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Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Wednesday 13 July 2016 at 4.00 pm

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

The Press and Public are Welcome to Attend

Membership

Councillor Pat Midgley (Chair), Sue Alston (Deputy Chair), Pauline Andrews, David Barker, Mike Drabble, Adam Hurst, Douglas Johnson, George Lindars-Hammond, Anne Murphy, Shaffaq Mohammed, Zahira Naz, Moya O'Rourke, Bob Pullin, Jackie Satur and Garry Weatherall

Healthwatch Sheffield
Helen Rowe and Alice Riddell (Observers)

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

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

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

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

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

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

If you require any further information about this Scrutiny Committee, please contact Alice Nicholson, Policy and Improvement Officer on 0114 27 35065 or email alice nicholson@sheffield.gov.uk

FACILITIES

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

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

HEALTHIER COMMUNITIES AND ADULT SOCIAL CARE SCRUTINY AND POLICY DEVELOPMENT COMMITTEE AGENDA
13 JULY 2016

Order of Business

1. Welcome and Housekeeping Arrangements

2. Apologies for Absence

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

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

5. Minutes of Previous Meetings (Pages 5 - 12)
To approve the minutes of meetings of the Committee held on 23rd March and 18th May, 2016

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

7. Care Quality Commission Inspection Report 2016 - Sheffield Teaching Hospitals NHS Foundation Trust (Pages 13 - 64)
Report of the Policy and Improvement Officer
(David Throssell, Medical Director, Sandi Carman, Head of Patient and Healthcare Governance, Sheffield Teaching Hospitals NHS Foundation Trust, to attend)

8. Draft Work Programme 2016/17 (Pages 65 - 72)
Report of the Policy and Improvement Officer

For Information Only

9. Quality Accounts 2015/16 - Quality Assessment Submissions (Pages 73 - 80)
Report of the Policy and Improvement Officer

10. Joint Health Overview and Scrutiny Committee - Commissioners Working Together Programme (Pages 81 - 82)
Report of the Policy and Improvement Officer

11. Sheffield Clinical Commissioning Group Primary Care Strategy 2016 (Pages 83 - 142)
Report of the Policy and Improvement Officer

12. Date of Next Meeting

The next meeting of the Committee will be held on Wednesday, 14th September, 2016, at 4.00 pm, in the Town Hall

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

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

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

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

You **must**:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You have a personal interest where –

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

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

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

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

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

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

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

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SHEFFIELD CITY COUNCIL

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 23 March 2016

PRESENT: Councillors Cate McDonald (Chair), Sue Alston (Deputy Chair), Pauline Andrews, George Lindars-Hammond, Shaffaq Mohammed, Mick Rooney, Jackie Satur, Geoff Smith, Garry Weatherall, Brian Webster and Joyce Wright

Non-Council Members (Healthwatch Sheffield):-

Helen Rowe

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1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors Katie Condliffe and Peter Price and Alice Riddell (Healthwatch Sheffield).

2. EXCLUSION OF PUBLIC AND PRESS

2.1 No items were identified where resolutions may be moved to exclude the public and press.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest.

4. MINUTES OF PREVIOUS MEETING

4.1 The minutes of the meeting of the Committee held on 24th February 2016, were approved as a correct record subject to:-

(a) an apology being recorded for Councillor Joyce Wright; and

(b) Paragraph 9.2(a) (Work Programme 2015/16) being amended to read 'a report would be submitted to a future meeting of the Council with regard to proposals for the establishment of a regional Joint Overview and Scrutiny Committee, at the request of NHS England and NHS Sheffield Clinical Commissioning Group, to comprise representatives from the local authorities of Sheffield, Barnsley, Doncaster, Rotherham, Wakefield, Nottinghamshire County Council and Derbyshire County Council, to consider substantial variations to local health services under the Working Together Programme, and'.

4.2 Arising from consideration of the minutes, it was reported that the Council's Cabinet had thanked the Home Care Scrutiny Task Group for its report which it had recently received.

5. PUBLIC QUESTIONS AND PETITIONS

5.1 Responses were provided to public questions as follows:-

- Consideration would be given to the inclusion of the Dementia Strategy on the Committee's Work Programme for the next Municipal Year.

- The Working Together Programme would assist in maintaining the valued features of Primary Care in the wider region. Furthermore, the Committee's value of Primary Care was reflected in it being included on the agenda for this meeting. The Committee was also working with the Clinical Commissioning Group and the Health and Wellbeing Board to ensure that these valued aspects were preserved.

- The issue as to whether the proposed Primary Care Strategy had been piloted elsewhere would be addressed in the following item on Access to GP Services.

6. ACCESS TO GP SERVICES

6.1 The Committee received a report of the Policy and Improvement Officer on Access to GP Services which included an extract from the National Patient Survey on making an appointment. This was supplemented by a presentation on the Draft Primary Care Strategy for Sheffield and a handout on the Enhancing Primary Care Programme.

6.2 In attendance for this item were Katrina Cleary (Programme Director, Primary Care, NHS Sheffield Clinical Commissioning Group (CCG)), Dr. St. John Livesey (GP Clinical Lead Primary Care, NHS Sheffield CCG) and Steven Haigh (Enhancing Primary Care Programme, Prime Minister's Challenge Fund).

6.3 Katrina Cleary opened the presentation on the Draft Primary Care Strategy for Sheffield, making reference to the way in which the strategy had been developed and the reasons why Primary Care needed to change in Sheffield. In doing this, she highlighted the increasing volume of demand for Primary Care services and the increasing proportion of patients with complex needs, together with increasing physical and mental health co-morbidity.

6.4 Members made various comments and asked a number of questions, to which responses were provided as followed:-

- It was important for Primary Care practices to consider sustainability, which could include either merging or working more collaboratively together to take advantage of economies of scale.

- Katrina Cleary indicated that, with effect from 1st April 2016, she would be the contact point at the CCG for any problems relating to General Practice issues. She added that the CCG would be taking responsibility for any issues and

would work closely with NHS England in this regard.

- Whilst each age group had shown increased GP visits per symptom, there had been a big increase in respect of the elderly, due to their longevity and more complex needs.

- The weighted payment was a national formula which took account of deprivation, level of demand and the amount of long-term limiting illness. The CCG was currently looking at practices that had lost money as a result of the weighted payment formula.

- It should also be noted that there was a national GP recruitment shortage.

- The development of a local Primary Care Strategy would enable some local issues to be addressed and would reflect the knowledge of the City and the GPs in it. GPs were clear that change was required and, in answer to the earlier public question, other areas had introduced their own strategies, but as yet there had been no evaluation of them.

- It was not anticipated that fewer GPs would be required, but this was a possibility. The need to make Sheffield more attractive for GPs to come and work here was recognised and it was felt that the neighbourhood way of working would contribute to this. Managing the work of a GP was challenging and interesting and it was felt that if the job was made more do-able, then GPs would come to the City.

- Rather than passing the buck, the increased use of pharmacists and practice nurses to perform certain tasks currently undertaken by GPs, was more about using skills as appropriate. It was also worth noting that a large number of practice nurses and practice managers were nearing the point of retirement.

- Other areas were in a worse position than Sheffield with regard to attracting GPs, but it all went back to making the job more do-able. There was a need to be clear about the workforce strategy and to see Information Technology as an enabling capacity.

6.5 Katrina Cleary then continued the presentation, making reference to the Out of Hospital Services plan and the need to do something about Primary Care but as part and parcel of the Health and Social Care system. Dr. St. John Livesey added that the system was struggling to adapt to a new type of patient, which were those living with illness or frailty and highlighted the need for such patients to be looked after out of hospital. He went on to illustrate the position by means of a diagram which showed how GPs were carrying out the vast majority of out of hospital work and how this should change with the involvement of district nurses, practice nurses and other practitioners to free up GP's time. Dr. Livesey emphasised the importance of people being looked after at home where possible and the importance of neighbourhood support.

6.6 Members made various comments and asked a number of questions, to which

responses were provided as follows:-

- A number of engagement events were being planned for over the Summer, with members of the public and local groups being encouraged to comment on the overall strategy.

- It was accepted that the perception of non-GP access was a challenge, but if a nurse or other practitioner thought there was a need for the patient to see the GP, then this would happen. It was important to reinforce this message, but it appeared that people were now getting used to this way of working.

- Pharmacy was a much wider profession than merely dispensing prescriptions, so the next stage in the process was looking at pharmacists being part of the Primary Care team.

- Representatives of the CCG were happy to engage with Councillors in an attempt to improve communication and establish links with local groups.

- Hospitals were not resistant to the proposals being put forward.

- The way in which funding would be redistributed as a result of the proposals would be solved nationally.

- In relation to the National Patient Survey, it was recognised that not everyone had a computer or visited a GP, so Healthwatch Sheffield had been engaged, together with community groups and local media, with a view to reaching as many people as possible.

- The aim was to encourage collaboration between the providers of Primary Care with a view to looking for integrated provider solutions, but there would be occasions where the market would need to be used.

6.7 Steven Haigh then referred the Committee to the circulated handout on the Enhancing Primary Care Programme and explained that Sheffield had been awarded £9.3m by the Prime Minister's Challenge Fund to deliver the programme. Primary Care Sheffield, which was a federation of GPs in the City, had been set up to lead the programme, working together with other health and social care organisations. He went on to refer to proposals for seven day access, the use of Satellite Units to provide urgent primary care appointments and the positive feedback received from patients who had been seen by pharmacists. In conclusion, he informed the Committee of an evaluation of the programme which was being undertaken by Sheffield Hallam University, which would look at issues such as added value and the citizen experience.

