GP Five Year Forward View (GPFV) Submission and Primary Care Work Plan Update

Primary Care Commissioning Committee meeting

C

4 January 2017

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Is your report for Approval / Consideration / Noting

Noting

Are there any Resource Implications (including Financial, Staffing etc)?

GPFV requires resources both CCG and primary care infrastructure to deliver the GP transformation agenda over the next five years. NHS England (NHSE) are currently recruiting to a transformation team, as yet it is not clear how this will support the CCGs work programme.

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?
All of the CCG objectives feature throughout the elements of the delivery of the GPFV.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached?
Not currently but this will be required as the delivery plan is starting to be implemented.

PPE Activity

There is a section of engagement within the GPFV implementation. Patients and the public will play a huge part in the delivery of the transformation agenda of general practice. The CCG's Primary Care Co-commissioning Manager has attended the city-wide Patient Participation Group (PPG) networking event.

Recommendations

The Primary Care Commissioning Committee is asked to:

- Note the GPFV report submission
- Feedback and input into the implementation plan and primary care programme actions

NHS
Sheffield
Clinical Commissioning Group

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1. Introduction and Background

The CCG has written a response to the GPFV which was submitted to NHS England (NHSE) on 23 December 2016 along with the Operational Plan.

Our GPFV is based around our Primary Care Strategy and identifies how we intend to invest our resources to transform primary care to be future proof.

We are working on a further draft and would welcome comments from PCCC members.

A high level implementation plan (Appendix 1 of the GPFV) was submitted with the GPFV response and this will be used to develop a detailed primary care work programme for the primary care team at the CCG. The primary care work programme will be shared with PCCC at the February meeting. This programme will be how we will deliver the priorities of the GPFV to support general practice transformation. NHS England are keen to ensure we are clear on our priorities and how we will deliver and deploy the resources available to us for primary care.

The GPFV document concentrates on several key areas:

- Neighbourhoods / primary care at scale
- Improving access and urgent care
- Development of the workforce and training
- Infrastructure – Estates and Information Technology (IT)
- Governance and redesign through accountable care

2. Recommendations

The Primary Care Commissioning Committee is asked to:

- Note the GPFV report submission
- Feedback and input into the implementation plan and primary care programme actions

Paper prepared by Rachel Pickering, Primary Care Co-Commissioning Manager

On behalf of Katrina Cleary, Programme Director Primary Care

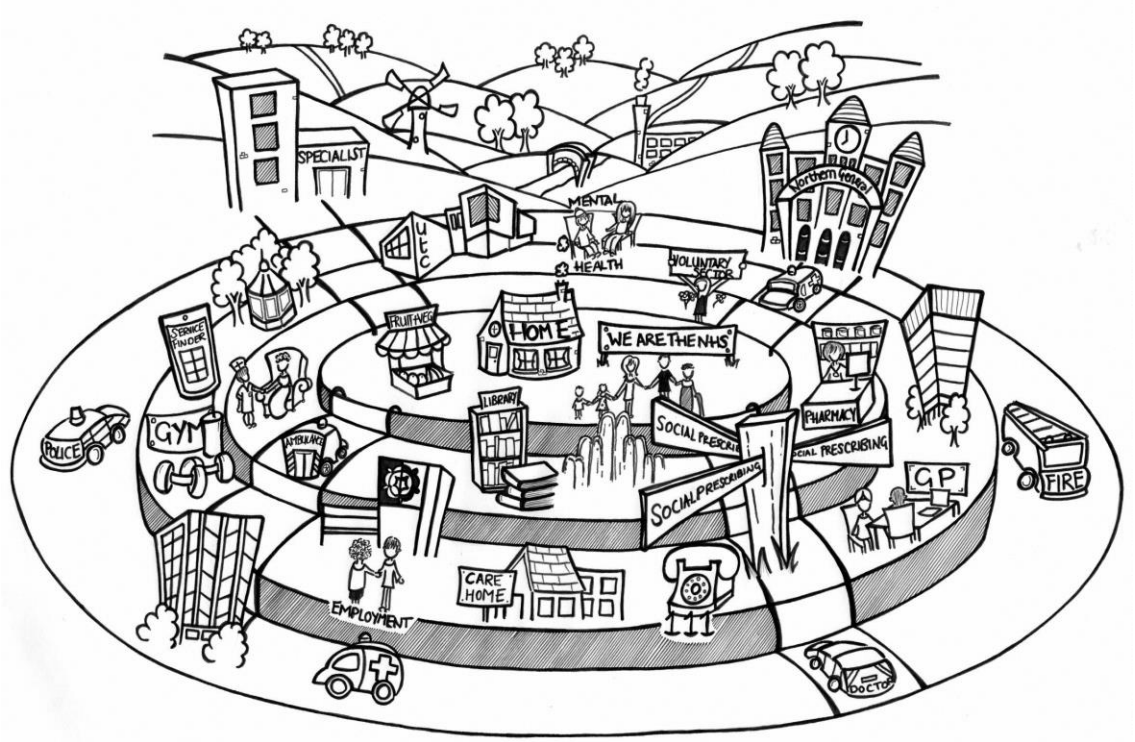
23 December 2016

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Sheffield CCG Delivering the GP Forward View – Transformation Plan

Incorporating Sheffield Primary Care Strategy & Sheffield Placed Plan



Shaping Sheffield

Illustrated by: Kate Woods

Contents

1. Our strategic vision to transform care in Sheffield

Mission:

Our mission is simple: For the children, young people and adults of Sheffield to live long and healthy lives with affordable and quality support in place to help them do that.

Vision:

To be recognised nationally and internationally as a person-centred city that has created a culture which drives population health and wellbeing, equality, and access to care and health interventions that are high quality and sustainable for future generations.

We will have a reputation for working in partnership to co-produce, improve outcomes, experience and inclusion and to influence national policy and regulation; this will be visible in our success.

Aims:

- Develop Sheffield as a healthy and successful city
- Increase Health and Wellbeing
- Reduce mental and physical health Inequalities
- Provide children, young people and adults with the help, support and care they need and feel is right for them
- Design a Health and Wellbeing System that is innovative, affordable and offers good value for money
- Improve people's experience of and access to care
- Be employers of caring and cared for staff with the right skills, knowledge and experience and supported to work across organisational boundaries
- Deliver excellent research, innovation and education
- To develop and expand specialised services for children and adults across the region

Sheffield Placed Based Plan – Shaping Sheffield

The importance of having a Plan for Sheffield is in bringing the city together to work differently in delivering the mission, vision and aims above in order to make significant change that is not possible for any one partner to achieve alone. We have a strong track record of working together on transformational programmes of work in Sheffield but, as is common everywhere, there is no record of significant impact on stemming growth or managing demand.

Shaping Sheffield brings together the transformation plans from health and care, from education, from employment and from wider partners. Drawing together Sheffield's collective energy to shape and transform for a sustainable future.

The plan sets out:

• **Memorandum of Understanding** to transform the way we provide services across organisational boundaries
• Manage our resources as **a single account for the city;** every decision in the best interest of the city not individual organisations
• **Financial Strategy** that underpins the transformation
• **Stronger Together**: agree a set of principles and behaviours that develop us as system leaders working together to do the best for Sheffield and to unlock solutions that we cannot do when thinking only of individual organisations

Expected Primary Care Outcomes/Impact from Shaping Sheffield

• Strong and sustainable General Practice as part of Primary Care through access to services and that supports continuity
• Reduced demand on the secondary care system (elective and non-elective admissions and attendances)
• More People Cared for at Home
• Increased Access to Primary Care across the week

The South Yorkshire and Bassetlaw STP

Bringing together 25 partner organisations; the South Yorkshire and Bassetlaw STP sets out the vision, ambitions and priorities for the future of the region's health and care. The goal is for everyone in South Yorkshire and Bassetlaw to have a great start in life with support to stay healthy and live longer.

Prevention is at the heart of this – from in the home to hospital care. The plan focuses on people staying well in their own neighbourhoods while introducing new services, improving co-ordination between those that exist and having staff working in the best way to meet people's needs.

With plans to invest in, reshape and strengthen primary and community services, access to specialist hospital care will be improved so that no matter where people live, they have excellent, high quality care and experiences.

Other factors affecting health will be a focus, including education; employment and housing to not only improve the health but the wellbeing and life chances of everyone in the region.

Operational and Finance Plans

The NHS Sheffield CCG (SCCG) Financial Plan and the Operational and Activity Plan set out how the CCG will deliver the transformational plans for Sheffield. These plans are set out in the South Yorkshire and Bassetlaw Sustainability and Transformational Plan (SY&B STP) and the Sheffield Plan, alongside the "9 Must Do's"[1] and other national requirements detailed in the NHS Operational Planning and Contracting Guidance 2017-2019.

GP Forward View

Transforming and strengthening primary care is core to the delivery of the ambitions of the CCG, as outlined in the placed based plan and the STP. Our GP Forward View (GPFV) response is set out throughout this document.

[1] NHS England (2016) *Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21*

Delivering the transformational objectives, in particular the "Must Do; Number 3"[2] for primary care is instrumental in delivering the change required:

Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues

Our response to the GPFV and our plans for how we will invest in primary care including additional funding through the GPFV (*Appendix 1 and 2*) are ambitious.

The Sheffield Primary Care Strategy, along with the Urgent Care Strategy and the Active Support and Recovery Programme, comprise the key components of the Sheffield Out of Hospital Strategy that will help us transform care in Sheffield and deliver the GPFV response required.

[2] *Ibid.*

1.1 Our vision for general practice within Sheffield

Our vision for primary care in the city is threefold, and our primary care strategy developed in 2016 outlines how the future of primary care in Sheffield might work together to:

- improve the health and well-being of people in the city;
- contribute to reducing health inequalities;
- have high quality, sustainable primary care services that is fit for purpose now and in the future;
- see health, social and voluntary care services working collaboratively for the benefit of individuals and in tune with the needs of the particular population they serve.

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

- better equality in health outcomes for people living in Sheffield; this means improving how people manage their own health and ill health and making sure they have access based on need to the support they need, regardless of their social circumstances;
- stable primary care services with sufficient numbers and skill mix of staff to manage the demand plus IT and buildings that support and enhance service provision;
- people receiving the right interventions at the right time from the right professional – mostly in their local neighbourhood.

The above objectives and outcomes are what we are setting out to achieve. This will require a change in behaviour and culture for patients, providers and commissioners alike:

The public will be encouraged and enabled to seek support and interventions from a wider range of professionals and not use their GP as the default option for all health queries; they will play a much bigger part in managing their own health;
Providers of primary care services will be encouraged and enabled to work differently – from the way they interact with patients to their working relationships with the health, social care and voluntary sector, to sharing contracts and resources with other providers;
Commissioners of health and social care services will need to make changes to enablers within the system i.e. change the way they contract and pay for services, shift more resource into primary care and lead on the changes needed to grow the primary care workforce and develop the right IT and estate infrastructure.

2. Transforming Primary Care

2.1 Introduction

There are many drivers for change within health and social care. The most significant of these is the ever increasing perception of the rise in the volume of demand for services[3] met with the degradation of the investment in primary care[4]. This is being experienced within all parts of the system; the resultant pressure from this will impact on the quality of services if it is not addressed.

The resident population of Sheffield is increasing and this will inevitably have an impact on demand levels for primary care services. Projections indicate that the population will continue to grow[5] along with the percentage of the population with multiple long-term conditions[6]; the complexity of which creates additional burden on primary care services.

General practice plays a highly significant part in primary care. Sheffield CCG is committed to adhering to the principles of the NHS and how these are applied locally to best meet the needs of our population.

The CCG is working with GP practices in Sheffield to transform primary care in order to respond to transferring services out of hospital over the next 3-5 years.

We expect to achieve the following key outcomes:

- Improved consistency in access to general practice; a combined, collaborative workforce across primary, secondary and community care providing a seamless pathway for patients with GPs as the linchpin for care;
- Patients able to self-manage their conditions from home utilising technology to connect with healthcare professionals;
- Reduction in health inequalities by delivering appropriate access, ensuring greater need has greater access, achieving equity of access (versus equity of outcome) with patients accessing equivalent, consistent standard and high quality services;
- Increase of the wider workforce within general practice to improve consistency in patient experience;
- A programme of patient education and engagement with strong outcomes;
- Support of the requisite infrastructure in Information Technology (IT) and estates in order to deliver sustainable primary care;
- A programme of service shifts from traditional hospital settings to community bases.

