within a practice. They will take the necessary steps to assure themselves that adequate and effective support is being provided to reduce the risk, identify areas for improvement and be able to demonstrate and measure that improvement.

In conducting investigations into individual performer concerns, the AT representative will ensure that where there is a potential risk posed to any CCG-commissioned services, the practitioner involved will be mandated to inform the CCG of the investigation, so that the necessary conversations can take place between all parties in order to protect patient safety and make arrangements to sustain business continuity.

In addition, where the AT representative has concerns relating to gaps in a contractor's general service delivery of the contract, he/she will also prompt the contractor to review their compliance with other commissioners' service specifications, and inform the relevant commissioner of any relevant issues.

Practical Mechanisms of Working together

To implement the above, NHS England South Yorkshire and Bassetlaw Area Team will:

- Provide the The CCG with information as to what is routinely collected under core GMS & PMS contractual arrangements from practices.
- Provide an AT primary care locality manager to meet with the CCG as and when required (this could be a regular monthly meeting if CCG request it), to discuss and share information relating to practice contracts, performance and development; and as a minimum, hold a wider meeting with the CCG twice a year to consider the information available from:
    - the National Assurance Management Framework for Primary Care,
    - Contract performance data & annual practice declaration
    - CQC inspections, if applicable
    - Incident and complaints records
    - Outcomes of any (closed) performer investigations which are in the public domain
    - Implications of ongoing investigations where this is legitimate (see above section on Managing Poor Performance)

  and triangulate these with any additional intelligence held by either party, for discussion; agree with the CCG any required actions and how to take them forward as co-commissioners of the primary and community care system; and co-produce practice improvement plans as described above
- If requested by the CCG, and on an individual practice needs basis, support/participate in the CCG's practice visit, to an extent which is mutually agreed upon by the CCG and NHS England personnel
- Work closely with the CCG on interpretation and implementation of Direct Enhanced Services, and liaise on the CCG's design and commissioning of Local Improvement Schemes, to ensure best fit within the local health system

- Define an offer to CCGs, in terms of SY&B AT's involvement in locally protected learning time sessions run by the CCG for GP practices.
- Work closely with the CCG on the co-production of the SY&B Primary Care Strategy, to ensure coherence with the CCG's strategic commissioning intentions regarding community-based services
- Work with the CCG to agree a plan for workforce training and development, with clearly defined roles and responsibilities for each organisation in taking it forward
- Share learning from other CCGs in South Yorkshire and Bassetlaw with regard to the commissioning of primary care services, and facilitate the pooling of ideas and innovations.
- Maintain regular dialogue with the CCG on quality and performance issues as appropriate, on an ongoing basis, built around the following approach
    - Upon being made aware of issues regarding performance in a particular practice, from whichever quarter (CQC, CCG, practitioner, provider, etc), contact the CCG MOU manager (see Key Contacts below) to make them aware, where this is legitimate and appropriate
    - Monitor individual contractors and performance of providers and carry out investigations, at any time in response to concerns
    - Take action if it is found that a service isn't meeting the standards, using the available regulatory and contractual powers

The CCG will:

- Meet with the SY&B AT twice a year to consider the information available from:
    - the National Assurance Management Framework for Primary Care,
    - Contract performance data & annual practice declaration
    - CQC inspections, if applicable
    - Incident and complaints records
    - Outcomes of any (closed) performer investigations which are in the public domain
    - Implications of ongoing investigations where this is legitimate (see above section on Managing Poor Performance)

  and triangulate these with any additional intelligence held by either party, for discussion; agree with SY&B AT any required actions and how to take them forward as co-commissioners of the primary and community care system; and co-produce practice improvement plans as described above
- Work closely with SY&B AT on interpretation and implementation of Direct Enhanced Services, and liaise as required with the AT regarding the CCG's design and commissioning of Local Improvement Schemes, to ensure best fit within the local health system
- Share with SY&B AT the CCG's strategic commissioning intentions relating to community-based services which have an interface with primary care, ensuring they are taken account of in the Area Team's primary care strategy
- Work with SY&B AT to agree a plan for workforce training and development, and clearly define roles and responsibilities for each organisation in taking it forward
- Actively engage in discussions regarding primary care through input into the Local Professional Networks
- Keep SY&B AT fully informed about developments in their services, approach and methodologies in which they share a mutual operational interest
- Maintain regular dialogue with SY&B AT on quality issues as appropriate, on an ongoing basis and notify the SY&B AT (via key contacts list, see below) where the CCG perceives there to be performance issues or has concerns (about relevant incidents and complaints) with a practice, for further discussion and mutually agreed action plan.

Resolution of disagreement

Any disagreement between SY&B AT and The CCG will normally be resolved at working level. If this is not possible, it will be brought to the attention of the MoU managers identified in key contacts who may then refer it upwards through those responsible, up to and including the Chief Executives of the two organisations who will then jointly be responsible for ensuring a mutually satisfactory resolution.

Duration and review of this MoU

This MoU will be effective for at least a twelve month period commencing from the date on which it was signed by the two organisations. Its operation shall be reviewed at the end of the first twelve months in order to inform any changes necessary going forward.

Day-to-day business will be managed outside regular meetings. Both organisations have identified staff responsible for the management of this MoU as set out in the key contacts list below, who will liaise as required to ensure this MoU is kept up to date and to identify any emerging issues in the working relationship between the two organisations.

SY&B AT and The CCG are committed to exploring ways to develop more effective and efficient partnership working to promote quality and safety within their respective remits.

The named contacts with responsibility for each area of cooperation identified below will liaise as required to carry out day-to-day business.

Key Contacts:

SY&B Area Team:		
MoU Manager		
Responsible Officer		
Quality Lead		
Primary liaison		
The CCG		
MoU Manager		
Lead Clinician		
Primary liaison		

Date of sign-off: 3 September 2013

Date of review: 3 September 2014