6.8 Members made various comments and asked a number of questions, to which responses were provided as follows:-

- The Satellite Units were designed to deal with urgent cases, with the key question being their impact on A&E attendance, however it was too early to

evaluate this. Data was being collected on outcomes, but there was no reason to suspect that patients were getting a second opinion from their own GP.

- A decision would be taken in the surgery as to whether to use the City-wide Rapid Access Team in any particular situation.

- The £9.3m was not a recurring sum, but the Department of Health and NHS England had indicated that they didn't want to see features of the programme (those that specifically provided extended access) discontinued. This was likely to result in additional funding being made available.

- Primary Care Sheffield was accountable to the GPs who had signed up to it and to the Prime Minister's Challenge Fund, which required reporting on the progress in achieving set milestones. In addition, there was a local programme board, with all key stakeholders, including the Council, being members.

- The CCG and Local Authority had a role in assessing need and the Primary Care Strategy also set out health needs. The Local Delivery Group had also requested that the Primary Care Strategy reflected health needs and these were also accounted for in the wider CCG Strategy and the Better Care Fund Strategy. The key point was whether commissioning and contracting decisions had made an impact on the delivery of Primary Care.

6.9 RESOLVED: That the Committee:-

(a) thanks those attending for their contribution to the meeting;

(b) notes the contents of the report, presentation and circulated handout and the responses to questions; and

(c) requests that:-

(i) the Policy and Improvement Officer includes Access to GP Services on the Committee's Work Programme for the next Municipal Year;

(ii) the Primary Care Strategy and the Enhancing Primary Care Programme adequately reflect the key issues of public communication, access and equity;

(iii) the results of the consultation on the Primary Care Strategy and the evaluation of the Enhancing Primary Care Programme be sent to the Policy and Improvement Officer for circulation to Committee Members; and

(iv) a final version of the Primary Care Strategy be sent to the Policy and Improvement Officer for circulation to Committee Members.

7. ADULT SAFEGUARDING AND SCRUTINY - DEVELOPING THE RELATIONSHIP

7.1 RESOLVED: That the Committee notes the contents of the report now submitted on proposals for strengthening communication and developing the relationship between the Adult Safeguarding Service and the Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee.

8. ACTIVITY 2015/16 AND FUTURE WORK PROGRAMME 2016/17

8.1 RESOLVED: That the Committee:-

(a) notes the contents of the Activity 2015/16 and the Future Work Programme 2016/17 report; and

(b) requests that any comments on the report be communicated to the Policy and Improvement Officer.

9. DATE OF NEXT MEETING

9.1 It was noted that the next meeting of the Committee would be held on a date to be arranged.

S H E F F I E L D C I T Y C O U N C I L

Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee

Meeting held 18 May 2016

PRESENT: Councillors Pat Midgley, Sue Alston, Pauline Andrews, David Barker, Mike Drabble, Adam Hurst, Douglas Johnson, George Lindars-Hammond, Anne Murphy, Shaffaq Mohammed, Zahira Naz, Moya O'Rourke, Bob Pullin, Jackie Satur and Garry Weatherall

Non-Council Members (Healthwatch Sheffield):-

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1. APOLOGIES FOR ABSENCE

1.1 No apologies for absence were received.

2. APPOINTMENT OF CHAIR AND DEPUTY CHAIR

2.1 RESOLVED: That Councillor Pat Midgley be appointed Chair of the Committee and Councillor Sue Alston be appointed Deputy Chair.

3. DATES AND TIMES OF MEETINGS

3.1 RESOLVED: That meetings of the Committee be held on a bi-monthly basis on dates and times to be determined by the Chair, and as and when required for called-in items.

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 13th July 2016

Report of: Policy & Improvement Officer

Subject: CQC Inspection Report June 2016 – Sheffield Teaching Hospitals NHS Foundation Trust

Author of Report: Alice Nicholson, Policy and Improvement Officer
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0114 273 5065

The Care Quality Commission (CQC) undertook an inspection visit 7th -11th December and 23rd December 2015 of Sheffield Teaching Hospitals NHS Foundation Trust. Their report was published 9th June 2016. Representatives of the foundation trust have been invited to the meeting to present the findings of the quality report and respond to questions the Committee may have on the findings of this inspection report. The Quality Report is attached.

The Scrutiny Committee is being asked to:

- Consider, comment on findings in this inspection quality report following presentation by representatives of Sheffield Teaching Hospitals NHS Foundation Trust

Category of Report: OPEN

Sheffield Teaching Hospitals NHS Foundation Trust

Quality Report

Herries Road,
Sheffield,
South Yorkshire,
S5 7AU
Tel: (0114) 271 1900
Website: http://www.sth.nhs.uk

Date of inspection visit: 7– 11 Dec and 23 Dec 2015
Date of publication: 09/06/2016

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Sheffield Teaching Hospitals NHS Foundation Trust from 7 -11 December 2015 and undertook an unannounced inspection on 23 December 2015. We carried out this inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme.

We included the following locations as part of the inspection:

- Northern General Hospital
- Royal Hallamshire Hospital, including Jessop Wing
- Weston Park Hospital
- Charles Clifford Dental Hospital
- Community services including adult community services, community inpatients, community dentists, renal dialysis unit and end of life care.

We did not inspect the GP out of hours service based at the Northern General Hospital site.

We rated the trust as good. Royal Hallamshire Hospital, Northern General Hospital, Charles Clifford Dental Hospital and the community services were rated as good. Weston Park Hospital was rated as requires improvement.

Our key findings were as follows:

- The trust was led by a stable and respected board.
- We found the hospital was clean and staff adhered to infection control principles. The trust scored 99% for cleanliness in the patient-led assessments of care environments (PLACE) report for 2015.
- There was a trust infection control accreditation programme in place. This programme set standards for infection prevention and control practice. Most clinical areas had achieved accreditation; plans were in place where this was not the case.
- There had been four cases of MRSA reported by the trust between June 2014 and June 2015.
- There had been 88 cases of C.difficile between June 2014 and June 2015. This was a rate in line with the England average per 10,000 bed days. The trust's rate of C.difficile was below the trajectory target with 42 cases against a stretch target of 52 cases at the end of November 2015.
- The trust had a well-established governance framework in place and incidents were reported and actions taken in response.
- The trust used the safer nursing care tool, professional judgement and nursing hours per patient day to determine appropriate levels of staffing. There were some areas where staffing fell below planned levels on a regular basis, particularly in the Emergency Department and Weston Park Hospital wards, although the trust was mitigating risks as far as possible. Recruitment to vacancies was in progress. Staff were able to use bank or agency staff, where available, to fill staffing shortfalls.
- The trust was committed to the development of advanced nurse practitioners to ensure patient care was maintained and the potential recruitment difficulties to junior doctor posts mitigated. This also allowed good advancement opportunities for nurses.
- Mortality indicators showed no evidence of risk.
- Patients were assessed for their nutritional needs. The trust had introduced HANAT (hydration and nutrition assurance toolkit) to encourage good nutrition and hydration best practice in the hospital environment.
- We saw patients being cared for with kindness, dignity and respect and many services across acute and community patients told us they were very happy with their care.
- We saw examples of effective multi-disciplinary working across both acute and community services
- There was a well-established culture of continuous quality improvement. This was supported and assured by robust governance, risk management and quality monitoring. The trust used a Microsystems Coaching Academy which worked well to support small scale service improvements.
- The trust's vision and values were embedded in practice. These informed performance reviews and staff felt they were meaningful.
- Clinical directorates had individual five year strategies that were linked to trust's strategy, aims and objectives. The directorate strategies had consideration of the other clinical departments they worked with to deliver high quality care and the assistance required from corporate directorates and

other partners. There was, however, no local end of life care strategy that provided an integrated acute and community vision of care for patients who were at the end of life.
- The trust did not record the preferred place of death for those patients coming to the end of life and there were occasions when patients had to wait for up to two weeks to access a bed on the palliative care unit.
- A culture of innovation and improvement was evident throughout all levels of the organisation.
- There were concerns regarding the emergency department at the Northern General Hospital this included the clinical decision unit. Specifically we had concerns regarding the quality of care of patients during times when the department was busy.
- There were concerns regarding the clinical decision unit specifically regarding the monitoring and escalation of deterioration patients in the seated area of this unit. We raised this with the trust at the time of inspection and a protocol was put in place.
- The introduction of a new IT system had resulted in the trust not being able to record performance targets in the emergency department.
- There were variable levels of compliance across both community and acute services for mandatory training levels. In the dental hospital staff had not received any training in Mental Capacity Act or Deprivation of Liberty standards.
- We were concerned about the use of the teenage and young adult unit for patients who required an acute bed.
- There was variation in the quality and completeness of Do Not Attempt Resuscitation (DNACPR) forms across all of the acute hospital sites.
- In medicine there were concerns regarding the access to nursing guidelines that were held electronically and could not always be accessed by agency nurses. Care was conveyed between nurses using the handover sheets rather than referring to the nursing care plan.

We saw several areas of outstanding practice including:

Community dental service

- A collaboration between the Sheffield Community Dental Services, NHS commissioners, Dental Public Health consultants and local general dental practitioners led to the development of the Residential Oral Care Sheffield service for residents living in care homes. This collaboration was cited as good practice by the British Society for Disability and Oral Health. This service now covers 80 out of the 88 residential care homes who participate in the scheme in the city of Sheffield.
- The clinical lead was instrumental in developing a national benchmarking tool used by other community dental services and NHS dental commissioners for describing the complexity of patients treated by community dental services. An evaluation of the outcomes of the pilot project was delivered at the National Association for Dentistry in Health Authorities and Trusts in 2014.
- Collaboration between the Clinical Lead of Sheffield Community Dental Services and the Head of Psychotherapy Services within Sheffield NHS Foundation Trust developed a dental nurse led Pain and Anxiety Service. This led to a reduction in the numbers of patients needing intra-venous sedation for dental treatment and the overall waiting times for intra-venous sedation.
- Sheffield Community Dental Service provided a service for the Sheffield homeless under the auspices of the 'Archer Project at the Cathedral'.
- Sheffield Community Dental Service had developed a communication tool known locally as 'the widget sheets' enabling children with autistic spectrum disorders and other communication difficulties to accept dental treatment. An evaluation of this audit tool was published in the peer reviewed international scientific publication 'Journal for Disability and Oral Health in 2014.
- The development of a number of nationally recognised clinical benchmarking tools by Sheffield Community Dental Service was a result of exceptional leadership provided by the current Clinical Lead of the Service.