We will do this by delivering an *implementation plan* supported by a detailed *primary care work plan* over the course of the GPFV 5 years (appendix 1), the implementation plan has 3 main aims:

AIM 1 *- To ensure that all practices have a clear plan to remain sustainable to deliver the future primary care agenda*

AIM 2 *- To develop our existing primary care workforce to increase capacity as necessary to deliver high quality, capable service offer in out of hospital community and primary care settings*

[3] The King's Fund (2016) *'Understanding pressures in general practice'*
[4] *Ibid.*
[5] Sheffield City Council (2016) *'Director of Public Health Report for Sheffield'*
[6] Department of Health (2012) *'Long Term Conditions Compendium of Information; Third Edition'*

AIM 3 *- To ensure that our estate and technology strategies support the sustainability and transformation of primary care*

2.2 Working in Neighbourhoods

Our population is increasing and despite people living longer they are living with multi-morbidities and ill health[7]. This places additional demand on all services and requires a change in provision which in turn is driving the city to provide services in a different way.

The CCG needs to continue to sustain and move services forward in keeping with the transformation required under the Forward View and importantly for primary care the GPFV.

We expect that there will be big improvements in peoples' health and well-being if the existing services already rooted in local communities (health, social care, voluntary sector, police, education and others) work in a more collaborative way and through various events[8], public, patients and carers also tell us this. There is a growing recognition that organisational boundaries have prevented healthy collaboration in the past and that this culture is now shifting.

Active Support & Recovery Design Workshop; Illustrated by Megan Duggan

Collaboration between services covering populations of 30-50,000 people is recommended in a number of national documents[9]; we refer to this as a 'neighbourhood'. The neighbourhood approach forms a key part

[7] Sheffield City Council (2016) *'Director of Public Health Report for Sheffield'*
[8] Reference is made specifically to the Active Support & Recovery Design workshops held in 2015.
[9] Reference is made to services being delivered to a population of 30,000-50,000 in *Five Year Forward View*, NHS England, (2014); *Place-based systems of care. A way forward for the NHS in England*, The Kings Fund, (2015); *General Practice Forward View*, NHS England, (2016); *The Primary Care Home*, National Association of Primary Care (2015).

of our Out of Hospital Sheffield Strategy to transform care delivered by key partnerships including the CCG, General Practice, Sheffield City Council, secondary care, social care and the third sector.

We have some great examples of care and transforming services in Sheffield already with ambitious plans set out in our 'Shaping Sheffield' plan.

Sheffield is a divided city with high levels of health inequality[10]. Many of the GPs who work in these areas have a long history of seeking to respond to the real challenges of supporting very disadvantaged communities where there are many people on low incomes, a wide range of cultures and nationalities as well as a higher number of people with long term conditions.

In 2014 the CCG responded to these pressures by supporting those practices to form a collaborative network with the local voluntary sector organisations (community anchors) in their neighbourhoods. This 'Alliance of the Willing' (AoW) now consists of over 12 Practices, 6 Community Anchor Voluntary Sector organisations and has a growing membership of other health professions (*Appendix 2*).

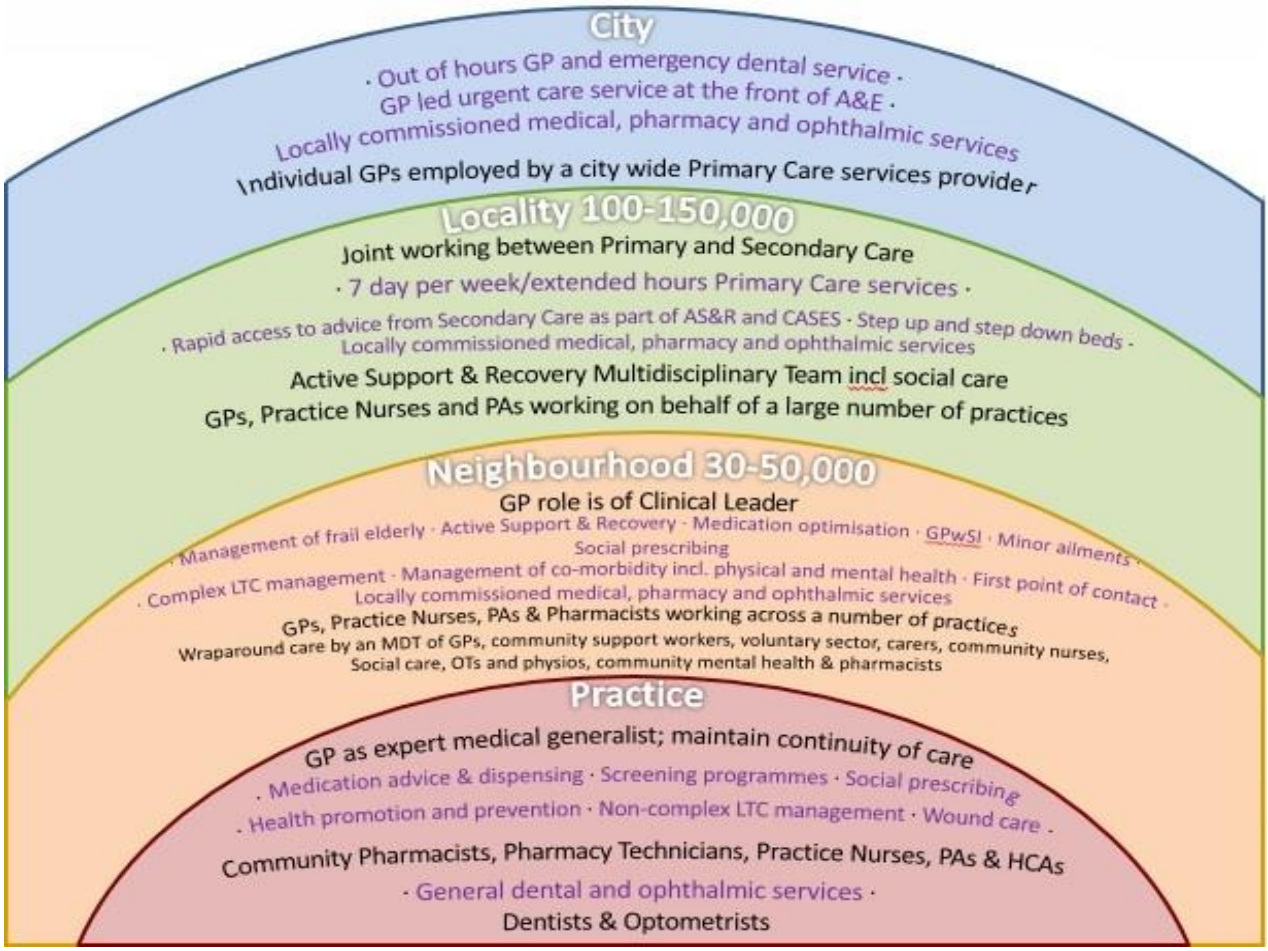
Outcomes that the AoW is aiming to achieve over the next two years include:

- Contribute to the current development of Social Prescribing at a City and Neighbourhood level in particular through contributing to the work of the Active Support and Recovery Board;
- Support the development of a service delivery models that bring together the local voluntary sector and primary care through contributing to the development of the GP as Clinical Leader at Neighbourhood level;
- Work with the CCG to develop datasets that help highlight areas of difference or pressure in disadvantaged communities.

[10] Sheffield City Council (2016) *'Director of Public Health Report for Sheffield'*

Figure 1 illustrates our vision for primary care, Active Support & Recovery (AS&R) and urgent care services within the broader range of out of hospital services:

Fig. 1: Care outside of hospital by level



2.3 Local drivers for change

Healthy life expectancy remains a major challenge in Sheffield and there are significantly more preventable deaths per head in the city than in England as a whole[11] . We now have to deliver healthcare in a different way whilst continuing to improve outcomes for patient, improving the quality of healthcare provided within the limited resources we have available. This is why it is key to align all of our strategic priorities, working closely with our local partnerships, and more widely within the health and social care system.

There are many local drivers for change; the most pressing of these that we must address are:

- health inequalities and the variation in quality and length of life of people living in different parts of the city and in different social circumstances. Not only are those living in deprived areas, with a disability or with a mental health illness more likely to die at a younger age but they are also more likely to live their life in poorer health and find it harder to get the healthcare services they need[12];

[11] Sheffield City Council (2016) *'Director of Public Health Report for Sheffield'*
[12] Sheffield Fairness Commission (2013) *'Making Sheffield Fairer'*

- the amount of staff required to manage the growing need for services and the number of staff approaching retirement or leaving their jobs early due to work pressures. The latter suggests that the workforce will shrink within the next 5 years.[13]

2.4 Issues Facing Primary Care

We are clear that we will tackle the issues facing primary care to enable providers to be ready to respond to the shift in system change required.

Many GP practices in Sheffield are reporting that they are under increasing pressure due to a number of factors. This is also supported by national data available demonstrating a significant increase in consultation rates, an increase in the consultation length and a significant increase in the administrative burden placed upon practices.[14]

The factors exacerbating the pressures in primary care include[15]:

- A significant proportion of GPs and practice nurses approaching retirement age and difficulties in recruiting replacements;
- Fewer GPs entering the profession and increased numbers leaving early due to work pressures and concerns about income;
- Long hours and insufficient capacity to meet the demands of their practice populations;
- Reductions in funding for some practices, e.g. via PMS equitable funding reviews;
- A transfer of workload from secondary to primary care without funding following;
- Increased administrative work, e.g. from CQC and CQRS;
- Fragmentation of systems between organisations that do not support patients' needs; GPs spending large amounts of time trying to organise support to enable patients to stay at home;
- Increased numbers of patients with complex needs, including frail elderly and those with co-morbidities;
- Inequities in service provision to housebound patients with long term conditions;
- Greater level of patient expectation for faster access and more services;
- Negative media and increased public criticism;
- The population trends, increased demand, increased appointment length.

The CCG has listened to these messages and to what providers of primary care services across the city are saying; these discussions have generated ideas and momentum and have resulted in the development of a Sheffield Primary Care Strategy.

We aim to commission and support the provision of primary care services that improve health outcomes for all people in the city focusing on community provision, the role general practice, including other primary care providers, e.g. pharmacists and third-sector partners.

Future models of primary care would serve to be mindful of some key principles and enablers for service providers in order to create the platform to deliver new out of hospital services. Commissioners and providers will need to come together to create the environment in which change will happen.

The principles should include:

- Consideration of how GP lists could be maintained to aid continuity and relationships;

[13] British Medical Association (2015) *'Responsive, safe and sustainable; Towards a new future for general practice'*
[14] Hobbs, F.D.R. (2016) *'Clinical workload in UK primary care'*
[15] The factors included are sourced from national and local reports; *'Understanding pressures in general practice'*, King's Fund (2016); '*Clinical workload in UK primary care'*, F.D.R. Hobbs (2016), '*Responsive, safe and sustainable'*, British Medical Association (2015), '*Primary Care Strategy'* (2016) Sheffield CCG.

- How contracts can support delivering primary care at scale;
- Ensuring equity and reducing inequalities in everything that we do and
- Harnessing a culture of innovation and risk taking.

3. Investment in Primary Care

The CCG has made significant investment into primary care and plan to do so with the use of drawing down funding via the STP, and the GPFV (*Appendix 2*); much of our plans are predicated on this money being released to us. As well as these funding streams, investment into general practice will need to increase further in order to achieve the real change required. The shift of services from secondary care to primary and community care can only be achieved with a move of the resources to deliver sustainable transformational change.

Sheffield CCG has a delegated co-commissioning budget for primary care in 2016/17 of £71.1m Included in this is £48m to pay for the core contract with GPs, £10m for reimbursement of premises' costs and £10.5m for QOF and Enhanced Services. In addition, there is a further £13m which is for CCG-Commissioned services. These include a number of locally-commissioned services (LCS) such as Care Homes, Anti-Coagulation, Care Planning and DMARDS. A full list is attached at appendix 5.

The £13m also includes funding for GPs to provide expanded services as well as additional capacity for elective service transformation, funding to facilitate Neighbourhood working, and money to ensure winter resilience. Appendix 5 shows how much budget is available for each area in 2016/17 and what the planned forecast expenditure is.

The total investment for LCS for primary care by the CCG has risen each year on developing new schemes. In 2015/16 it was £3.9 million, rising to £9.4m in 2016/17 including £3m funding available from the PMS equitable funding review.

The shift of services into primary care also requires investment both in infrastructure and, in some cases, dual running. As a city we are developing a shared financial strategy that robustly sets out where and when investment is required as well as how it might be delivered, this will be completed during early 2017. Additionally the CCG has initiated a stretch challenge to the financial savings that need to be delivered through QIPP with an intention of supporting some of the out of hospital investment that will be required to support transformation.

3.1 Locally Commissioned Services

Sheffield CCG have significant sign-up to Locally Commissioned Services (LCSs) which support the delivery of strengthened community interventions, e.g. Prescribing Quality Improvement Scheme, Care Homes, Person Centred Care Planning and engaging in a neighbourhood approach. The value and effectiveness of the provision will be reviewed in 2017/18 to ensure that the schemes are strategically aligned with our plans for out of hospital care delivery and support a neighbourhood way of working.