Community Adults

- The active recovery service was a responsive service, which aimed to reduce un-necessary hospital admissions and facilitate the timely discharge of more complex patients from hospital. The team was multidisciplinary and multiagency with health and social care working closely together. The service had redesigned the traditional model of assessing to

discharge to the more patient centred approach of discharge to assess resulting in reduced length of stay for patients and improved patient flow within the hospital.
- The Single Point of Access (SPA) service managed referrals from patients and health professionals into all community health services. The service used a call routing system to direct patients to the right professional from the start. The team had extensive local knowledge and specialist expertise and were able to access to up to date information on service capacity. This meant that they could ensure patients were seen by the right professional at the right time at a venue of their choice.
- We thought the person centred care planning was outstanding. The aim of this was to provide support for patients considered to be at high risk of hospital admission at an early stage. Community nurses and GPs worked together to develop patient and carers confidence in managing their own health. The community matron supported this. There were locality champions for person centred care planning in each of the four localities.

Northern General Hospital

- The patient care and experience delivered by staff in the Bev Stokes Day Surgery Unit was outstanding, particularly in relation to patients living with learning disabilities and dementia.
- The duty floor anaesthetist role in theatre developed in Sheffield was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- The development of a relative's room in the theatre complex.
- On general intensive care unit /general high dependency unit there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services.
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in critical care.
- The use of the Enhanced Recovery After Thoracic Surgery (ERAS) programme had resulted in marked improvements in the quality of care for patients on cardiac intensive care unit (CICU).
- The laboratory team had introduced a 'Patient Safety Zone' project into the inpatient wards and in the community. The aim was to reduce labelling errors. Disturbance or distraction while taking blood samples has been identified as a major risk factor for errors. This initiative had been introduced to improve patient safety. Pathology staff showed us lots of publicity material, including branded biro pens.
- In laboratory medicine, we observed large screens above the bench dealing with urgent samples. It contained a full list of patients waiting for results in the accident and emergency (A&E) department. The same screens were on display in A&E. This meant laboratory staff could see exactly who was waiting in A&E and gave context and 'humanity' to the samples they were analysing. Urgent results for A&E samples were available in one hour because of the use of this management tool.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for A&E patients; results were ready within 20 minutes.
- Geriatric medicine had historically been part of acute medicine but was now combined with community services to provide an integrated service.

Royal Hallamshire Hospital

- Staff in theatre had introduced a learning disability pathway. An operating list was dedicated to patients with a learning disability, if the patient needed more than one procedure this was carried out on the same operating list under the same general anaesthetic.
- The use of duty floor anaesthetist role in theatre, developed in Sheffield, was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for minor injury patients; results were ready within 20 minutes
- Histopathology was using cross-site digital pathology to speed up processing time for frozen sections.
- On GICU and NICU there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies,

procedures and guidelines The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in Critical care.
- The one to one team and specialist midwife clinics gave greater assurance that high risk women continued to have a choice on the care they received in pregnancy.
- The rapid access clinic reduced readmissions of babies with feeding problems.
- The GRIP project responsible for getting research into practice improved services for maternity and gynaecology.
- The termination of pregnancy service gave women continuity of care in an appropriate caring environment. The seven day service gave women choice and improved accessibility.
- The use of the Enhanced Recovery programme in both maternity and gynaecology improved the service for women.

Weston Park Hospital

- Specialised cancer services provided a patient-centred holistic approach to patient care where the whole multidisciplinary team worked together to ensure the patient's experience of the service was the best that it could be.
- The teenage cancer unit had a number of innovations which had been paid for out of charitable funds. These included a 'couples retreat' for end of life patients and their partners. They could spend time away from home and explore issues about coming to the end of life.

Community end of life care

- The intensive home nursing service provides support for patients and their families in the last days and hours of life. Relatives consistently praised the service and the staff who provided it.

Community inpatients

- Feedback we received from patients was consistently positive about the way nursing and therapy staff treated them. Patients told us that staff go the extra mile. Staff and patients confirmed that the unit had a flexible approach to care.
- Patients were supported emotionally. Activities such as singing, arts and crafts were arranged to prevent social isolation and boredom.

Charles Clifford Dental Hospital

- An holistic approach to individual patient's requirements was modelled within CCDH, and anxious patients had the option of utilising cognitive behavioural therapy (CBT), acupuncture, hypnosis, inhalation, or intravenous or oral sedation to assist with their dental treatments.
- Staff were sensitive to the needs of vulnerable patients, making reasonable adjustments to ensure that effective two-way communication was achievable to allow patients to be fully empowered to make decisions about their treatment options.
- The service worked with a local dental unit to provide an out of hours (17:00 – 20:00) oral surgery Consultant led clinic for patients who were unable to be released from work within core hours, enabling them to attend one evening each week.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must ensure patients do not wait longer than the recommended standard for assessment and treatment in the emergency department.
- The trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.
- The trust must monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department.
- The trust must ensure the safe storage of intravenous fluids.
- The trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.
- The trust must ensure that guidance is followed in the documentation of foetal heart rate monitoring.

Summary of findings

- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at Weston Park Hospital.
- The trust must ensure the divisional risk registers reflect issues in the emergency department demonstrate evidence of actions and reviews.
- The trust must ensure there is a clear strategy for the end of life care which is implemented and monitored.
- The trust must ensure that staff implement individualised, evidence based care for patients at the end of life.
- The trust must ensure that DNACPR records are fully completed.
- The trust must ensure that staff complete mandatory training in accordance with the trust policy

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield Teaching Hospitals NHS Foundation Trust provides acute and community services to a population of 640,000. The trust provides specialist services for the populations of Yorkshire & Humber, parts of Mid-Yorkshire and North Derbyshire. The trust operates from five hospital sites:

- Northern General Hospital
- Royal Hallamshire Hospital
- Jessop Wing Maternity Unit
- Weston Park Hospital
- Charles Clifford Dental Hospital

The trust also provides community services for the population of Sheffield.

The trust has 1,840 beds

- 1678 general and acute beds
- 97 maternity
- 77 critical care

The trust employs 15,976 staff

- 1,747 medical
- 4,466 nursing
- 9,763 other

The trust financial position:

- Revenue: £993,418,000
- Full costs: £985,027,000
- Surplus: £8,391,000

We carried out the inspection as part of the Care Quality Commission comprehensive inspection programme.

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Powis, Medical Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

The team included CQC inspectors and a variety of specialists: including consultants, specialist nurses, student nurses, community nurses, therapists, medical directors, nurse directors and experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following eight core services at Sheffield Teaching Hospitals NHS Foundation Trust:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and diagnostics

We also inspected the Charles Clifford Dental Hospital.

The community health services were also inspected for the following core services:

- Community adult services
- Community end of life
- Community inpatient services
- Dental Services

Before the announced inspection, we reviewed a range of information that we held and asked other

organisations to share what they knew about the hospitals. These included the clinical commissioning

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held a listening event on 1 December 2015 at St Mary's Church and Conference Centre and attended focus groups in Sheffield for with people with learning disabilities and older people to hear people's views about care and treatment received at the hospital and in community services. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas, outpatient services community clinics, hospice and in patients' homes when visiting with District nursing teams. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records. We undertook Short Observational Framework Inspections to watch how staff provided care for patients.

We carried out an announced inspection on 7 to 11 December 2015 and an unannounced inspection on 23 December 2015.

What people who use the trust's services say

From July 2014 to November 2015, the trust performed the same or better than the England average for the percentage of inpatients who recommended the trust in the Friends and Family Test.

Both the national maternity survey for 2015, which looked at the experiences of people receiving maternity services, and the national inpatient survey from 2014, showed the results for Sheffield Teaching Hospitals NHS Foundation Trust was about the same as other trusts.

Facts and data about this trust

Sheffield Teaching Hospitals NHS Foundation Trust is an integrated provider of health care with a two main acute hospitals Royal Hallamshire Hospital and Northern General Hospital, maternity services are provided at Jessop Wing and cancer services at Weston Park Hospital. The trust has a dental hospital, Charles Clifford Hospital. The trust operates their community services across Sheffield.