There are also a number of key Directed Enhanced Services (DESs) and public health enhanced services that we are keen to maximise sign-up and coverage across Sheffield. We will work closely with the other commissioners of these services (Public Health and NHS England) to ensure that we are taking a comprehensive approach to coverage on a Sheffield-wide footprint. We will also develop a contracting and commissioning approach that supports disproportionate investment that tackles inequalities head on (as set out in the place based plan).

The CCG is committed to expanding the uptake of enhanced services as part of our quality contracting arrangements. As we move forward we will look to develop an offer to neighbourhoods to deliver LCSs and new contracts on a more collaborative (at-scale) basis. This is likely to require independent contracting and business advice being made available to practices and we would wish to explore how this can be best resourced as part of a wider resilience/GPFV package to increase the investment into primary care over and above the levels currently planned.

3.2 The shift from secondary care

To move care closer to home, we intend to see an increase in the range of services traditionally provided within a hospital setting being provided more locally.

Sheffield general practices are already delivering a number of services which traditionally have been provided by secondary care. These include:

- Anti-coagulation monitoring;
- Community Dermatology (minor surgery);
- DMARD monitoring (plus gold);
- Ring Pessaries fitting;
- Prostate Cancer (zoladex);
- Endometrial Pipelle Sampling;
- Over and above core contract (following equalisation funding review);
- Engaging with the elective commissioning agenda including the CASES 7 specialities (see below).

We understand with a strengthened, appropriately resourced and skilled general practice model that patients could be more appropriately managed by their GP or other community services and therefore our approach is to significantly strengthen the neighbourhood and wrap-around model (Fig. 1, p. 4). To change the patient flow from secondary care into primary and community care will require investment, news ways of working and new partnerships (particularly with the third sector). This is difficult to achieve when there are current capacity issues in primary care and a significant amount of new resource is required.

More evidence is needed on the commissioning of out of hospital services which is one of the reasons why we are supporting Clinical Assessment Services Education Support (CASES) development.

3.3 CASES

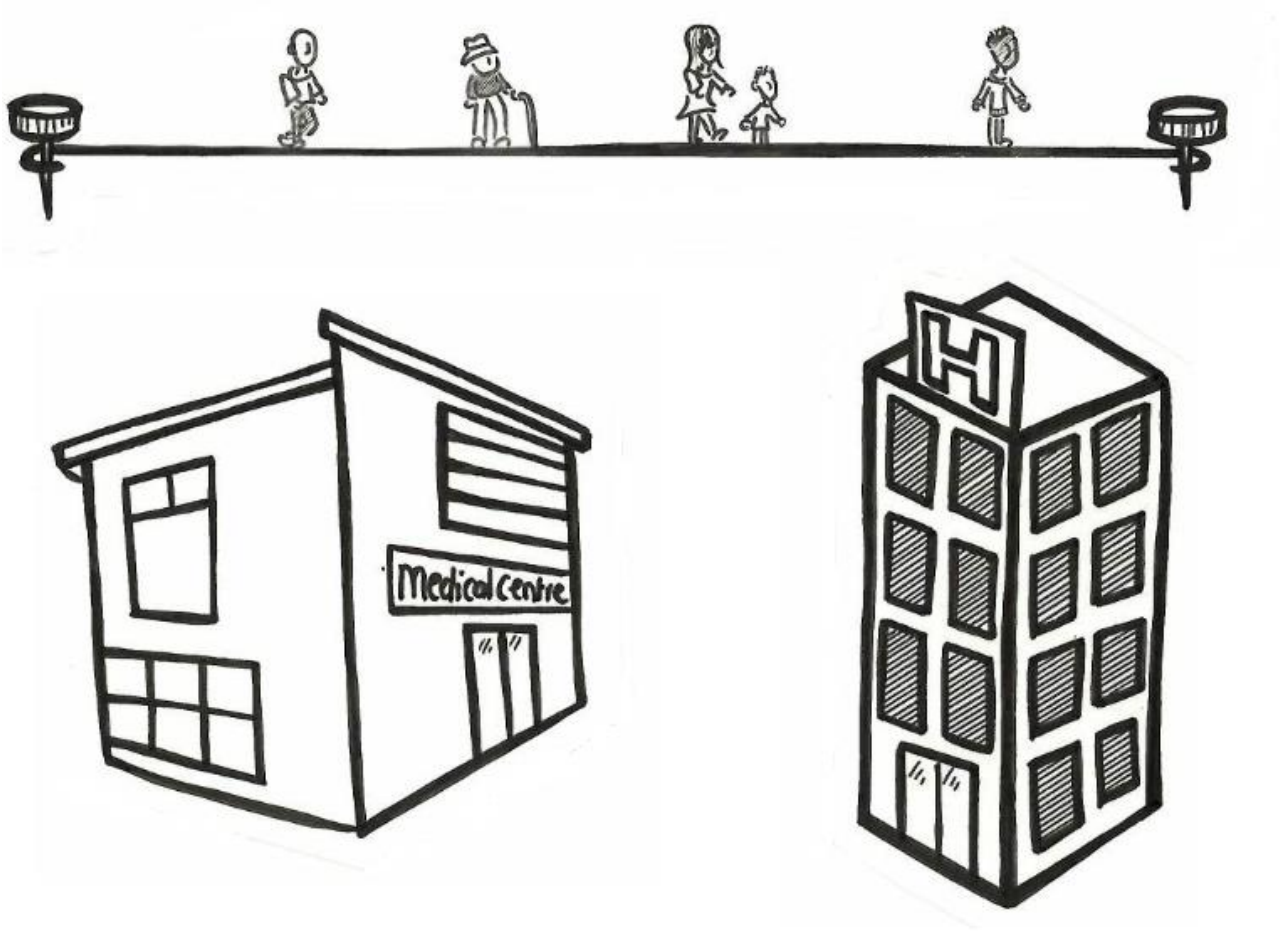
The pilot concept tests the following key elements of the CASES model:

- identification and implementation of education and upskilling requirements within primary and secondary care;
- impact of clinical assessment of referrals;
- identification of evidence to indicate new services s to be developed for delivery in a non-hospital setting;
- requirements to develop new or amend existing pathways of care;
- identification of opportunities to develop support services to facilitate patient self-management of their healthcare.

From May 2016 GPs were commissioned via the LCS to send all routine GP referrals from the following specialties to CASES:

- cardiology
- dermatology

- ear, nose and throat
- gastroenterology
- gynaecology
- respiratory
- urology



The pilot is being undertaken in order to concept test key elements of the CCG's CASES model for elective care and will provide evidence for the CCG to effectively evaluate and commission services that will meet the patients' needs closer to home, outside the hospital setting, reducing costs both to the patient and the healthcare economy.

This programme of work will enable the CCG to obtain more detailed outpatient service data than is currently available which will provide evidence to inform further refinement of the CASES model and future patient service developments.

An evaluation of the effectiveness and outcomes of the programme is required to support the future growth of CASES to ensure that the future commissioning alternatives is cost effective.

4. Support and Grow the Workforce

4.1 Workforce Plan

The primary care workforce is changing. Traditionally Sheffield has been considered to be appropriately 'doctored' as a whole but has struggled to recruit and retain staff in areas of deprivation. The overall picture has changed recently with more clinical staff retiring earlier and practices are struggling to recruit. In actuality, from a position of relative strength in January to March 2014 (based on the GP Workforce quarterly tool submitted by practices) the picture has changed to reflect a possible loss of 50 WTE GPs[16] in Sheffield alone (based on returns of the tool April-June 2016.) Advertisements for salaried, partnerships and long term locum GPs stand at 11 for the month of December 2016[17] in the Local Medical Committee bulletin.

From listening to local practices we believe that there is an appetite to make significant radical change and address some of the pressures primary care providers have been reporting for some time.

The role of the GP as a Clinical Leader and 'experts in generalist care'[18] within our neighbourhood model will enable GPs to provide leadership on the care of complex patients without also having to be the hub that mobilises this care.

It is estimated that 50 GPs and practice nurses will retire across SY&B each year[19]. The success of the CCG will be dependent on its ability to embrace, utilise and develop the potential of a more diversified workforce. It will also work with provider organisations and the Local Authority to harness the skills of the wider health and social care teams through neighbourhood developments including district nursing, social work and community support workers, pharmacy, podiatry, physiotherapy. The third sector will play a significant role in the transformation of out of hospital community and primary based care, and the increased potential that increased social prescribing integrated into a primary care will bring.

[16] Information submitted by Health Education England to South Yorkshire & Bassetlaw STP executive and Local Workforce Action Board
[17] Available via http://www.sheffield-lmc.org.uk/website/IGP217/files/NLDec16.pdf
[18] Information submitted by Health Education England to South Yorkshire & Bassetlaw STP executive and Local Workforce Action Board
[19] *Ibid.*

4.2 Sheffield Age Profile[20]

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

4.2.1 Comparison to South Yorkshire & Bassetlaw

The table below shows the whole time equivalent Staff per 1,000 patients broken down into cities within South Yorkshire & Bassetlaw.[21]

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

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

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

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

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

[20] Information provided by Health Education England via practice return of which 76 of 85 practices submitted a return, April – June 2016.
[21] Information provided by HSCIC (now NHS Digital)

4.2.2 Increasing Resources

Our workforce plan is being developed and will incorporate the national 10 point plan[22]. This plan will include our priorities for developments around care navigation, training administrative staff, upskilling unqualified staff, nurse leadership and developing our practice and business managers to have the skills to lead a future primary care infrastructure.

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

Based on modelling in the workforce data below from Health Education England[23] we expect Sheffield to see their proportion the workforce grow from new STP investment to support general practice and meet NHS requirements to address aspects of the GP forward view . This requires the following to happen each year for 2017 to 2021:

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

4.3 Nursing & Support Staff

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

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

[22] NHS England and Health Education England (2015) '*Building the Workforce – the New Deal for General Practice*'

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

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

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

4.4 Clinical Pharmacists

One of our Prime Ministers Challenge Fund (PMCF) work-streams included clinical pharmacy input into general practice in Sheffield which has been extended until December 2016. The pharmacists that have been involved with the scheme have been involved in undertaking medication reviews and long terms condition management amongst many other developments. This pilot programme has been recognised nationally and is influencing developing a model for primary care locally. The CCG plans to develop this work further in developing the role of the clinical pharmacist to improve integration within the primary care setting. We are currently awaiting the evaluation of this work which will help inform the CCG when we seek to secure additional 120 clinical pharmacists as below.

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

The role of the integrated clinical pharmacists will be the patient co-ordinator and link between the community and secondary care pharmacies to ensure that the required medicines management support is optimised and patients are better managed.

4.5 Management and Administrative Staff

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

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

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

4.6 Physician Associates

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

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

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

4.7 Mental Health Workers in General Practice

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

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

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

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

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

4.8 Training & Development

Development of the workforce is essential to transforming primary care in Sheffield. We will be undertaking a skills audit to determine the readiness of our workforce to become future leaders as well as the skills required in delivering out of hospital care. The results of this audit will be used to determine the skills and qualifications required to then map the needs of our neighbourhoods and work closely with our

universities in developing the right training and workforce required in the future. This intelligence will also be used to inform our workforce plan.

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

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

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

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

- The Productive General Practice programme and/or support to put in place relevant high impact changes for every practice;
- Expansion of the Resilience Funding work and a support programme for primary care to explore federations and models of primary care at scale;
- A programme of education for reception teams which will include care navigation and enhanced medical documentation/read coding training for every practice;
- Releasing GP leaders to make this significant change within practices;
- Developing Practice Managers to lead different business models in the future;
- Working with our Advanced Training Provider (ATP) in the North of the city (The Foundry Medical Group) to help us scope out the opportunities around teaching and training and the support required for primary care;
- Work with the ATP programme to support practices to host the GPN ready scheme
- Academic Health Science Network (AHSN) supported work to primary care leaders in sharing best practice and developing knowledge and expertise on potential new contract models within the new models framework;
- Action learning approach to support leaders (clinical and non-clinical) within the emerging neighbourhood approach;
- Supporting our citywide provider company for general practices, Primary Care Sheffield (PCS), to develop its primary care at scale offer to support much of the above and progress the emerging new models of care approach within the city.

5. Improving Access to General Practice In and Out of Hours

5.1 Access Models

The CCG continues to receive feedback from the public that good access to their GP remains a key priority. Sheffield has been delivering considerable change in relation to delivering and testing out new models of improving access.

Active Support & Recovery Design Workshop; Illustrated by Megan Duggan

The initial success of the PMCF pilots has led to a continuation of investment via the GP Access Fund into delivering the successful work-streams including the 7-day working delivered by the satellite units through Primary Care Sheffield. We will continue to spend the GP Access Fund £6 per head recurrently on improved access from 2017/18.

5.1.1 National GP Patient Survey

We have identified, via the National GP Patient Survey (Fig.2), areas in relation to GP access that require focussed work to improve patient experience and are currently completing a full analysis of the survey results.

There are some positive areas in the national survey responses; with Sheffield responses scoring above national averages in the care delivered by a GP or nurse which (despite increasing challenges placed upon primary care) has remained consistently high and above average for a number of years. However, many of the Sheffield indicators fall consistently below the national averages indicating that there continues to be problems with how patients access GP services across the city.

From evaluating the data from the GP Survey, we will commence work with practices about their capacity and their access systems as part of our scheduled practice visits during 2016/17. This work will also feed into the urgent care review and delivery of the GP Access Fund scheme.

Table 2: Sheffield Summary of National GP Patient Survey

National Patient Survey	2013/14		2014/15		2015/16	
Patient Experience	**CCG Average**	**National Average**	**CCG Average**	**National Average**	**CCG Average**	**National Average**
Ease at getting through to someone at your GP Surgery on the phone?	69%	73%	67%	73%	66%	73%
How helpful do you find the receptionists at your GP surgery?	86%	87%	85%	87%	86%	87%
How often do you see or speak to the GP you prefer?	58%	55%	58%	60%	56%	59%
Last time you wanted to see or speak to your GP or Nurse , where you able to get to see or speak to someone?	84%	61%	83%	85%	83%	85%
Convenience of the appointment you got?	91%	92%	91%	92%	93%	92%
Overall how would you describe your experience of making an appointment?	70%	75%	69%	73%	70%	73%
How long after your appointment time do you normally wait to be seen? *(15 minutes or less)*	62%	57%	62%	65%	62%	65%
How do you feel about how long you normally have to wait to be seen?	54%	58%	53%	58%	55%	58%
How good was that GP at giving you enough time?	87%	86%	86%	87%	85%	87%
Last time you saw or spoke to your GP, how good was that GP at listening to you?	88%	88%	88%	89%	89%	89%
How good was your GP at explaining tests and treatments to you?	83%	82%	82%	86%	82%	86%
How good was your GP at involving you in decisions about your care?	76%	75%	74%	81%	76%	82%
How good was your GP at treating you with care and concern?	84%	83%	84%	85%	84%	85%
Did you have confidence and trust in your GP?	96%	93%	96%	95%	96%	95%
How good was your nurse at giving you enough time?	81%	81%	80%	92%	81%	92%
How good was your nurse at listening to you?	80%	80%	78%	91%	80%	91%
How good was the nurse in explaining the tests and treatments?	78%	78%	76%	90%	78%	90%
How good was the nurse in involving you in decisions about your care?	68%	67%	65%	85%	67%	85%
How good was your nurse in treating you with care and concern?	79%	79%	77%	90%	79%	91%
Did you have confidence and trust in your nurse?	97%	86%	97%	97%	98%	97%
How satisfied are you with the hours that your GP surgery is open?	75%	77%	72%	75%	74%	75%
Overall, how would you describe your experience of your GP surgery?	85%	86%	84%	85%	85%	85%
Would you recommend your GP surgery to someone who has just moved to your local area?	78%	79%	77%	78%	78%	78%

5.2 Local urgent care pathways – 7 Day Working

To ensure Sheffield has a resilient, efficient and sustainable local urgent care system we will explore the development of urgent primary care access solutions working collaboratively with current providers of extended access systems e.g GP Access Fund satellite units, walk-in, emergency services and A&E departments, on the development of a consistent and integrated offer across primary and secondary care. This work will be completed early in 2017.

We will implement a clear and robust pathway committed to by all local partners, primary care, social care, community and acute providers and the Yorkshire Ambulance Service.

We will continue to develop the Sheffield model with regard to the provision of local clinical hubs. Our aim is to deliver consistent and equitable access offer across Sheffield primary care to ensure that patients requiring urgent care receive a timely response, where clinically appropriate without recourse to A&E services.

Through our GP Access Fund hubs, we will implement key initiatives across the system to reduce acute emergency demand. At the centre of our hubs will be primary care led coordination, with the development of alternative community based approaches to deliver better use of ongoing care provision. We will work with our secondary care providers to deflect minor injuries and primary care conditions presenting at A&E sitting alongside this the need to develop implementation of the 'assess to admit model'. At present there are 4 GP access hubs providing 300 hours (approximately 30 minutes per 1000 currently). The review will look at the number of hubs required in order for the CCG to achieve the 30 per 1000 rising to 45 per 1000 as required.

All GP Practices in Sheffield will be supported to implement the GP Access Tool to monitor capacity and assess utilisation across the city.

There have been some improvements to the satisfaction in opening times for general practice across Sheffield since the opening of the satellite hubs, however this still remains lower than the national average and further work is required to meet the increased primary and urgent care demands whilst improving services for patients. A piece of work has been commissioned by the SCCG December 2016, on how best to meet these demands to provide equitable access across the city in and out of hours.

The urgent care focus will be around primary urgent care being principally delivered by neighbourhoods in a way that relationships and local knowledge is able to maintain an element of the individual care a GP traditionally provided. There will then be a range of services (not limited to urgent care) that will offer better value at a locality level and then at citywide level. Access to diagnostics and other services that support decision making will be important to understand and access to this will be considered as part of the review currently underway.

The aims of course are the same as for the primary care strategy and the place based plan – shift in the proportion of care provided outside of hospital, stemming demand/growth for acute hospital service need through prevention and crisis planning and access to alternative services/support from the neighbourhoods/localities. This obviously also links to the section on extended access as it is likely the GP Access hubs as they currently stand will work very differently in the future. Extended access is likely to be part of neighbourhood delivery.

5.3 Self Care and Social Prescribing

We intend to empower patients to manage their own health and ill health through the use of digital advancements and a person-centred care approach.

We intend to grow the social prescribing offer and have made a commitment that social prescribing will be delivered across the whole of Sheffield. Social prescribing will become a core part of the services available to enable people to address other issues in their lives that are impacting on their ability to address their health/ill health such as employment, housing, benefits, transport etc. The role of care navigation will be key in developing this work in linking the community and third sector with the patient.

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

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

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

5.4 General Pharmaceutical services

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

- Minor ailments scheme
- Not dispensed scheme
- Anticoagulation service
- Extended hours
- Carpal tunnel splints
- Advice to care homes
- Emergency 111 supply
- Assured availability of palliative care drugs
- Sub-cut fluid service
- Stop smoking Varenicline patient group directive
- Stop smoking nicotine replacement therapy (NRT) voucher scheme
- Stop smoking one to one service
- Supervised methadone consumption
- Needle exchange
- Needle exchange condom supply scheme
- Emergency Hormonal Contraception (EHC) patient group directive
- Chlamydia Screening

5.5 Developing joint working between general practice and community pharmacy

There is currently an ambitious, citywide programme of Community Pharmacists, working with GPs at scale across Sheffield which is successfully demonstrating a new model of care. Community Pharmacists are making a significant impact on reducing GP workload, improving medicines optimisation and driving the patient-centred care agenda. Facilitated by Primary Care Sheffield and Sheffield Clinical Commissioning Group, this is the first and largest example of large scale collaborative working between General Practice and Community Pharmacy in the UK.

The programme has 80 GP practices being provided with pharmacy support (78 by a pharmacist and 2 by technicians). The pharmacists/technicians are working within their local GP practice 1-2 sessions a week, performing a variety of work including; domiciliary visits, reconciliation of hospital discharge and repeat medicines, education, medication reviews and solving ad-hoc medication queries. From October 2015 – May 2016, 7,383 provisions of work have been recorded; the majority being reconciling of hospital discharge medicines and medication reviews. In 87% of cases the pharmacists completed the work or resolved the issue without referring to a GP. 95% of the work would have been dealt with by a GP in the pharmacists' absence.

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

5.6 General Ophthalmic services

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

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

These services are commissioned by the CCG via Primary Eyecare Sheffield (PECS), a limited company formed by participating optometry practices in the city, which successfully tendered to

provide the services from April 2015. There are regular meetings between the CCG and PECS to review activity, performance and quality and to work together to solve any issues. There are clear criteria identified for each scheme that participating practices must meet.
There is good coverage of all the above services across the city with around half of all practices belonging to PECS and participating in one or more of the schemes.

5.7 General Dental services

There are 77 general dental practices in Sheffield providing NHS services and 4 specialist orthodontic practices. As with general medical, pharmaceutical and ophthalmic services there is a national contract for general dental provision. There is an alternative national contract currently being trialled across the country and 3 of the dental practices in Sheffield are on this contract.
The CCG does not commission any local services with dentists in Sheffield, however, the local area team of NHS England contracts with 10 practices for Residential Oral Care Sheffield (ROCS) providing services to 78 care homes and with 2 practices for tier 2 Minor Oral Surgery services.

6. Transform the Way Technology Is Deployed and Infrastructure Utilised

6.1 Information Management & Technology

Sheffield has a flagship technology 'Testbed' programme and this is driving innovation; identifying, implementing and evaluating new technologies which meet local need.

Information Technology (IT) needs to support and enable the provision of GP and primary care services. Citywide IT developments and GP IT developments are both critical to supporting primary care development and digital advancements in enabling patients to self-care.

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

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

1. Shared Records and Interoperability
2. Mobile working
3. Online appointment booking and prescription ordering for patients
4. Patient access to records
5. E-consultations
6. Technology to support remote assessment and treatment of patients in their own homes via telemedicine and self-observation
7. Use and accreditation of apps to support treatment and intervention

Points 1 and 2 are the two key priorities for the CCG and will be subject to the outcome of the Estates and Technology Transformation Fund proposals. Points 3 and 4 are national products and the remaining priorities will be key in supporting our delivering strategy over the coming years.

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

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

6.2 General Practice IT

There is a range of digital maturity across the 85 practices in Sheffield. There are currently 2 clinical systems in use (EMISweb: 25% and TPP SystmOne:75%) with a range of document management systems. There is currently a move towards paper-light and paperless working in some practices. Most practices are already operating 'paper-free at the point of care' with no reference to paper based notes during patient consultations. Despite developments towards paper-light and paperless working, there is still a reliance on fax communication in some GP practices.

Key recent achievements within primary care include

- 99% of practices have signed up to utilise the Medical Interoperability Gateway (MIG) to enable real-time sharing of clinical data
- STHFT has live access to primary care records via MIG links to their Clinical Portal
- Primary care has access to Secondary Care test requests and results reporting via the Integrated Clinical Environment (ICE)
- More than half of practices achieved 90-100% of tests transferred electronically for Pathology and Cytology in January 2016[24]
- All practices have moved towards paperless/light running
- Approximately 43% of referrals to STHFT are via e-Referrals as at April 2016[25]
- 61/82 practices using the Electronic Prescription Service (EPS2)[26]
- 16.9% of patients enabled to electronically view/order repeat prescriptions[27]
- 1,119 patients were registered for detailed coded record access for SystmOne practices as at April 2016[28]

Current initiatives within primary care for 2016-2020 include:

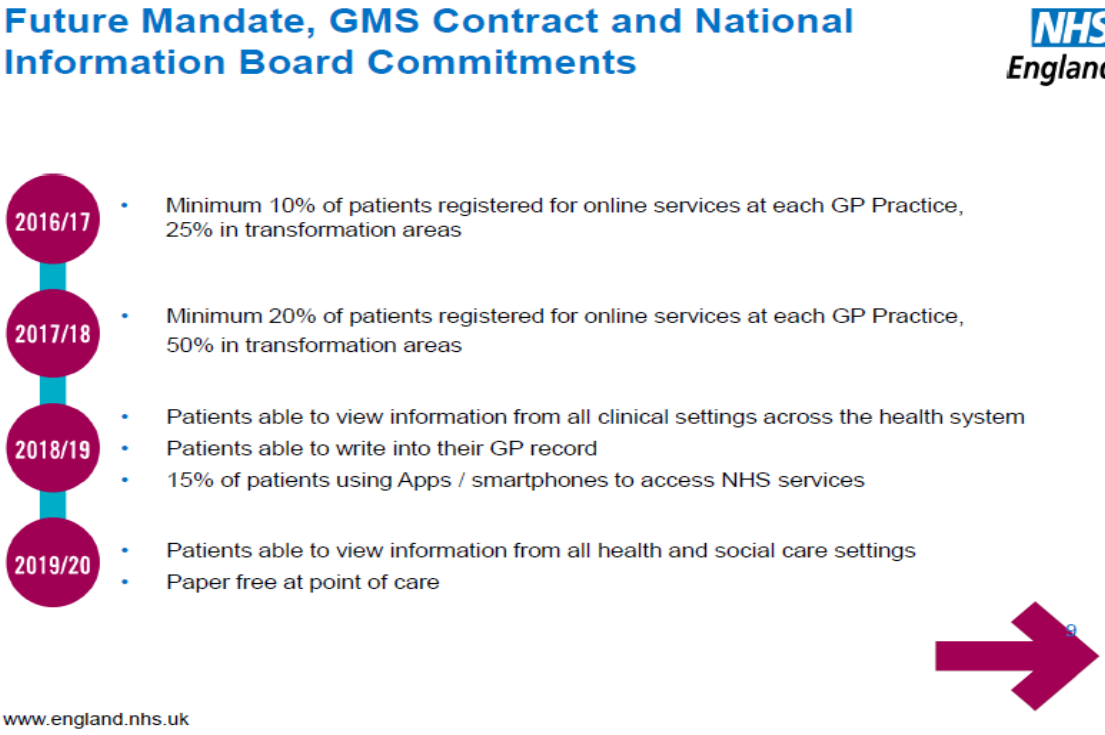
- Plan to share GP health records between practices / multidisciplinary teams in neighbourhood areas of shared working via EMIS web / TPP SystmOne interconnectivity, and/or by extending use of MIG
- Roll out of MIG record viewer to wider system including Sheffield Children's Hospital Foundation Trust (SCHFT), Sheffield Health and Social Care Trust (SHSCT), and Sheffield City Council (SCC)
- Development of practice reporting system including validation/expansion of risk scoring algorithms and case finding, management of citizen health and care demand, and resource utilisation efficiencies through robust neighbourhood business intelligence systems
- Plan to support remote working through the purchase of additional laptops, and the installation of Wi-Fi in GP practices

[24] Based on Integrated Clinical Environment (ICE) statistics reporting from Sheffield Teaching Hospitals Foundation Trust
[25] National NHS Digital reporting of e-Referrals
[26] Information provided by eMBED Business Systems Support as of November 2016
[27] NHS Digital Patient Online Management Information (POMI) indicator set
[28] SystmOne central reporting analysis snapshot run on 14 April 2016 by eMBED

- Minimum 10% of patients registered for online services at each GP practice for 2016/17 (rising to 20% in 2017/18)
- Development of a single consent model across all Sheffield practices with associated data sharing agreements
- CCG Prescription Ordering Line (POL); the current pilot is live with 5 practices as at June 2016, to be extended to 3 additional practices. This provides the central handling of repeat prescription requests on behalf of practices with the overall aim to reduce the number (and cost) of items prescribed.

6.3 Future IT Aspirations

Figure 2: Future Mandate, GMS Contract and National Information Board Commitments



6.3.1 SCCG Plan to roll out online consultation systems

Stage 1 - will be to identify technical solutions that fit with our existing GP Systems (SystmOne and EMIS Web). We will explore TPP SystmOne and EMIS supplier offerings (possible use of SKYPE). Also consider making use of the national e-referrals system to support inter-practice advice and guidance for e-consultations, clinician to clinician.

We will take advantage of NHSE support commencing with attending GPFV Transformation Team webinars early in 2017, and utilise national guidance on eg 'good practice' for procuring software solutions when it becomes available.

We will look to the STP for the potential to share approaches.

We will need to consider networking / security issues and link these to next year's HSCN Health and Social Care Network procurement.

Stage 2 - We will consider trialling solutions within a neighbourhood with a mix of systems (SystmOne, EMIS).

We will utilise project days from within the eMBED IT Support contract to provide technical support.

We will use the trial to demonstrate benefits.

Stage 3 – will be to work up a full implementation plan

Our vision and our specific digital and IT priorities are clear however, we remain heavily reliant upon future financial investment in order to fully achieve our ambitions. We are making determined efforts in order to ensure we make maximum use of available resourcing opportunities including IT Capital and Revenue budgets, working closely with our newly appointed commissioning support service for IT (eMBED). We will therefore be seeking additional/further funding from external sources that will be critical to future success including:

- National Transformation Funding including the Driving Digital Maturity Investment Fund
- NHSE Estates and Technology Transformation Fund
- GP Access Fund
- Additional funding opportunities e.g. through social investment opportunities

The primary care web tool used in Sheffield (i.e. Practice Reporting System), has a range of dashboards covering areas such as emergency admissions, patients who regularly attend hospital, risk stratification, and activity data. There are plans to review the use of the Combined Predicted Model (CPM) to ensure we have the right technology to support how we identify patient need.

We have received confirmation that 4 of our proposals under the Estates and Technology Transformation Fund will be considered under:

ETTF Cohort 2 (17/18 and 18/19):

- Promoting Interoperability: Shared Care Records - technology
- Promoting Integrated and Remote Working: Mobile Devices - technology

ETTF Cohort 3 (2019):

- New Models of Care Delivery: Business Intelligence for New Care Models - technology
- Promoting Integrated and Remote Working: Wi-Fi - technology

6.4 Premises strategy

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

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

Table3: Sheffield GP Practice Premises

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

There are 7 NHS Local Improvement Finance Trust (LIFT) buildings across Sheffield, offering purpose built accommodation. Current utilisation of these buildings is poor; usage of one site was assessed over an extended period and found to be 34% underutilised. Usage across all 7 LIFT buildings is estimated at 33-50% of potential capacity; further detailed utilisation studies are planned for all LIFT buildings. The potential to use these buildings to operate primary care at scale needs to be worked through in our Strategic Estates Plan.

The CCG has a strong financial and quality incentive to improve the utilisation of LIFT assets but also recognises that there are barriers within the system that can prevent this from happening. As a system enabler and leader it is part of the CCG's role to find solutions to obstacles that are preventing a primary care strategy from being implemented.

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

Primary care will need buildings based in neighbourhoods in which they can jointly work with health, social care and voluntary sector colleagues. The majority of these buildings will already exist and there is a real need and opportunity for public services to work more collaboratively to reduce duplicated overhead costs and to deliver more joined up services at a local level.

6.5 Strategic Estates Plan

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

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

Sheffield Strategic Estates Plan makes it clear that significant efficiency and quality gains are achievable with limited investment; a smaller, higher quality estate can be provided at lower cost and the additional costs associated with out-of-hospital care can be significantly mitigated. We have 9 (1 in 2016/17, cohort 1 and 8 in cohort 2 by 2019) practices identified through the Estates and Technology Transformation Fund (ETTF).

We have currently commissioned a further key piece of work to develop a detailed primary care estates plan to enable us to make confident decisions when investing in primary care facilities and how this aligns with our primary care and urgent care strategies.

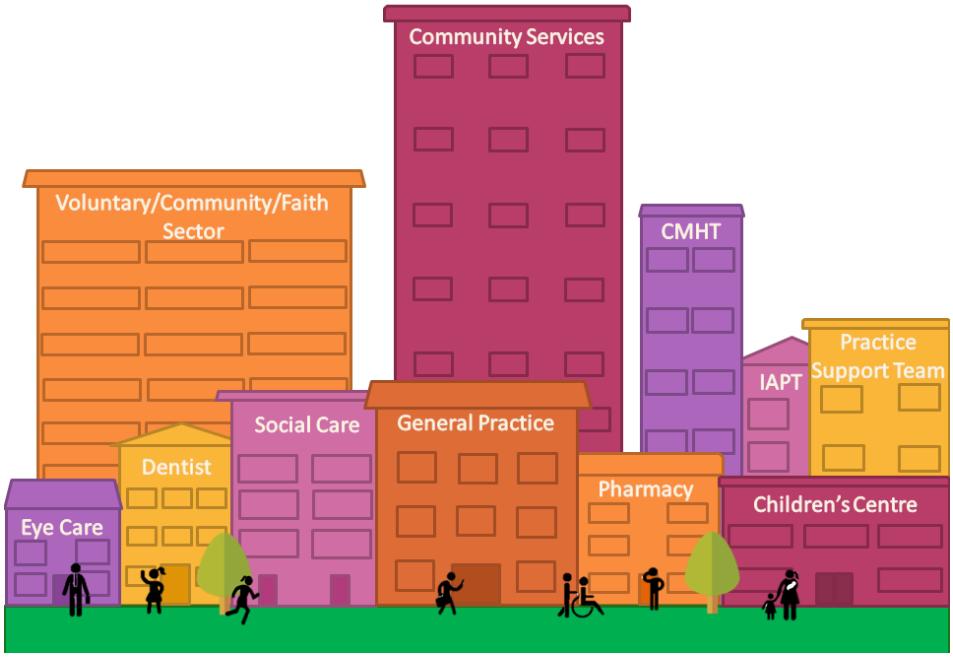
NHS England has recently procured site surveys of 88 GP practice sites to provide CCGs with an assessment of the current estate suitability for primary care. Whilst some estate issues have been identified, the estate is in fairly good order.

The CCG is prioritising core capital investment for the next two years into developing estate that meets our strategic direction in line with neighbourhood development, developing teaching and training and expansion of integrated working.

7. Better Managed Workload and Redesign How Care is Provided

Primary care will need significant investment, support and development in order to meet our challenging transformation agenda required in Sheffield. We plan to invest much of our £3 per head over the next two years to support the core structures of the neighbourhood models as part of our Sheffield plan.

7.1 Neighbourhoods & Federations



The CCG concludes, based on recommendations in a number of national documents[29], that GP practices will be better able to operate and thrive in the future if they work more closely together to cover larger population groupings of 30,000-50,000. Whilst being mindful that we need to developing a contracting and commissioning approach that supports disproportionate investment that tackles inequalities head on (as set out in the place based plan).

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

This may be through joint-working between practices with shared governance agreements ('neighbourhoods') or practices may choose to adopt a more formal federated model. By using this approach practices will be better able to meet the needs of the communities they serve by:

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

7.2 Releasing time to care

Sheffield recently commenced a whole-scale programme of Productive General Practice in September 2016 with 50 practices receiving intensive support to release time to care. From previous programmes, this releases on average 10% of practice time as well as supporting individuals to consider their individual practices to ensure they are as efficient as feasible.

The CCG will be supporting practices to access training around signposting (through care navigation) and managing the workflow to release time for clinicians. These two key pieces of work will enable practices to increase their efficiency and release capacity among the clinical workforce to enable clinicians to test different ways of working:

Workflow Optimisation is a new approach for administration that has proven to save up to 40 minutes of admin time per day per GP, along with enhancing data quality and renewed job satisfaction for clerical staff[30].

Care Navigation training enhances receptionists' ability to improve the patient's journey and connects the patient with services within the NHS and the wider care network[31]. Adding more resource and expertise to Sheffield's growing social prescribing network.

We are piloting 'shared medical appointments' across a group of our practices working in a supportive group setting with patients with long term conditions. This is a method of working that focuses on patient empowerment, peer to peer support, with clinical input to create patient ownership. This method of working has the potential to release resource and improve patient outcomes[32]. We are keen to roll this out across our neighbourhoods once the pilot has been evaluated.

[30] NHS England (2016) *General Practice Forward View*
[31] NHS England (2016) *10 High Impact Actions Case Study 145: West Wakefield reception care navigation*
[32] Kuma, Manson and Varnam (2016) *Time for Care – Group consultations in general practice* [Webinar]

Additional information regarding the 10 High Impact Actions to release time to care and CCG plans can be found in the infographic in Appendix 4.

7.3 Federating

The CCG are fortunate that all practices in Sheffield are individual stakeholders in Primary Care Sheffield. In addition, currently we have some practices considering the possibilities of working more closely either through formal or informal arrangements. Our neighbourhood proposal will encourage local practices to work together to consider the opportunities available to them if they collaborate more closely.

We anticipate that there will be funding opportunities through the resilience funding available to CCGs to support practices with resources to enable them to create the space to consider their options. We will be working closely with our practices to support them to have these conversations where they are appropriate.

Primary Care Sheffield also continue to support and work with practices to consider their working arrangements and the opportunities of working at scale and have an enhanced role to support the transformation of primary care and the implementation of GP Forward View initiatives.

7.4 Working with Community Pharmacy & Local Practice Schemes

The CCG is responsible for all GP prescriptions issued by its member practices. In 2015/16, the CCG spent £95 million on prescriptions in primary care.

The CCG is focused on ensuring all patients are receiving the right medications, at the right time, and efficiency savings of over £0.8m were achieved in 2015/16.

A Prescribing Quality Improvement Scheme commenced in 2016/17 and is reviewed regularly to ensure more effective practice is achieved. The scheme this year covers:

- Analgesics
- Anti-depressants
- Anti-bacterials
- Pregabalin

The citywide scheme has to show an overall saving within the primary care prescribing budget in order to generate the pot of savings to distribute. The incentive payment will be shared between all practices that participate in the scheme on a list size basis, regardless of whether that individual practice has achieved any savings. There is a set of criteria on what the savings in primary care can be spent on e.g. specialist pharmacists, diagnostic equipment, to improve or enhance prescribing. We will work with practices to develop the incentive scheme further as an option to support the employment of the future clinical pharmacist scheme as funding tapers off.