The trust activity for period September 2014 – August 2015:

- Inpatient admissions: 47,398
- Outpatients: 928,702
- A&E attendances: 137,416 (including 19,090 Minor Injuries attendances)

The population of Sheffield have a health and life expectancy are generally worse than the England average including the rate of hospital stays due to drug and alcohol related harm; smoking related deaths; teenage pregnancy and a higher than average mortality rate in the under 75 age group for cardio-vascular and cancer disease. Smoking rates and adult obesity is slightly worse than the England average

Sheffield is the 26th most deprived local authority area in England and have over 22,000 children living in poverty. Obesity in children is the same as the England average.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated safe as good because: • The trust had appropriate systems and procedures in place to keep patients safe, including safeguarding and infection control. • In the patient led assessment of the care environment (PLACE) (2015) the trust scored 99% for cleanliness which was above the England average of 98%. • There was an established incident reporting system and policy in place which staff understood. We saw that lessons were learnt and actions taken. • There were appropriate staffing levels in most areas across the trust, staffing was reviewed using an acuity and dependency tool and professional judgement. There was ongoing recruitment and the trust had recruited 130 registered nurses, there were 150 vacancies remaining at the time of inspection. • There were process in place for identifying patients whose condition was deteriorating and staff were aware of the escalation procedures to follow. However, we also found: • Staffing in the Emergency department at the Northern General Hospital was a concern with staffing levels falling below established levels on 49 shifts out of 63 shifts reviewed. The department had staff vacancies. There was a process in place to redeploy staff from other areas and to request agency staff. • There were concerns regarding the assessment and monitoring of patient risk particularly in the Emergency Department at the Northern General Hospital. We raised concerns regarding the clinical decision unit and the identification of the deteriorating patient in this area. This was addressed by the trust in response to our concerns. • On the neonatal unit, nurse staffing was not at current recommended staffing levels. Staffing levels at Weston Park Hospital were below the expected levels. • Concerns about the safe and secure storage of intravenous (IV) fluids in some clinical areas, medicines reconciliation and prescribing of oxygen. • There were concerns regarding access to nursing care guidelines in medicine as these were held electronically and could not always be accessed by agency or bank nurses.	Good

Summary of findings

Duty of Candour

- The trust was aware of its obligations in relation to the Duty of Candour requirements. The legal Duty of Candour requires the trust to disclose openly events that have led to moderate, major or catastrophic harm to a patient.
- The trust's incident management policy included guidance on implementation of the Duty of Candour and was available to staff.
- The trust's electronic incident reporting system had been adapted to prompt consideration of the Duty of Candour.
- Three levels of training had been implemented across the organisation on Duty of Candour. A leaflet introducing Duty of Candour was sent to all staff in early 2015 as part of the level 1 education.
- We found that staff were aware of the duty of candour requirements and could explain the principles of being open and transparent with patients, families and carers.
- During the inspection we reviewed six root cause analyses from serious incidents and saw that Duty of Candour had been applied.

Safeguarding

- The trust had appropriate safeguarding policies and procedures in place for both adult and children.
- The policies and procedures were supported by staff training. We found 86% of staff had received level 1 children's safeguarding training, 65% had received level 2 and 58% had received level 3 training against a trust target of 90%. A total of 85% of staff had received level 1 safeguarding vulnerable adults training and 75% level 2. Safeguarding leads were aware of the areas that had low compliance with training, such as the emergency department, and gave examples of action to improve compliance.
- The trust had a safeguarding committee which reported to the healthcare governance committee, a sub-committee of the board.
- The executive lead for safeguarding both adults and children was the Chief Nurse. The Deputy Chief Nurse had operational responsibility for safeguarding.
- There was a lead nurse for children and young people, lead nurse for safeguarding adults, named midwife and named doctor. In addition, each care group had a safeguarding lead who attended the safeguarding committee.
- A specialist team of ten whole time equivalent midwives worked to deliver a 24-hour service providing care and support

for women with more complex social needs. The team performed daily maternity ward rounds and discussed new cases, ensuring all women within their caseload had a named midwife from the vulnerability team.

- Midwives were identified by a recent CQC review for looked after children, as high referrers for the Family Common Assessment Framework (FCAF) and to the local Multi Agency Support Teams (MAST) to elicit early support.
- The recent Care Quality Commission review of health services in safeguarding and looked after children services in Sheffield, noted "excellent examples of strong paediatric liaison", and good liaison with children and young people mental health service (CAMHS) within the emergency department. However, they noted a city-wide reliance on telephone calls for referral concerns rather than written follow up information.
- The trust had a strong focus on safeguarding, for example in the emergency department a 'Pathway for Vulnerable Young People' had been developed in partnership with an external stakeholder. This had been highly commended at the National Children and Young People Awards.
- The trust had implemented an action plan in place in response to the Savile Inquiry.

Incidents

- The trust is part of the 'Sign up to Safety campaign.'
- The trust reported 15,342 incidents reported in the period August 2014 to July 2015, of these 98% were of no or low harm. There were 29 serious incidents of which four were categorised as never events. Two of the never events occurred in 2014 and were surgical incidents at the Northern General Hospital and two occurred in outpatients at Weston Park during April 2015.
- The incident reporting rate is 7.2 per 100 admissions compared to the England average of 8.4.
- There was a weekly serious incident review group that was attended by the Chief Nurse and Medical Director.
- The trust has an incident management policy that set out the processes and lines of accountability for reporting incidents.
- Across the acute and community services, we saw established good practice of reporting incidents through an electronic reporting system. Staff were able to explain how they would report and escalate incidents.
- The 2015 National NHS Staff Survey found the percentage of staff who reported witnessing potentially harmful errors, near misses or incidents was in line with the national average. In the same survey, errors, near misses or incidents witnessed in the last month was 89%, which was also in line with the national

average. Fairness and effectiveness of procedures for reporting errors, near misses and incidents was similar to the national average; however staff confidence and security in reporting unsafe clinical practice was worse than the national average.
- Grade three and four pressure ulcers were not always reported as serious untoward incidents; this was in accordance with new guidance and in agreement with the trust's commissioners. However, we saw evidence that root cause analyses were still undertaken within the trust.
- Human factors training was offered to staff.

Staffing

- Recruitment to registered nurse posts was challenging. Data from June 2015 showed there were 250.9 wte vacancies of nursing and midwifery staff at band 7 and below. This equated to 6.3% vacancies for this staff group across the trust. At the time of inspection the trust had improved staffing and recently recruited 130 nurses; there were 150wte registered nurse vacancies. This figure included staff that had been appointed but not yet started at the trust.
- There was an active recruitment process including bespoke recruitment for specific areas for example theatres and international recruitment was being pursued. Areas of concern regarding staffing included emergency care and care of older people which was reflective of the national staffing shortages.
- The average staff turnover rate was 7%. Staff turnover in the dental hospital was higher at 30% however this was a training hospital and turnover was attributable to trainees moving following completion of training
- At the time of inspection, the average staff sickness rate was reported as 4.4% against a trust target of 4%.
- Nursing bank and agency usage was low with 2% usage in March 2015.
- The trust utilised the Safer Nursing Care Tool, an acuity and dependency tool endorsed by NICE as part of its approach to review staffing levels. At the time of inspection the safer nursing care tool was being piloted in emergency department. The trust was joint authors of the Safer Care Nursing Tool. There was a formal staffing review every six months.
- New roles including enhanced training of non-registered nurses were being progressed within the organisation. The trust had approximately 600 advanced nursing roles to address service needs.
- A ‘careers elevator’ had been developed to allow staff to develop from apprentice through to registered posts.

- Staffing in maternity was monitored using the midwife to birth ratio. The midwife to birth ratio was 1:28 which was in line with the Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- On the neonatal unit, nurse staffing was not at current recommended staffing levels. The staffing establishment for the ward was based on 2010 recommendations due to funding. The unit had a full establishment of nursing staff at the time of inspection. We found that staffing levels were consistently at 85% of the current national recommendations.
- In Emergency department at the Northern General Hospital there were concerns regarding current staffing levels; the department had 15 whole time equivalent (WTE) vacancies. We reviewed staffing rotas which showed that of the 63 shifts reviewed 49 shifts had staffing levels that were below established staffing levels. The trust had a process to redeploy staff from other areas and request agency staff; however from records we reviewed we were unable to see whether this policy was used at these times.
- The department had developed advance nurse practitioners to address gaps in medical staffing.
- We had concerns regarding the staffing in the resuscitation area of the Emergency department, particularly during times when major trauma cases were admitted. During the inspection we saw that during an admission of a major trauma case this resulted in one nurse looking after four patients the in resuscitation room. This had been highlighted by senior nursing staff as a key area for improvement.
- The senior management and executive teams were aware of the staffing issues in the Emergency department and had recently undertaken a safer staffing review which we were told had identified the need for approximately 42 WTE additional nursing posts. However, with the emergency department pathways changing this had been re-reviewed and 19 WTE had been agreed.
- In critical care, the Intensive Care Society and British Association of Critical Care Nurses (BACCN) standards were used for assessing patient acuity and staffing requirements. We found staffing levels were in line with national guidance and staffing shortfalls were met by using in-house bank staff and agency staff. However it was noted that there was not always a supernumerary clinical co-ordinator at the general intensive care unit at the Northen General Hospital.
- There was an established escalation process to identify and address short notice staff shortages. This involved moving staff

to work in other areas. However, staff were unhappy that they were moved to cover other wards across hospital sites regularly and at short notice. Staff recognised the need to keep patients safe; however it was clear this had an impact on staff morale.

- Team leaders within the integrated community nursing teams reviewed the caseloads daily and allocated patients to nurses. Nurses visited on average 12 to 14 patients a day however this could vary dependant on the individual needs of the patients. A safe caseload tool had been developed and was being rolled out across community nursing to establish and record the dependency of patients.
- The trust had implemented a transfer register for nursing staff who wished to transfer to gain experience elsewhere in the trust. There were rotational programmes in place for example in elderly care and community services. These schemes we were told had helped with staff retention.
- The trust has the same proportion of consultant staff (39%) compared to the England average (38%) but has more registrars (48%) compared to the England average (38%) and the same proportion of junior doctors (16%) compared to England average (15%)
- Physician's assistants had been recruited to support the reduction in medical training posts.
- Staff told us of concerns regarding medical cover at Weston Park Hospital overnight, however we discussed this with the medical director and were assured that the trust had undertaken a risk assessment of this. A registrar was on site until 9pm and there were standard operating procedures to follow during the out of hour's period when there was no medical cover in the building. During this period, cover was provided by the hospital at night team based in the Royal Hallamshire Hospital.