The CCG also has a minor ailment scheme in place with our community pharmacists; providing the ability for patients to be redirected to pharmacies for medicines not requiring prescription.

7.5 Planned Activity Across Primary and Secondary Care 2017-2019

The redesign of how care is provided and how services come together to better manage the workload will impact on the projected activity levels across primary and secondary care (table 4). The transformation of care and the development of neighbourhood delivery models in primary and community care will release

resources to develop care out of hospital and should realise the planned reduction in activity as demonstrated below. This will require the shift in resources and additional running costs to ensure the infrastructure is right in order to strengthen the primary care offer.

Table 4

Planning summary for Primary care						
Activity Line	Fin Year	Q1	Q2	Q3	Q4	Annual % change
Total GP Referrals (General and Acute)	2017/18	22,153.73	23,537.82	23,687.76	22,784.92	-7.5%
	2018/19	20,802.54	22,121.48	22,230.64	21,379.23	-6.1%
Total Other Referrals (General and Acute)	2017/18	24,408.07	25,845.63	26,121.39	25,082.43	1.0%
	2018/19	22,712.72	24,087.13	24,287.14	23,321.25	-6.9%
Consultant Led First Outpatient Attendances	2017/18	42,717.24	45,305.92	45,696.47	43,915.00	-4.9%
	2018/19	39,922.26	42,393.22	42,676.86	41,009.61	-6.5%
Consultant Led Follow-Up Outpatient Attendances	2017/18	86,719.79	92,277.03	92,601.27	89,061.02	-1.3%
	2018/19	86,020.11	91,537.26	91,845.36	88,322.62	-0.8%
Total Elective Admissions	2017/18	16,488.42	17,518.60	17,573.99	16,845.51	-2.0%
	2018/19	16,328.06	17,346.80	17,401.63	16,676.62	-1.0%
Total Non-Elective Admissions	2017/18	11,672.27	11,551.44	12,009.54	11,559.87	-7.2%
	2018/19	10,625.54	10,518.33	10,932.33	10,523.25	-9.0%
Total A&E Attendances excluding Planned Follow Ups	2017/18	49,052.81	48,597.40	50,465.65	48,580.88	0.6%
	2018/19	49,446.49	48,987.35	50,870.68	48,970.78	0.8%

8. Organisational Form

8.1 Current General Practice

There are 82 general practices across Sheffield City with list sizes ranging between 1,200 and 27,000 and an average list size of 6,800[33]. As each practice is independently contracted, the way services are provided varies. For example, different practices will have different systems in place for accessing services, providing long term conditions management, in the skill mix of their practice team and so on.

Sheffield's resident population is 563,750[34] who are cared for by Sheffield's GP practices alongside a centrally based walk-in centre providing 14 hour/7 day access. At the present time, 7 GP practices in Sheffield are singlehanded compared to 78 practices with multiple GP partners or which are alternative providers.

National average list size	6,287
Sheffield average list size	6,800

With regard to type of contract there are:

[33] As at October 2016, information provided by NHS England
[34] As at September 2016

45 Personal Medical Services (PMS) practices
38 General Medical Services (GMS) practices
2 Alternative Provider Medical Services (APMS) practices

8.2 Primary Care at Scale

A citywide primary care organisation, Primary Care Sheffield (PCS), has recently been established, the membership of which includes the majority of practices within the city. This has opened up the possibility of commissioning general medical services at scale and is a model that many other health systems are striving for. We would want to seek further funding to develop PCS as part of developing our primary care at-scale work.

PCS are already managing the largest multi-site practice in Sheffield jointly with Sheffield Health and Social Care NHSFT as well as providing specialist services for asylum seekers and the Sheffield violent patient service. PCS are also the lead provider of our Clinical Assessment Services Education and Support (CASES) pilot (see section 3).

PCS were also successful in their application for wave 2 of the Prime Minister's Challenge Fund ('An Enhanced Integrated Primary Care Model for Sheffield') which includes a number of pilot schemes across the city aimed at:

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

The successful elements of the first year of this work are now being taken forward under the continuation of the GP Access Fund (see Improving Access section).

8.3 Future State

We are in the process of developing our own model of Accountable Care System (ACS) for the Sheffield system tailored to the needs of our local system and population.

This will build upon a number of foundations we have already started to lay out in development of neighbourhoods and the focus we have on prevention, technology, integration and risk stratification of our population as a whole.

In order to deliver a successful accountable care solution for Sheffield it is important that our leaders agree a set of key principles, that we describe the functions of the ACS and establish a form on which we all agree as partners that will have a long term beneficial impact on the health and wellbeing of the Sheffield population. The first stage of this approach was completed in July 2016, under the Memorandum of Understanding referenced in Section 1 which has created a framework for achieving the delegation of health and social care to a collaborative framework of Sheffield Commissioners and Providers within a Sheffield Transformation Governance Structure.

9. Engagement

Sheffield CCG is committed to active and meaningful engagement with all its practices and communities and to improve patients' experience of healthcare.

Our engagement principles are supported by the four 'Gunning Principles'[35] and are outlined below:

- *We allocate **sufficient time and resource** into engagement, recognising it as an important and valuable part of commissioning.*
- *We share all the information we have. Being **open and honest**.*
- *We give a **genuine opportunity to influence change**. Maintaining open minds to suggestions. Involving people whilst we are still forming our plans, not when decisions have already been made. Making patients a part of the process of commissioning. Striving for co-production.*
- *We **support and empower**, providing an equal footing for patients and the public to be a part of our work.*
- *We **consider all feedback** that we receive thoroughly and seriously when developing plans and making decisions.*
- *We give due regard to the implications of any changes we make for **protected categories of people**.*
- *We close the loop. Showing the difference that people's involvement has made. Using **'You said, we did'** examples as a badge of honour that we have made better decisions as a result of engagement. Encouraging continued involvement.*

If the CCG is to develop new ways of working it will be vital to ensure that patient experience actively and meaningfully informs new systems and processes. This cannot be done in one way, and will need to include a range of feedback tools to ensure that there is wide engagement across Sheffield; particularly those that are seldom heard.

Active Support & Recovery Design Workshop; Illustrated by Megan Duggan

Patient Participation groups (PPGs) will be a key method to support the transformation of general practice particularly as these groups are plugged into primary care directly as well as other groups, professional committees and localities

PPGs have been in existence for several years and the changes to primary care commissioning, and especially the delivery of the GPFV priorities, will mean that the CCG can more effectively:

- Work with practices to ensure that wherever possible, practices have an active PPG, operating to acknowledged good practice;
- Support PPGs through the PPG Network with information, shared good practice, and the opportunity to consider wider, cross Sheffield issues.

We recognise that PPGs are only one way of engaging the public and understanding patient experience.

[35] For more information on the Gunning (or Sedley) principles, please see: https://adminlaw.org.uk/wp-content/uploads/18-January-2012-Sheldon.pdf

Other areas of engagement will include:

- Connection with community groups;
- Working closely with Healthwatch;
- Condition specific focus groups;
- Patient interviews;
- Patient experience – from the national GP patient survey, local survey work, consultations, the Friends and Family Test and other feedback (i.e. social media, compliments and complaints and issues raised with other bodies such as Healthwatch);
- Links and relationships with our professional committees;
- Ongoing programme of GP practice visits;
- Neighbourhood engagement events;
- PPG network events

Sheffield CCG will aim to triangulate a range of patient experience data to identify themes and trends, areas of good practice and quality concerns, using this data to drive improvements in patients' experience of care and to ensure good performance against NHS Outcomes Indicator Domain 4; 'Ensuring that people have a positive experience of care'[36].

[36] NHS Outcomes Framework (NHS OF) indicators available via http://content.digital.nhs.uk/nhsof

10. Risks and Mitigation

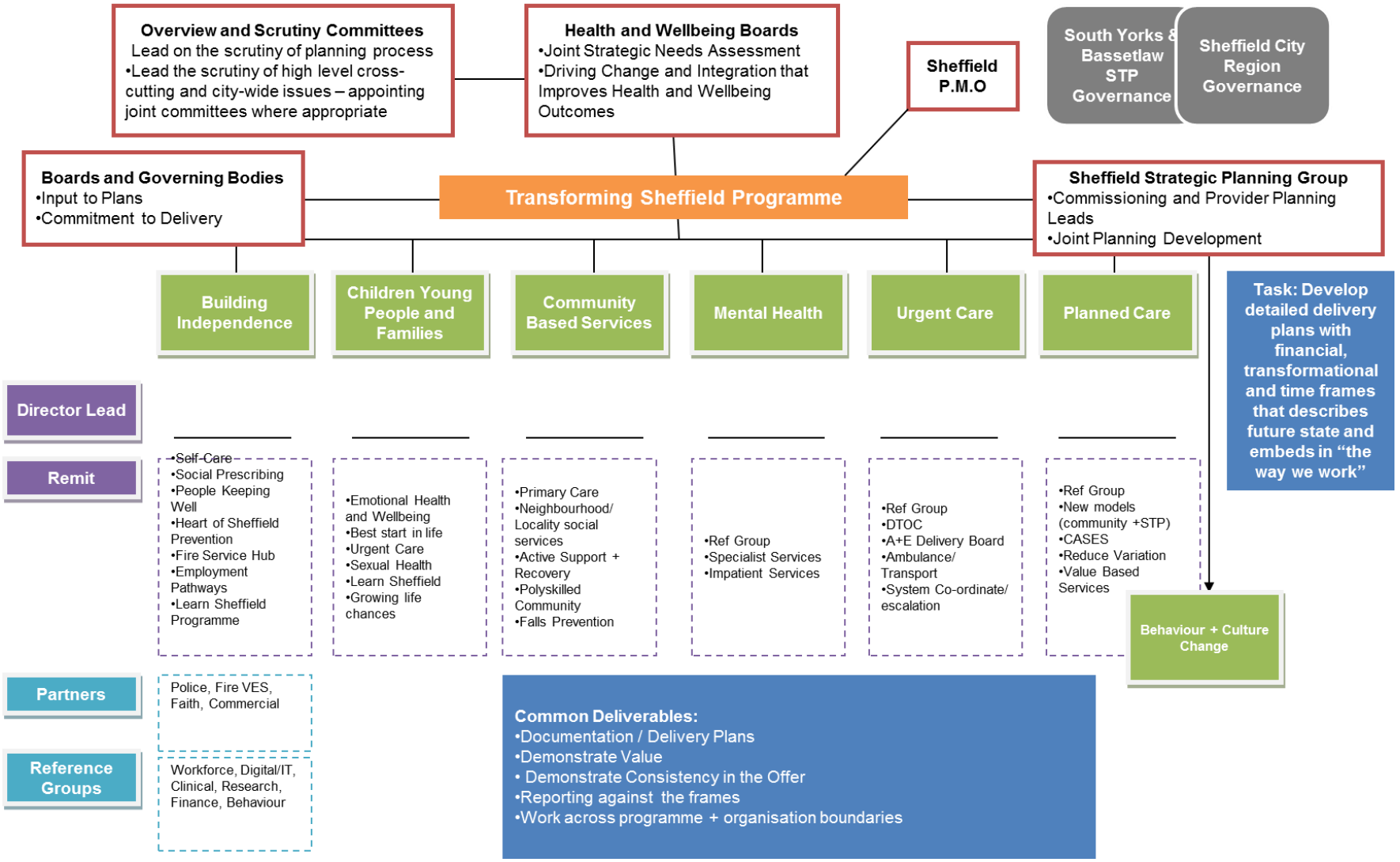
Table 4: Risks and Mitigating Actions

RISKS IDENTIFIED	Key Mitigating Actions
Lack of financial investment	Maximise opportunities for accessing external funding e.g. Primary Care Estates and Technology Transformation Funding, Core Capital Funding
Staff and citizen engagement	Develop effective Organisational Development initiatives; Communications and Engagement strategies; Digital Literacy programmes
Existing workforce skills and training	Increase in teaching practices and trainee placements around nursing, PA's and modern apprenticeship schemes Development of effective OD initiatives supporting change management and digital literacy; undertake training needs analysis; deliver programmes for IT/digital skills development
Practice Engagement	Practice visits, practice support packages through the resilience funding. Locality manager support with CCG strong links into primary care and good relationships
Pace of change required	Ensure the investment available into primary care is targeted in the right areas, with priorities in the CCG clearly identified in the primary care work plan
Unintended negative impact on health inequalities	Robust development of business and technical requirements; identification of benefits; ongoing management/oversight of benefits/disbenefits and risk through PMO approach
Governance	Mature local and SYB STP governance arrangements related to primary are work streams supporting ongoing coordination and collaboration across footprints.
HSCIC/national standards	Delivery of key programmes and deliverables currently within the remit of HSCIC

11. Governance

We are developing a Transforming Sheffield Board structure to support the wider transformation agenda strategically across key partners across Sheffield (*Figure 3*). The Board consists of senior key representatives from across the health and social care system in the city. The structure has a number of working groups supporting and reporting into the new structure. Where relevant the Sheffield CCG response to the GPFV key elements will be taken through this structure.

Fig. 3 - The Sheffield Transformation Programme Governance Structure (draft)



Sheffield GPFV Implementation Plan; Supporting, Developing and Transforming — Appendix 1

1. Supporting Primary Care Infrastructure – Sustainability and Future-Proofing

Aim 1; To ensure that all practices have a clear plan to remain sustainable to deliver the future primary care agenda

Actions	Outcome Measures	Funding & Links to Finance Plan (FP) Appendix 2	16/17 (£k) Est	17/18 (£k) Est	18/19 (£k) Est	19/20 (£k) Est	20/21 (£k) Est
1.1 Resilience **Support all practices to work through their future plans to work across neighbouring areas to explore federations & mergers, branch closures – work with our practices and our Federation, Primary Care Sheffield to explore these options.** ***Resilience Plan being developed for 16/17 – to include e.g., rapid intervention and direct support, practice diagnostics (Dr First, PCC), Change management support*** **Support primary care and neighbourhoods to maximise funding opportunities through delivery of enhanced services (LCS, DES, PH) and continue to develop the LCS offer to support the development of**	Sustainable, fit for future primary care Increase out of hospital activity and reduced secondary care spend	5. GP Resilience Programme (FP)	75	35	35	35	
		Existing CCG Budgets (FP)		74	74	74	
		7. Existing CCG budgets and Transformation Funding (FP)	9 M	13M	13M	13M	13M

Actions	Outcome Measures	Funding & Links to Finance Plan (FP) Appendix 2	16/17 (£k) Est	17/18 (£k) Est	18/19 (£k) Est	19/20 (£k) Est	20/21 (£k) Est
primary and community care							
1.2 <u>Primary Care at Scale</u> **Support practices through resilience programme e.g. practice mergers (see 1.1)** **Continue to support the development of our Federation, Primary Care Sheffield and the vision of 'primary care at scale' for Sheffield and to deliver CASES.** **Support the primary care approach to developing the Local Place Accountable Care system for Sheffield to include scoping the expanded role for citywide federation. Different contracting models will be explored for general practice within the ACO context.**	A fit for purpose deliver vehicle to support delivering primary care at scale Appropriate ACO model in place						
		2. Existing CCG Budgets (FP)	1M	1M			
		7. Transformation funding (FP)		Tbc	Tbc	Tbc	Tbc
1.3 <u>Practice development – releasing time to care</u> **Practices funded to participate in the quick start and**	Time released in primary care by creating efficient	NHSE Funding for PGP					

Actions	Outcome Measures	Funding & Links to Finance Plan (FP) Appendix 2	16/17 (£k) Est	17/18 (£k) Est	18/19 (£k) Est	19/20 (£k) Est	20/21 (£k) Est
full Productive Practice Programme to support releasing time for care – 50 Practices **Deliver Productive Workflow (Care Navigation and Medical Assistant) training across all general practice - Concentrated in 16/17 on workflow optimisation training – HERE training provider** **Care Navigation training programme to be worked up with Sheffield APT from 17/18** **Additional funding required on top of GPFV delegated budget to implement workflow optimisation**	practice systems	4. Training Care Navigators (FP)	51	101	101	101	101
		2. Non-recurrent reserve (FP)		100			
1.4 <u>Access</u> **Carry out capacity demand assessments across practices (working within neighbourhoods) to identify key areas for improving and offering equitable access dependent on need – utilising the nationally commissioned tool from 17/18 for each participating**	Appropriate demand for appropriate need delivered, narrow the gap Effective 7 day access for primary and acute	NHSE National Tool Funding	None required				

Actions	Outcome Measures	Funding & Links to Finance Plan (FP) Appendix 2	16/17 (£k) Est	17/18 (£k) Est	18/19 (£k) Est	19/20 (£k) Est	20/21 (£k) Est
practices **Deliver 7 day access across Sheffield linking in the work around the acute same day hub/urgent care centre and the neighbourhood developments. Delivering services after 6.30 pm week day, Saturdays and Sundays (30 minutes per 1000 rising to 45 minutes per 1000)** **Look at new models of appointments e.g. shared medical appointment model, wound care and support practices to develop and implement.** **Shared learning through clinical masterclasses – To complement the existing PLI but focussing on the Neighbourhoods. Plans combine opportunities for participant practices to discuss and debate responses to the issues surrounding Frailty, LTC and unplanned admissions with clinical sessions to enhance and improve practice. *Developed as part of neighbourhoods 1.5 below.*** ***Develop the primary care estates strategy to include the needs identified above, including ETTF, core capital***	care reducing secondary care spend Released time in primary care Priorities clear for estates developments	6. Improve access to general practice (FP) 7. Transformation funding (FP)	NHSE	3.5M	5.4 M	5.4 M	5.4 M
		Existing CCG Budgets (FP)	45				
		Existing CCG Budgets (FP)	10	5			

Actions	Outcome Measures	Funding & Links to Finance Plan (FP) Appendix 2	16/17 (£k) Est	17/18 (£k) Est	18/19 (£k) Est	19/20 (£k) Est	20/21 (£k) Est
1.5 <u>Neighbourhood Development</u> **Support the neighbourhoods to develop their leadership models and explore the potential for a fully integrated pilot – or *<u>super neighbourhoods</u>*.** **Work within neighbourhoods to reduce and tackle health inequalities.** **Developing, strengthen and support further work to improve partnerships between primary and community third sector organisations – *continuation of the Alliance of the Willing work, PKW, social prescribing.*** **Joint fund the Slovak Roma work with Local Authority** **Explore the opportunity of a fully integrated model through new contracting routes**	Models delivering effective out of hospital care, reducing secondary care spend and reducing health inequalities	Existing CCG Budgets (FP)	580	883			
		Existing CCG Budgets (FP)	20	20			
		Existing CCG Budgets (FP)	25				

2. Developing Primary Care Infrastructure – Training and Leadership

Aim 2; To develop our existing workforce to increase capacity as necessary to deliver a high quality, capable service offer in out of hospital community and primary care settings

Action	Outcome Measures	Links to Finance Plan	16/17 (£k)	17/18 (£k)	18/19 (£k)	19/20 (£k)	20/21 (£k)
2.1 Increasing Training to increase clinicians into Sheffield **Increase the number of training practices in Sheffield or work with neighbourhoods to develop training across the practices.** ***Assessment of the training capacity and coverage across the city.*** **Explore the opportunities of developing local training packages for Sheffield as well as explore the opportunities working with Barnsley CCG around their 'clinical fellowship programme'.** **Work with our ATP to ensure that nurse and HCA training is maximised and numbers increased in Sheffield –(** ***explore the Barnsley Receptionist to HCA model)***	Increased number of training practices in Sheffield and numbers in training Increase HCA apprenticeship in Sheffield An effective practice nurse training plan delivering the required numbers for primary care	7. Transformation funding (FP)	Tbc				
		Existing CCG Budgets (FP)	Tbc				
		Existing CCG Budgets (FP)	Tbc				

Action	Outcome Measures	Links to Finance Plan	16/17 (£k)	17/18 (£k)	18/19 (£k)	19/20 (£k)	20/21 (£k)
2.2 Nurse Leadership **Recruit senior nurses (2) to work across Sheffield to develop, support and drive the primary care workforce agenda to become super mentors to support the nurse mentorship scheme** **Nurse mentorship training programme – 10 nurses trained per year**	Delivery of a primary care workforce plan and reduced impact on workforce gaps Every GP practice in Sheffield with access to a nurse mentor	Existing CCG Budgets (FP)	30	80			
		Existing CCG Budgets (FP)	10	10	10	10	10
2.3 Business/Practice Management Development **Identify business and practice managers to undertake accredited leadership development programme – (await further info re GPFV support)** **+ Leadership Academy training for 10 Sheffield Managers** **Developing local practice management training programme through Sheffield Hallam University – For all Sheffield Managers in:** • **Leadership** • **Communication**	X numbers of business managers trained ready to deliver the primary care at scale agenda	5. Resilience Programme (FP) Await info from GPFV management funding	75	35	35	35	
		Existing CCG Budgets (FP)	45	Tbc	Tbc	Tbc	Tbc

Action	Outcome Measures	Links to Finance Plan	16/17 (£k)	17/18 (£k)	18/19 (£k)	19/20 (£k)	20/21 (£k)
• **Change management** • **Recruitment and retention** • **Succession planning**							
2.4 Clinical Pharmacists **Implement the role of the practice pharmacist working as part of the GP practice team to include 20 senior pharmacists across the neighbourhoods (1 per 30,000) and 100 additional pharmacists working into every GP practice – *further guidance awaited from NHSE***	Released time in general practice by increase in clinical roles and appropriate management of medicines optimisation	GPFV	Tbc	Tbc	Tbc	Tbc	Tbc
2.5 Workforce Planning **Undertake a skills audit and as a result complete a primary/community care workforce plan for Sheffield - *Link in with Doncaster CCG who have completed a skills audit*** **Explore the opportunities of other roles supporting primary care, PAs, primary care mental health, voluntary sector Emergency Care Practitioners (ECP) Physios, Children's Community Nursing, and the voluntary sector**	A clear understanding of the skills available to Sheffield and a plan to utilise – LCS, Neighbourhoods A diversified sustainable workforce	1. Practice Transformational Support (FP) 7. Transformational funding (FP)	10 Tbc	Tbc	Tbc	Tbc	Tbc

Action	Outcome Measures	Links to Finance Plan	16/17 (£k)	17/18 (£k)	18/19 (£k)	19/20 (£k)	20/21 (£k)
2.6 Increase the Workforce **Work with ATP and NHS Y&H on GPN ready scheme to increase opportunities for newly qualified staff nurses seeking posts in primary care.** **Encourage apprenticeships by engaging with careers officers at local secondary schools & work with ATP** **Engage with the planned recruitment fayre for PAs trained by Y&H to retain newly qualified PAs in primary care.** **Look at other healthcare professionals who have skills to offer by means of a matrix of competencies.**	**Increase nurse mentor numbers by 10 per year.** **Increase number of nurses going into primary care.** **By increasing nurse mentors in practices opportunities will be afforded to student nurses to spend time in general practices and come to see primary care as a destination on completion of training.**	1. Practice Transformational Support (FP) 7. Transformation Funding (FP) NHSE funding to be identified for clinical pharmacy programme		883	883		

3. Transforming Primary Care Infrastructure – Technology and Estates

Aim 3, To ensure that our estate and technology strategies support the sustainability and transformation of primary care

Action	Outcome Measures	Links to Finance Plan	16/17 (£k)	17/18 (£k)	18/19 (£k)	19/20 (£k)	20/21 (£k)
3.1 Estates Development **Completion of a primary care estates plan, in keeping with the Strategic Estates Plan for Sheffield and delivery of other key strategies – Out of Hospital Care, Primary Care Strategy and our response to the GPFV.** ***Align ETTF and core capital developments to the estate plan.*** **Review of revenue requirements as part of the delivery of the ETTF schemes**	Buildings fit for future delivery of out of hospital care	Community Health Partnerships/Existing CCG Funding (FP)	5	5			
		ETTF and Existing CCG Funding (FP)		Tbc	Tbc	Tbc	Tbc
3.2 IM&T Development **Deliver the top two IT priorities through the ETTF**	Increased capacity in	ETTF		Tbc	Tbc	Tbc	Tbc

Action	Outcome Measures	Links to Finance Plan	16/17 (£k)	17/18 (£k)	18/19 (£k)	19/20 (£k)	20/21 (£k)
scheme and implement on a citywide basis **1. Shared Records and Interoperability** **2. Mobile working** **& Implementation of our other IT priorities:** **1. Roll-out laptop programme (Hardware, licences and mobile ready for every GP practice)** **2. Online appointment booking and prescription ordering for patients** **3. Patient access to records** **4. E-consultations** **5. Technology to support remote assessment and treatment of patients in their own homes via telemedicine and self-observation** **6. Use and accreditation of apps to support treatment and intervention** **7. Support practices to embrace new technologies**	primary care through the development of technology Increased self-help, less impact on primary care access	National IT funding and GP IT Existing CCG Funding (FP)	100k				
		GPIT and core capital	Tbc	Tbc	Tbc	Tbc	Tbc
3.3 Implementation of the on-line consultation general practice software systems **Stage 1 - will be to identify technical solutions that fit with our existing GP Systems (SystmOne and EMIS Web). We will explore TPP SystmOne and EMIS supplier offerings (possible use of SKYPE).** **GPFV Transformation Team webinars early in 2017,**	Increased capacity, more consultations, less face to face contact	3. On-line general practice consultation software systems- GPFV (FP)		152	203	202	