Medicines

- The trust's medicines management policies were regularly reviewed. These were accessible via the hospital intranet to all staff.
- A self-medication policy was also in place. We saw seven patients who were self-medicating, but no documentation or formal assessment of their capability had been completed in line with the policy. Therefore we could not be sure patients were supported to take their own medicines safely, including the arrangements for risk assessment and care planning. We also found four examples of inhalers on bedside tables which were not stored securely.

- Pharmacy staff checked (reconciled) patients' medicines on admission to wards. The ward-based clinical pharmacy service was available at Northern General Hospital and Royal Hallamshire Hospital between the hours of 9am to 5pm on Monday to Friday. A basic dispensary service operated at the weekends. A trust snapshot audit conducted in September 2015 showed 55% of patients' medicines were reconciled within 24 hours of admission by the pharmacy team. This figure had worsened since the last audit carried out in May 2015 which showed that 62% had been completed within 24 hours. National guidance [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE 2015] sets a standard of 95% completed within 24 hours. Medicines reconciliation was on the medicines management risk register and there had recently been an increase in pharmacy staffing on the Acute Medical Unit (AMU) in an attempt to improve the service.
- Some aspects of medicines management were regularly audited across the trust including medicines reconciliation, medicines storage, medication errors and clinical pharmacist activity. However, some audits were lacking in scope and detail and action plans were not always put in place based on the results, for example with controlled drugs incidents. No audits of delayed or missed doses had been carried out in the last 12 months; a baseline audit was underway at the time of the visit prior to the introduction of electronic prescribing which would enable ongoing reporting of missed doses.
- Pharmacy audits on medicines storage and security in August 2015 had identified concerns about the safe and secure storage of intravenous (IV) fluids. They had a work plan in progress, however this remained a concern during our inspection and we found doors to medicines storage rooms were unlocked or wedged open on ten of the wards we visited. Some wards did not have locks fitted to medicine room doors at all. This meant that access to drugs and IV fluids was not restricted to authorised staff.
- We saw four patients receiving oxygen when it had not been prescribed despite there being a dedicated prescription included on drug charts. In one case the prescription details were incomplete. This was a failure to follow national guidance and meant that there was a risk of inappropriate administration and a lack of monitoring which could put patients at risk.
- Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated through the trust

governance arrangements. We saw examples of learning from errors being shared at ward and department level. Trends and patterns across the trust were identified and discussed at monthly safety and risk management board meetings.

- Patient Group Directions (PGDs) were in use in some clinical areas in the trust and these were prepared and used in a safe way. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked PGDs used in the accident and emergency department at Northern General and saw they were being used effectively to support patient access to medicines in a timely way.
- Community services had a Head of medicines management. Pharmacists worked with community teams and had written and reviewed standard operating procedures to improve safety around medicines. We saw some examples of good practice in the community services. For example, the community pharmacy team had introduced the use of 'tiny tags' which tracked the medicines fridge temperature. Tiny tags were also used to check that cool packs were kept at the correct temperature when staff were transporting vaccines.

Infection Prevention and Control

- The trust had infection prevention and control policies in place, which were accessible, understood and used by staff.
- The trust had developed an internal infection control accreditation programme. This programme set standards for infection prevention and control practice with the aim to optimise and assess infection prevention and control practices in clinical teams throughout the hospital to reduce infection rates. The programme was in place across the acute and community services.
- Across both acute and community services patients received care in a clean and hygienic environments.
- Implementation of an annual rolling deep clean programme had resulted in a reduction in the cases of C.difficile.
- There were four cases of Methicillin Resistant Staphylococcus Aureas (MRSA) between June 2014 and June 2015, since then the trust has had no further incidents.
- In the patient led assessment of the care environment (2015) the trust scored 100 for cleanliness which was above the England average of 98.
- There was access to hand gel in all clinical areas.
- The trust was proactive in monitoring the use of antibiotics and there were specialist pharmacists who supported clinicians directly on the wards and performed regular audits.

- Trust figures showed C.difficile infection rates were lower than expected which is a useful indicator of appropriate antibiotic stewardship.
- The Director of Infection Prevention and Control chaired the infection control committee which reported to the healthcare governance committee, a board sub-committees and the trust executive group.
- There was a team of infection control nurses, with administrative support. An IT system was in place to support infection prevention and control. In addition, there were 4.8wte staff in the surveillance team.
- Members of the infection prevention and control team felt that they had a strong clinical profile at the trust and there was board to ward commitment to infection prevention and control.

Assessing and responding to patient risk

- The trust used a local adaptation of a national early warning tool called Sheffield Early Warning Score (SHEWS) that indicated and alerted staff to when a patient's condition was deteriorating. This was in use across the acute services. In medicine we saw that audit of SHEWS was undertaken on a monthly basis. There were clear processes for escalation of the deteriorating patients across most of the acute core services.
- We saw following a review of records that risk assessments were undertaken including falls, moving and handling, nutrition, tissue viability and venous-thromboembolism (VTE) assessments. In surgery we reviewed 36 records at the Northern General Hospital we saw that 21 of the risk assessments were incomplete, in other acute services we saw that risk assessments were completed.
- In the Emergency department at the Northern General Hospital there was a triaging system for patients arriving by ambulance that included patients arriving initially into an area known as the 'pit stop'. This area provided rapid assessment and initial treatment and was staffed by an Emergency Care Consultant. Patient's vital signs were not always obtained in this area.
- We raised concerns regarding the assessment and response to patient risk in the A&E at the Northern General Hospital. The College of Emergency Medicine (CEM) guidance states a face-to-face assessment of patients should be carried out by a clinician within 15 minutes. During the inspection we saw that patients waited on average 30 minutes for triage with a maximum recorded wait of 135 minutes.
- During the inspection we raised concerns regarding the clinical decision unit (CDU); the area included a bedded area and a separate seating area. Although there was criteria for the

referral of patients to the CDU we had concerns regarding the care of patients, escalation of patients who may deteriorate whilst in the seated area and staffing of this area. During the inspection we saw a patient who had deteriorated whilst waiting in the CDU seated area; this was raised with staff who took appropriate action however the patient was not moved from the area.

- Staffing of the seated area was overseen by a registered nurse on the CDU and the observation of patients was through an opening in the wall separating the bedded area from the seating area. We raised concerns regarding the current staffing of the unit.
- The CDU was also used as a quiet area for patients presenting with mental health conditions; the inspection team had concerns regarding the environment due to the presence of ligature risks in two of the side rooms and the toilet and the lack of visibility.
- Most surgical wards had medical patients (outliers); we were told by staff on five wards that there were no set procedures for medical staff to review these patients at the Northern General Hospital. However, trust managers told us that the patients were under the care of a nominated physician who reviewed them as part of their ward round. At the Royal Hallamshire Hospital there was a Consultant Physician who had responsibility for reviewing any medical patients who were being cared for on surgical wards.
- There were concerns in critical care regarding the emergency tracheostomy management on Osborn one and three. Staff did not have access to an emergency tracheostomy algorithm nor was there a standardised approach to escalating the deteriorating patient with a tracheostomy in the event of a blockage. There was no way of knowing which tracheal tube a patient had in place on Osborn one. The 2014 Intensive Care Society standards state a sign should be placed above the patient's bed. We escalated our concerns and these were addressed by the trust by the end of the inspection, including the addition of emergency tracheostomy boxes on resuscitation trolleys.
- The World Health Organisation (WHO) surgical safety checklist was in use, this is a core set of safety checks to improve safety during surgery. We observed the checklist being used appropriately across all surgical services. We saw evidence of audit of the checklist being carried out, 28 spot check audits across the two main hospital sites had been carried out up to 30 November 2015 which showed compliance rates of 61% to 100%.

Mandatory Training

- The trust had a comprehensive package of mandatory training through a variety of mediums including face-to-face and e-learning modules. We were concerned that mandatory training was not given sufficient priority across the trust due to the mandatory training rates not meeting the trust target in many of the core services. However, we were told that the Chief Executive led summits on the issue and the performance of the directorates was picked up at directorate reviews.
- Mandatory training rates were variable across the trust. There was a trust target of 90% however we saw rates varied depending on the type of mandatory training with many of the services not achieving the trust target. For example in surgery compliance was reported as 83%, in medicine medical staff groups were not compliant with the trust target with areas reporting to have achieved the quarter one target of 70% by the end of the second quarter.
- In community services mandatory training rates for community nursing were 64% overall.
- At the Charles Clifford Hospital paediatric resuscitation basic life support training was 34%
- Access to mandatory training had been improved through the provision of computers in staff rest areas to facilitate access to e-learning packages. Staff in many of the services told us they had protected time for mandatory training however there were areas where staffing shortages had impacted on ability to attend mandatory training for example in medicine at the Royal Hallamshire gastroenterology and stroke and geriatric medicine compliance was poor for infection control training, basic life support and moving and handling

Records

- The trust had a combination of paper based and electronic records. Care planning was based upon a system of nursing care guidelines that were evidence based and there was a process in place to ensure that these were reviewed on a regular based and were evidence based and referenced.
- In medicine, however, there were concerns regarding the care planning process. There were evidence based nursing care guidelines, which fulfilled the function of care plans, available for reference for a wide range of possible care needs. However, these were not printed and available at the patients' bedside or with the patients' care record. Some wards had printed reference files available for staff to use, however we did not observe staff using these. Other wards referred us to the intranet to view these guidelines and again we did not observe

staff referring to these. Staff told us computers were not always easily accessible and that new, bank and agency staff did not always have an individual log on. This meant that care plans and guidelines were not always accessible for staff delivering care. We did observe that planned care was included in the verbal handover in medicine.

- In surgery records were not always stored securely. The inspection team reviewed 40 sets of records across the two hospital sites, overall the content was accurate and in line with the Nursing and Midwifery Council guidance however none met the requirements of the General Medical Council (GMC) guidance on keeping records.
- In other core services and in community services we saw that records were overall complete and maintained.

Are services at this trust effective?

Good

We rated effective as good because:

- There were systems in place to ensure that staff had access to relevant evidence-based policies and guidelines.
- The trust had participated in a range of national and local audits. Patient outcome measures showed the trust performed mostly within the national averages when compared with other hospitals.
- The trust has developed and implemented an electronic clinical assurance toolkit (eCAT) which enabled wards and departments to monitor standards of care and outcomes for patients. Action plans were in place for any areas requiring action.
- We found many examples of multi-disciplinary working and coordinated care pathways.
- Staff had a clear understanding of consent, mental capacity and deprivation of liberty safeguards.

However, we also found:

- The guidance for staff caring for people at the end of life had been introduced recently and not all staff were clear how they should incorporate this into their clinical practice.

Evidence based care and treatment

- Policies and guidance were available to staff on the trust's intranet.
- Staff were aware of relevant policies and guidelines and showed us how they would access them on the trust intranet.

- Policies and guidelines were based on relevant and current evidence base and best practice from appropriate professional bodies, including National Institute of Health and Clinical Excellence (NICE), Royal College of Surgeons (RCS), Royal College of Physicians, Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Association of Day Surgery Guidance.
- There was an evidence based council established at the trust which reviewed clinical evidence to update practice guidelines.
- There was a process for reviewing and implementing NICE guidance.
- There were tools available to support staff implement evidence-based care such as the hydration and nutrition assurance toolkit (HANAT). Staff followed the enhanced recovery programme (NHS Institute for Innovation and Improvement) in many specialities.
- The guidance for staff caring for people at the end of life had been introduced recently and not all staff were clear how they should incorporate this into their clinical practice.

Patient outcomes

- The 12-month rolling Hospital Standardised Mortality Ratio (HSMR) for 1 June 2014 to 31 May 2015 was 98 (94-102) for all admissions and 'as expected' when compared with hospital trusts nationally. The HSMR for non-elective admissions was 99 (95-103) and elective admissions was 86 (66 - 110).
- The most recent 12-month rolling Standardised Hospital Mortality Index for 1 January 2014 to 31 December 2014 was 0.92 (0.91 - 1.10) with an expected number of deaths of 3414 versus an observed 3410. This was 'as expected' when compared with hospital trusts.
- There were no active Care Quality Commission mortality outliers for this trust at the time of inspection. However, following the inspection, the maternity service was identified as an outlier for puerperal sepsis. The trust reviewed case notes and responded appropriately; an action plan was put in place.
- The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence based standards. The trust scored 'D' overall in the SSNAP audit for 2014. The scale is A to E with A being the best rating. Local reports regarding the SSNAP results showed a clear understanding of issues affecting patient outcomes and plans to improve future patient outcomes and audit results.

- In the National Diabetes Audit 2013, RHH performed better than the England median in 15 indicators and worse than the England median in four indicators. NGH performed better than the England median in 13 indicators and worse than the England median in the other eight. The areas highlighted for improvement were, visit by a specialist team, foot risk assessment and seen by the multidisciplinary team in 24 hours, meal choice and staff awareness.
- The MINAP audit 2014 showed there was an increase from 2013 in the number of NSTEMI patients seen by a cardiologist, admitted to a cardiac ward, and referred for or had angiography. However, the percentages had decreased from 98.9% to 93.5%, 71.8% to 60.7% and 66.5% to 63.3% for the respective indicators. In 2014, the number of patients seen by a cardiologist was slightly lower than the England average of 94.3%. Patients admitted to a cardiac ward was above the England average of 55.6% and patients referred for or had angiography was lower than the England average of 77.9%.
- At a trust level, the standardised relative risk of readmission in elective admissions was higher than the England average. The top three specialties with the highest count of activity were clinical oncology, medical oncology and clinical haematology and they all had a rate around one third higher than the England average.
- NGH had a lower rate of elective readmissions than the England average for gastroenterology and higher readmission rates for cardiology and nephrology.
- The trust's standardised relative risk of readmission for all non-elective admissions is in line with the national average. However, NGH had a higher readmission rate overall for non-elective readmissions and for respiratory and geriatric medicine. NGH had a lower readmission rate for general medicine.
- The trust had higher than the England average standardised relative readmission rates (2014) for elective surgical patients for trauma and orthopaedics, colorectal and hepatobiliary and pancreatic surgery.
- The trust had higher than the England average standardised relative readmission rates (2014) for non-elective surgical patients for trauma and orthopaedics, colorectal and general surgery.
- The National Bowel Cancer Audit (2014) showed mixed results. The trust scored better than England average for multi-disciplinary team discussion, clinical nurse specialist involvement and scans undertaken. However, the trust

attempted laparoscopic surgery in 35.7% of patients (lower than the England average of 54.8%) and 76.8.8 % of patients undergoing major surgery stayed in the trust for an average of more than five days (worse than the England average of 69.1%).

- The Lung Cancer Audit (2014) results showed the percentage of patients receiving surgery was similar to the England average. The audit showed better results than the England average for multi-disciplinary team discussion and for scans undertaken before bronchoscopy.
- The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the hospital was better than the national average in five out of seven areas. Examples were patients admitted to an orthopaedic ward within four hours, surgery on the day of or the day after admission and preoperative assessment by a geriatrician. The hospital was worse than the national average in patients developing pressure ulcers and the total length of stay. The trust had set up a multi professional fractured neck of femur group to review length of stay and mortality.
- We found the National Emergency Laparotomy Organisational Audit 2014 showed 13 out of 28 measures (46%) were not available. For the 2015 patient audit results, the trust scored green (70-100%) for the standard “arrival in theatre in timescale appropriate to urgency”. The trust scored amber/red (below 69%) for the other 10 standards, which included “preoperative review by consultant surgeon and anaesthetist” and “consultant surgeon and anaesthetist present in theatre.” The trust submitted the report to the clinical effectiveness committee following the audit. An action plan was developed that included relaunching the pathway for emergency laparotomy patients across the trust and reviewing the daily input from elderly medicine.
- The trust underwent an Anaesthesia Clinical Services Accreditation review in 2015. This review assessed performance against 95 standards. The review concluded satisfactory evidence had been supplied to meet 89 of the standards. We saw evidence that the trust was working towards the recommendations of the review to meet the remaining six standards. The unmet standards included administration support, trust support for audit and research and evidence of training in the use of equipment. The trust was subsequently awarded accreditation.
- The trust’s overall performance record for Patient Reported Outcomes Measures (PROMs) for hip and knee replacements

and varicose vein surgery is in line with the national average. A PROM for groin hernia procedures (EQ-5D Index) had seen smaller improvements and worse results than the national average.
- Overall, the trust completed 52% of procedures as day cases. NGH had a day case rate of 37%.
- The trust participated in Hip Attack, which was an international research trial of patients with a hip fracture that required surgical intervention.
- The results from the latest ICNARC data available to us at the time of our inspection was for October 2014 – March 2015, showed patient mortality rates for GICU within the expected ranges when compared with similar units nationally and these had remained stable.
- All of the pathology laboratories were accredited with Clinical Pathology Accreditation (CPA). The pathology services were awaiting confirmation of a date for inspection by the United Kingdom Accreditation Service. There were no significant outstanding issues from the most recent CPA inspection.
- The trust has developed and implemented an electronic clinical assurance toolkit (eCAT) which enabled wards and departments to monitor standards of care and outcomes for patients. The tool was used annually in each area and reviewed by the governance team. Action plans were in place for any areas requiring action.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary teams.
- We found many examples of multi-disciplinary working and coordinated care pathways. For example, the Active Recovery Team and PhysioWorks were both excellent examples of multi-professional teams working closely together for the benefit of patients. We also attended a multi-disciplinary meeting on the neonatal unit during our inspection. The meeting was well attended by a range of professionals, including the neonatal outreach team and link staff to community services.
- The trust utilised a microsystems improvement methodology which involved the multidisciplinary team working together on improvements.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Most staff had a clear understanding of consent, mental capacity and deprivation of liberty safeguards.

- The trust had a Mental Capacity Act Facilitator who was responsible for supporting staff with Mental Capacity Act and Deprivation of Liberty concerns.
- The trust's DoLS policy was overdue for review from October 2013.
- We were concerned that Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) were not always made in line with national guidance. During the inspection we looked at 43 DNACPR forms across the hospital sites and four DNACPR forms in community. The forms in community were completed appropriately and there were no concerns. Across the hospital sites however there was variation in the quality and completeness of the forms for example delays in forms being countersigned, in six of the forms at Northern General Hospital discussions had not taken place with the family where the patient did not have capacity.
- We spoke with the Medical Director about DNACPR forms and they informed us that they were aware of the issues regarding completion of the forms and the lack of documentation of mental capacity. Action was being taken to address this.
- The trust had undertaken an audit in February 2015 on the McMillan Palliative Care Unit to assess the accuracy of form completion, results were variable for example 100% of forms had the patient name but only 65% had the name of the next of kin. The timescales for forms being countersigned by a consultant ranged from one to 28 days. Where DNACPR was not discussed with the patient 60% were discussed with a family member but 40% were not. There were 14 recommendations from the audit.

Are services at this trust caring?

Good

We rated caring as good because:

- Feedback from patients and relatives was positive about the care they received.
- There were a number of initiatives to provide emotional support such as a bereavement support group held in the community each quarter and bereavement support provided by teams of nurses and midwives within maternity services.
- We saw numerous examples of compassionate care being provided throughout the inspection.