Action	Outcome Measures	Links to Finance Plan	16/17 (£k)	17/18 (£k)	18/19 (£k)	19/20 (£k)	20/21 (£k)
Utilise national guidance on e.g. 'good practice' for procuring software solutions when it becomes available. **We will need to consider networking / security issues and link these to next year's HSCN Health and Social Care Network procurement.** **Stage 2 - We will consider trialling solutions within a neighbourhood with a mix of systems (SystmOne, EMIS).** **We will utilise project days from within the eMBED IT Support contract to provide technical support.** **Stage 3 – will be to work up a full implementation plan**							

NHS Sheffield CCG GP Forward View Funding Plan

Link to Work Plan at Appendix 1	*Funding Stream*			Core Contract/Delegated						Primary Care Additional CCG-Commissioned Services					
				2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/2021**	**2021/2022**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/2021**	**2021/2022**
		2016/17 Confirmed Allocation		74,747,000											
		In-Year Allocations Adjustments From NHSE		(94,000)											
	Existing CCG Budgets	Closing Allocation from 2016/17		74,653,000											
		Closing Recurrent Budget From CCG Programme								8,728,000					
		Recurrent transfer of resources to fund LCSs eg 'over and above' linked to PMS transition		(2,619,000)						2,619,000					
		Opening Total Budget 2017/18		72,034,000						11,347,000					
		2017/18 Cash Uplift on Allocation			1,375,500						831,000				
		Proposed Transfer of Resources - linked to year 3 of PMS transition			(831,000)						(100,000)				
		QIPP Savings													
see 2.5 & 2.6 on Work Plan	*Pot 1 - Non-rec monies in CCG Baseline*	1) **Practice Transformational Support** £1.50/head for 2 years									883,000				
		Proposed Baseline Budget 2017/18			72,578,500						12,961,000				
		2017/18 Cash Uplift on Allocation				1,469,000									
		Proposed Baseline Budget 2018/19				74,047,500						12,961,000			
		Potential Additional Investment - NOT INCREMENTAL													
see 1.3 on Work Plan	*Pot 2 - Spare budget from co-comm budgets*	2) **50% of non-rec 1% reserve** can be pre-committed on non-rec issues each year			374,000	374,000	374,000	374,000	374,000						
see 3.3 on Work Plan	*Pot 3 - GPFV additional funding incl access*	3) **On-Line General Practice Consultation Software Systems** (£45m over 3 years from 17/18 based on GP registration projections)	*If additional funding is not available from GPFV then the CCG will not be able to implement these schemes*		152,560	203,064	202,656								
see 1.3 on Work Plan	*Pot 3 - GPFV additional funding incl access*	4) **Training Care Navigators & Medical Assistants** (£45m over 5 years based on GP registration projections)	*If additional funding is not available from GPFV then the CCG will not be able to implement these schemes*		101,707	101,532	101,328	101,104							
see 1.1 on Work Plan	*Pot 3 - GPFV additional funding incl access*	5) **General Practice Resilience Programme** (£40m over 4 years - to be allocated on fair shares basis, Yorks and Humber to receive £796,967 in 17/18, 18/19 & 19/20). Assume Sheffield will get £70k pa	*If additional funding is not available from GPFV then the CCG will not be able to implement these schemes*		70,000	70,000	70,000								
see 1.4 on Work Plan	*Pot 3 - GPFV additional funding incl access*	6) **Improve Access to General Practice Services**. £6/head 17/18, £6/head 18/19 plus £3.34/head 18/19 then £9.34/head rec	*If additional funding is not available from GPFV then the CCG will not be able to implement these schemes*		3,496,272	5,442,530	5,442,530	5,442,530	5,442,530						
see 1.1, 1.2, 1.4, 2.1, 2.5 and 2.6 on Work Plan	*Pot 4 - Funding requested from STP by CCG*	7) **Transformation Funding** at £3/head in 17/18, £4/head in 18/19, £5/head in 19/20 & £6/head in 20/21 rec to support Place-Based-Plan	*If additional funding is not available from the STP then the CCG will not be able to implement these schemes*		1,748,136	2,330,848	2,913,560	3,496,272	3,496,272						
		Total Potential Additional Investment Each Year - NOT INCREMENTAL			**5,942,675**	**8,521,974**	**9,104,074**	**9,413,906**	**9,312,802**		-	-	-	-	-

Pot 2b	**Invest to save**	CCG has a number of 'invest to save' schemes to reduce admissions eg CASES, social prescribing & care-coordination where if a business case demonstrates a suitable return on investment then additional investment may be made in Primary and Community Care. Any agreed ETTF revenue implications will need to be funded from the contingency reserve in baseline budgets. The GPFV figures are an estimate based on the guidance issued to date, some assumptions have been made which may change over time.

PROJECT ON A PAGE

MOBILISING COMMUNITIES, GENERAL PRACTICES AND THE VOLUNTARY SECTOR TO IMPROVE HEALTH

WHAT IS THE PROBLEM?

Primary Care needs stronger links with citizens and communities, **particularly with those experiencing inequalities**

Evidence base shows that active citizens can make an important contribution to their own health, that of their families and their communities, **but the actions required for this to happen are not clear**

The 600 Community Anchor Organisations (CAOs) in England know how to engage communities, **but their role is not well understood by the NHS**

WHAT WILL THE PROJECT DO?

Develop tools informed by research and practical experience that will help local health systems develop stronger collaborations with neighbourhood community organisations in order to improve the health of disadvantaged communities.

HOW WILL WE DO THIS?

SHEFFIELD ALLIANCE OF THE WILLING

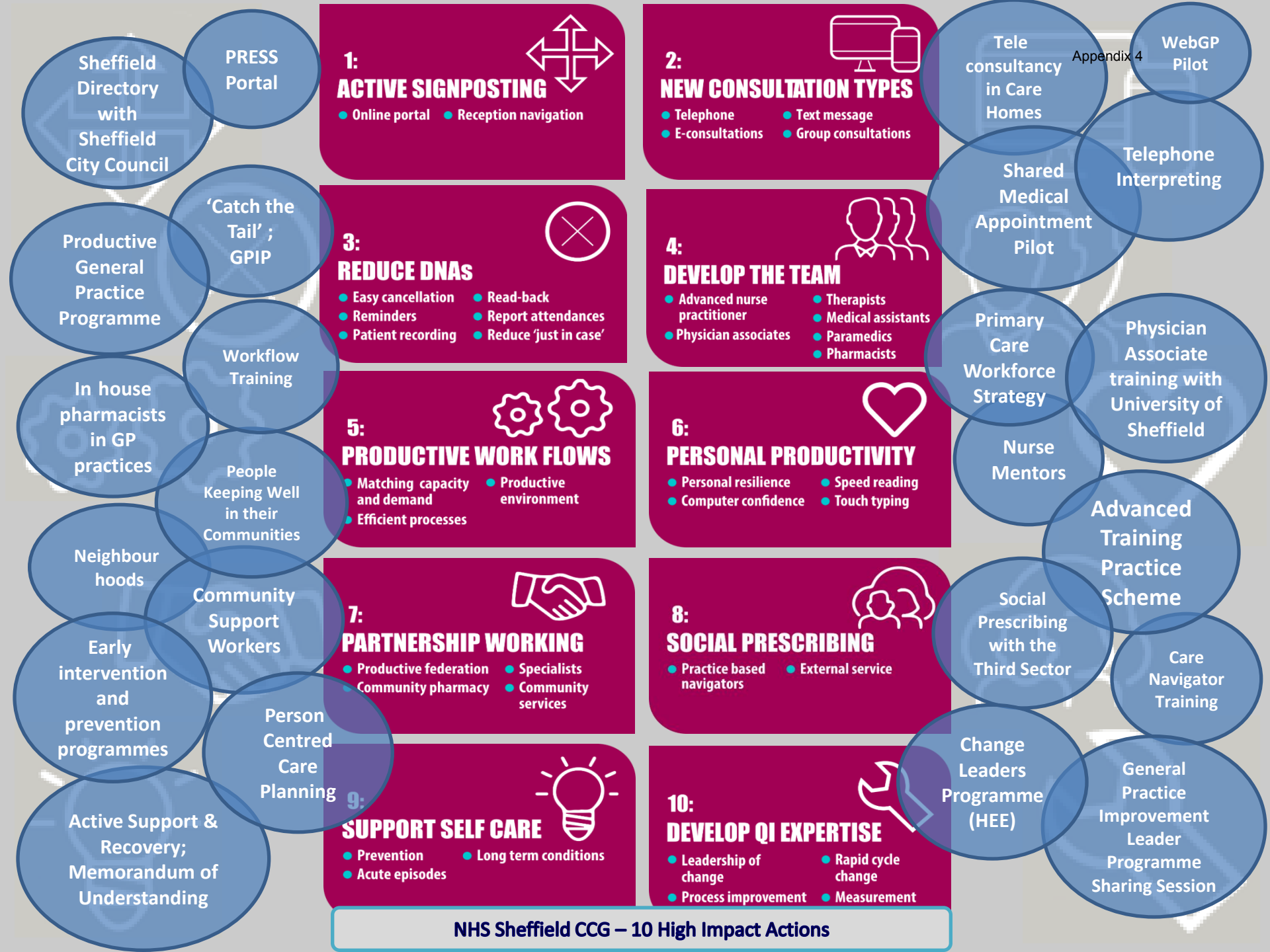
15 GPs
6 CAOs
1 CCG
1 Local Authority

&

LOCALITY HEALTH NETWORK (ENGLAND)

40 CAOs plus their existing relationships with CCGs and GPs

1
2
3
4
5
6
7a **SEND FEEDBACK ON IMPACT** to Locality Health Network
7b
FEEDBACK
IMPACT REPORT
DISSEMINATION



NHS Sheffield CCG – 10 High Impact Actions

Appendix 5

NHS Sheffield CCG
Locally Commissioned Expenditure on Primary Care Services
Month 7 Position - April to October - Financial Year 2016/17

Budget	Full Year Plan	Forecast Spend	Forecast Variance
	£000	£000	£000
Paediatric Referral Refinement	23	24	1
Glaucoma Service	7	7	0
CATS scheme	10	9	(1)
PEARS scheme	213	236	23
Ophthalmology Services - Sub Total	**253**	**276**	**23**
24 Hour Blood Pressure Monitoring	152	178	27
Anticoagulation	952	916	(36)
Care Homes	755	755	0
Care Planning	544	394	(150)
Care Of Homeless	43	43	0
Carpal Tunnel	35	23	(11)
Eating Disorders	37	37	(0)
D Dimers	4	3	(1)
Dermatology/Cryotherapy/Cutting	28	27	(1)
Dmards	180	195	15
Diabetes (note 1)	0	0	0
Central Locality ENT Pilot	88	104	16
Endometrial Biopsy	9	4	(5)
Hepatitis B	8	9	1
Mirena	22	22	0
Colorectal Screening	9	7	(2)
Pessaries	49	48	(1)
Zoladex	41	42	2
Minor Surgery	24	23	(1)
PMS Transition:"Over and Above" & Special Cases	3,216	3,216	0
GP Engagement Elective Service Transformation	1,149	1,149	0
GP Engagement Prescribing Quality	287	287	0
Winter Resilience	350	350	0
Contingency Reserve	200	200	0
Social Prescribing CSWs	0	70	70
GPs in A&E SCH and STH	0	70	70
GP Services - Sub Total	**8,178**	**8,170**	**(8)**
Pharmacy - Sub Total	**448**	**448**	**(0)**
Neighbourhood Developments Reserve	**1,064**	**634**	**(430)**
Other Primary Care Expenditure			
PLIs	106	106	0
GP IT	1,009	1,177	168
Contract With Primary Care Sheffield Ltd	1,083	1,083	0
GP Training	40	46	6
Interpreting Services	726	726	0
Other Primary Care Expenditure - Sub Total	**2,964**	**3,138**	**174**
Locally Commissioned Expenditure on Primary Care Services - Total (note 2)	**12,907**	**12,666**	**(240)**

Notes:
1) The CCG has received income of £22.5k for diabetes which will be spent by the end of the year
2) If this total is compared with the Governing Board Paper there is a difference of £106k as the PLI budget is recorded under Running Costs

Sheffield CCG Delivering the GP Forward View - Appendix 6

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