Compassionate care

- The Cancer Patient Experience Survey 2013/14 showed the trust was in the top 20% for two indicators, the bottom 20% for one indicator and in the middle 60% of trusts for the remaining 30 indicators.
- The Patient-led assessments of the Care Environment (PLACE) for 2015 scored the trust above the England average for privacy, dignity and wellbeing.
- The trust scored about the same as other trusts for all indicators except one which was better, in the Accident and Emergency survey (2014).
- The inpatient Friends and Family Test results showed the percentage of patients who would recommend the trust was around the national average at 96%.
- Friends and Family Test results were generally above the England average for antenatal care, birth, postnatal ward and postnatal community care between March 2014 and February 2015. Ninety eight percent of responses stated women would be 'likely' or 'extremely likely' to recommend the unit. The local inpatient survey dashboard asked women about their care at the hospital. The trust scored above the expected average in most areas.
- In the CQC maternity care survey 2015, the hospital performed the same as other trusts around the kindness and understanding by staff after the birth of their baby.
- We saw numerous examples of compassionate care being provided throughout the inspection.

Understanding and involvement of patients and those close to them

- The CQC maternity survey 2015 demonstrated that the trust scored similar to other trusts in women and partner involvement in care.
- The trust scored about the same as other trusts in the Accident and Emergency survey (2014) for patients being involved as much as they wanted to be in decisions about their care and treatment.
- The trust scored about the same as other trusts in the inpatient survey (2015) for being involved as much as they wanted to be in decisions about their care and treatment and for being given enough information on their condition and treatment.

Emotional support

- The trust scored better when compared to other trusts in the Accident and Emergency survey (2014) for feeling they had enough time to discuss their health or medical problem with a doctor or nurse.

- Specialist midwives were available to provide additional support for women in the form of a Birth Options clinic. This gave women the opportunity to discuss their fears and concerns and plan their care.
- Mental health guidelines and a care pathway existed for the care of women who had mental health disorders, including previous puerperal psychosis. Mental health screening was undertaken during pregnancy.
- Confidential professional counselling from a qualified therapist registered with the British Association of Counselling and Psychotherapy was available for women using the termination of pregnancy services. Consultations were available before and after procedures.
- Multi faith chaplaincy support was available 24 hours a day. We saw chaplaincy leaflets which indicated there was emotional and spiritual support for patients and families.
- The trust had a psychology service and staff could refer patients, for example from Weston Park Hospital. We were told this helped patients cope with emotional difficulties.
- There were a number of initiatives to provide emotional support such as a bereavement support group held in the community each quarter and bereavement support provided by teams of nurses and midwives within maternity services.

Are services at this trust responsive?

Good

We rated responsive as good because:

- The trust worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways.
- There were systems in place to support the needs of inviduals, including patients with learning disabilities and those living with dementia.
- Referral to Treatment (RTT) within 18 weeks for non-admitted patients and those on incomplete pathways had been performing above the national average since September 2014.
- There was a single point of access (SPA) service who managed referrals from patients and health professionals into all community health services. Effective systems were in place to direct patients to the right professional at the right time at a venue of their choice.
- There was an active recovery team who had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess. This had resulted in a significant reduction in hospitalisation of over 15,000 bed days.

- The trust reviewed monthly complaints and feedback. We found evidence that themes were shared and learning had taken place.

However, we also found:

- In the reporting period September 2014 to September 2015, the emergency department at Northern General Hospital was meeting the four hour target to discharge or decision to admit an average of 90.3% occasions. This was below the 95% national standard.
- Since July 2013, the trust's RTT performance for patients admitted to hospital had mostly been below the trust's 90% standard.

Service planning and delivery to meet the needs of local people

- The trust provided acute and community services. Community services became part of the trust in 2011. There has been integration of the community services and they are part of a combined directorate with geriatric and stroke medicine. We saw good examples of community services working closely and planning services with the acute hospitals to provide integrated care to patients. For example, the community stroke service formed an integral part of the stroke pathway.
- Staff told us they worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways. There were arrangements in place to facilitate patients who required support from mental health services or local authority social services.
- Care groups developed capacity and demand plans annually that fed into the trust capacity and demand plans for the year.
- Due to the increase in attendances at the Emergency Department, a review of the emergency department pathways into the trust had been undertaken. Changes to service delivery were being implemented to enable the service to meet the needs of people.
- Clinical directorates had individual five year strategies that were linked to trust's strategy, aims and objectives.
- The trust had approved a 5 year investment programme in technology to transform care delivery within the hospitals and people's own homes and communities. This was in the process of being implemented. This was planned to enable the organisation to support the work underway to develop integrated care teams and new models of care.

Meeting people's individual needs

- An alert was available on the computer based administration system to identify patients with learning disabilities. The Sheffield Case Register database was downloaded into the trust patient administration system; this identified patients with a learning disability.
- Nursing staff were aware of and used the learning disability passport.
- There was an identified nurse director to lead on the care of patients with learning disabilities. There was no dedicated specialist nurse. Matrons were notified of relevant admissions through the use of the learning disability passport.
- The trust had undertaken an adult inpatient survey for patients with learning disabilities with an external agency and was awaiting the report.
- We saw examples of how patients with learning disabilities were supported. For example, staff in theatre had introduced a learning disability pathway. An operating list was dedicated to patients with a learning disability, so if the patient needed more than one procedure this was carried out on the same operating list under the same general anaesthetic.
- Within the community dental services there were several outstanding examples of services implemented to meet individual needs. These included a communication tool enabling children with autistic spectrum disorders and other communication difficulties to accept dental treatment, a service for residents living in care homes and a dental service offered to Sheffield's homeless community.
- There was an interpreting service to support the communication needs of people who were non-English speakers, people for whom English is a second language, and people who are deaf, in order to ensure that they have appropriate and equitable access to hospital services.
- An external supplier was contracted to provide telephone, face to face and British Sign Language interpreting. During 2014/15, 66% of the spoken language interpreter services were provided by telephone and 34% were face to face.
- The trust had a range of approximately 1500 patient information leaflets. There was a process to request these in alternative languages or formats.
- Patients who are registered blind or deaf had an electronic flag on the patient administration system to alert staff.

Dementia

- The trust had a clinical lead and nurse practitioner for dementia care. They also had dementia link nurses who attended regular meetings and updated their teams on any pertinent issues.
- An electronic flagging system for people with dementia was being developed with the introduction of the new electronic patient record. An alert was available on the new computer based administration system to identify patients diagnosed as living with dementia in the emergency department.
- There was a process in place to notify the dementia nurse practitioner of relevant admissions.
- The trust had a dementia training needs analysis and strategy. Training on dementia was included in the trust induction. Nursing staff were also encouraged to complete an e-learning module 'care of patients living with dementia'. Staff who had completed this said they had found it useful.
- Nursing staff also told us about the 'this is me' document, which they encouraged patients and relatives to bring into hospital during their stay. 'This is me'is a simple and practical tool people living with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests.
- A memory box had been developed within the CDU. This box contained papers, activities and photographs to be used with patients living with dementia. A yellow patient wristband was used to highlight patients living with dementia to help staff provide appropriate care.
- The trust had achieved the 2014/15 CQUIN with more than 90% of patients over 75 screened for dementia.
- A ward at the Northern General Hospital had been developed to meet the needs of patients living with dementia. A site overview assessment of RHH using PLACE criteria (2015) showed that improvements were need on some wards with regard to being "dementia friendly". Common issues related to signage, flooring, lack of contrast colour for toilet doorways and seats.

Access and flow

- In the reporting period September 2014 to September 2015, the emergency departments at the trust were meeting the four hour target from attendance to discharge or decision to admit an average of 90.3% occasions. Data ranged from 74.8% in December 2014 to 97.5% in August 2015. Due to the implementation of a national computer patient administration programme the department was unable to provide any data, or confirm accuracy of data to report on performance activity in the emergency department following the introduction of the system on the 28 September 2015.

- The percentage of emergency patients waiting between four and 12 hours from the decision to admit to admission had been in line with the England average from April 2014 to July 2015.
- The trust's target was that 90 per cent of admitted patients should start consultant-led treatment within 18 weeks of referral. Since July 2013, the trust's RTT performance for patients admitted to hospital had mostly been below the 90% standard. Data reviewed for May 2015 showed general surgery, trauma and orthopaedics and cardiothoracic surgery did not meet the standard. Thoracic medicine and plastic surgery met the standard. However, the trust overall performed better than the England average during this period. The trust's target was that 95 percent of patients should start consultant-led treatment within 18 weeks of referral. The national standard is that 92 percent of patients on incomplete pathways should not have been waiting longer than 18 weeks since referral. Referral to Treatment (RTT) within 18 weeks for non-admitted patients and those on incomplete pathways had been performing above the national average since September 2014.Cardiology was not meeting the 18-week performance target of 92% (target). The trust recognised this issue and there was a plan for dealing with it. There was a trust level weekly meeting with cardiology.
- An outlier policy was in place. In August 2015, there were 207 outliers (patients who were not cared for on their speciality ward). There was one consultant employed to care for medical outliers across the Royal Hallamshire Hospital.
- There was a patient flow team to support bed management across the trust. Bed management meetings were held three times a day.
- There was also a daily community operational meeting for the combined community and acute care group. This involved staff from across the care group and demonstrated good liaison between the services to assist with patient flow.
- For community services, there was a single point of access (SPA) service who managed referrals from patients and health professionals into all community health services. It was available 365 days a year, from 8 am to 8pm. Outside of these hours the calls were answered by the GP Collaborative. The service used a call routing system to direct patients to the right professional from the start. The team had extensive local knowledge and specialist expertise and were able to access to up to date information on service capacity. This meant that they could give advice on which service would be most appropriate for the patient. Once referred to a service, confirmation was sent to referrers to ensure they were kept

informed of who was caring for their patients. The aims of the service were to ensure patients were seen by the right professional at the right time at a venue of their choice. We thought this service was outstanding.

- There was an active recovery service in the community which could see a patient within two hours of receiving the referral and was available from 8am - 2am, seven days a week. The team had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess. The first ward to implement discharge to assess had a sustained reduction in length of stay of 7 days. The service had provided support for over 6300 patients transferring from hospital back to home over the previous 12 months. We saw evidence that showed on average, a 2.4 day reduction in delay across the hospital-community interface, which represented a reduction in hospitalisation of over 15,000 bed days.
- Some of the medical wards were involved in a 'ready to go' service improvement project which was investigating discharge delays.

Learning from complaints and concerns

- The trust had an up to date concerns and complaints policy in place. Complainants are contacted in the first two days following receipt of the response and we corroborated this through a review of a sample of complaints. All complaints are signed off by the Chief Executive.
- Over 90% of complaints were responded to within 25 working days from July to September 2015 following improvements in the process.
- The trust reviewed monthly complaints and feedback dashboard reports at the Patient Experience Committee. These reports gave an overview of key performance indicators including numbers of complaints received/closed, response times, themes and exception reporting based on all complaints data. They were also discussed at the monthly meetings of the Healthcare Governance Committee, which is a sub-committee of the Board of Directors.
- Complaints were discussed to share findings and identify learning outcomes at departmental and governance meetings. Real examples of complaints were used as part of training to ensure learning.
- Changes made as a result of complaints were reported in the quarterly complaints and feedback reports. Examples of changes following complaints included the development of new guidelines for staff and changes to referral pathways.

- We reviewed a sample of 10 complaints and found them to be in line with the trusts own policy however seven of the complaints the inspection team felt lacked apology and there was use of clinical terminology that may not be fully understood. There was also limited identification of recommendations
- The trust monitors their complaints processes through audit of 50 complaints and interviews with complainants. We were told that following a recent audit actions from complaints were not always implemented. We were given an example of food on a specific ward, governors were asked to look at the issue and found that food was being given out differently on the ward where concerns had been raised.

Are services at this trust well-led?

Good

We rated well-led as good because:

- The trust had a clear vision and corporate strategy which was known and understood by staff. This was supported by the directorate strategies.
- The trust's values were clearly embedded across the organisation. Staff consistently spoke about the PROUD values.
- There was an effective governance and performance framework that was in place from ward to board that allowed assurance to be gained at board level.
- There was stable trust board in place. The Chief Executive had been in post for 14 years. There was effective leadership throughout most of the organisation.
- There was a strong focus on continuous learning and innovation and improvement was evident throughout all levels of the organisation. Staff were engaged in the quality and service improvement agenda.
- We identified some innovative patient experience engagement activity, such as the use of art therapy, pet therapy and a 'listening wall' for patients to say what they would like to improve the clinical environment.
- The trust had a number of initiatives that had been nationally recognised as good practice.

However:

- We were concerned regarding the lack of local end of life care strategy.
- The NHS staff survey (2015) found the trust's engagement score of 3.74 was below (worse than) average when compared with trusts of a similar type.

- There was some concern that learning from incidents although well-established within directorates it was not evident on wider care group basis.

Vision and strategy

- The trust had a clear vision and corporate strategy which was implemented in 2012 and was due for review in 2017.
- A set of values, were part of the strategy. These were known as PROUD values which was an acronym for Patient first, Respectful, Ownership, Unity and Deliver. We found that these values were clearly embedded across the organisation. The values were used within recruitment processes and appraisals. Staff consistently spoke about the PROUD values and reported these made appraisals more meaningful.
- The trust had an overarching corporate strategy called 'Making a Difference' which covered the period 2012 to 2017. This was refreshed in 2015 to ensure that the strategic direction of the trust was still fit for purpose and remained focussed on the delivery of high quality care. The corporate strategy was underpinned by a number of specific strategies. Five aims were set out in the strategy that informed organisational objectives, development of directorate business plans and supported individual development plans. These focussed on clinical outcomes, delivery of patient centred care, workforce, financial stability and research and innovation.
- The trust's quality strategy had clearly identified goals and actions.
- Clinical directorates had individual five year strategies that were linked to trust's strategy, aims and objectives. The directorate strategies had consideration of the other clinical departments they worked with to deliver high quality care and the assistance required from corporate directorates and other partners.
- There was a transformation through technology programme in the process of being implemented with a vision to provide quality healthcare enabled by technology.

Governance, risk management and quality measurement

- There was a Board Assurance Framework and corporate risk register that identified both strategic and operational risks. We reviewed the corporate risk register which documented actual risk, control measures and residual risk ratings. The Board Assurance Framework was reviewed by the board on an annual basis and was in line with the trust's annual report and quality

accounts. We reviewed the Board Assurance Framework and found it reflected the strategic risks, identified executive leads, controls identified for mitigating risks and the assurance of mitigation of risk.

- The trust had an effective governance system in place supported at board level by a number of assurance committees. The key assurance committees included the Healthcare Governance committee, Audit Committee and Finance, Performance and Workforce committee.
- The Healthcare Governance committee was held on a monthly basis and reported directly to the board. The committee was chaired by a non-executive director. There was a Healthcare Governance Arrangements policy in place that set out the governance framework and the committee had terms of reference that we reviewed during the inspection.
- We reviewed the Complaints, Incidents, Concerns, Claims and Inquest report for the Healthcare Governance meeting for June 2015 and the Health & Safety Report for 2014 to 2015 and plan for 2015 to 2016. Reports were linked to the trust strategic aims.
- The trust had a well-established governance framework that supported delivery of safe and high quality care from 'ward to board'. At a service level, across both acute and community services, there were processes in place for teams to review incidents and ensure learning was shared. Across the care groups and at directorate level there were monthly governance meetings. The framework was supported by governance leads in each of the directorates. There was some concern that learning from incidents, although well-established within directorates, was not evident on wider care group basis.
- There was a Safety and Risk Management Board that was a sub-committee of the healthcare Governance Committee. Directorate governance leads attended and risk scores were reviewed at this meeting.
- Governance leads had clearly defined roles and responsibilities at directorate level.
- The trust had a Risk Management Policy. Risk registers were held at directorate and care group level and there was a clear process for escalation of risk. Risks were categorised using a risk matrix and framework based upon the likelihood of the risk occurring and the severity of impact. Risk registers were up to date and reviewed by the directorates and staff were aware of how to escalate risks up through the governance structures. However, in the Emergency department at the Northern General Hospital, the risk register did not include some of the issues found on inspection or show when the risks were last reviewed.

- Staff we spoke with across the core services were able to articulate their operational risks and were taking actions to mitigate risks.
- There was a performance and accountability framework in place both within care groups with directorates being held to account and up to board level through the Director of strategy and operations. Directorates met with the Trust Executive Group to review business plans and risks twice a year. There were integrated performance reports.
- The trust had an internal and external audit programme and a clinical audit programme set for 2015 – 2016. Clinical audit priorities were based on national requirements followed by trust, directorate then consultant led priorities. Internal audit projects have an executive and operational lead identified.
- Nurse staffing levels were reviewed in line with the National Quality Board guidance 2013. We reviewed a six monthly staffing review report to the Board.
- There was a ward accreditation programme in place called 'eCAT' which was a clinical assurance toolkit that included safety thermometer data, incidents and infection control data.
- An external Annual Quality Governance Assessment against the Monitor Framework had been carried out in September 2015. This report identified many elements of good practice with a focus on patient quality and safety.
- The trust was forecasting an £11milion deficit at the time of the inspection with a cost improvement programme of £25million. The cost improvement programme was based upon the trust wide approach to improvement and was devolved to care groups and their directorates.
- Cost improvement programmes and business cases were reviewed for impact on quality and we were provided with examples of cases that had been declined due potential negative impact on quality.
- There was medical examiner at the hospital. They were in post to consider themes and risk management around cause of death.
- The trust participated in the Sign up to Safety Campaign.
- The trust had previously had concerns raised in a small number of services. These included concerns regarding clinical care and bullying and harassment. The information we received was taken into account by the teams inspecting the relevant core services. We did not find any evidence of bullying and harassment during the inspection.

- Where issues had been identified, we saw they had been investigated. This included the trust commissioning external independent reviews in response. Some reviews had taken longer than expected and this meant findings and actions were not always implemented in a timely manner.
- We looked at the commissioned external reviews in cardiac surgery, plastic surgery and audio vestibular medicine and noted that there were no substantial clinical concerns identified. We were satisfied that the trust had undertaken external reviews and we will continue to monitor them against their action plans.

Leadership of the trust

- There was stable trust board in place. The Chief Executive had been in post for 14 years and was well-respected across the organisation. The mostly recently appointed board member was the medical director who had been in post for over 3 years. The external governance review identified the board as being unitary, well-functioning with a focus on operational performance along with effective strategic discussion.
- The leadership of the board by the Chairman was noted in the external governance review to be impressive. Additionally the contribution of the Chief Executive was also described as impressive.
- We raised some concerns regarding the size of the portfolio for the Medical Director, however there were plans in place to address and reduce this in the near future. In addition there were plans to expand the number of executive directors to strengthen the board and support the strategic agenda.
- The trust was led through nine care groups. Each care group was led by clinical directors in conjunction with a nurse director and operations director. The levels of clinical engagement and leadership across both acute and community settings were exceptional and there was a strong clinical leadership model in place.
- We found examples of effective leadership throughout the organisation. Each of the care groups were led by a triumvirate of Clinical Director, Nurse Director and Operations Director. The clinical directors are appointed by the Chief Executive for a period of three years
- Leadership programmes were in place for varying levels of staff across the trust and leadership development formed part of the trust Organisational Strategy.

- There was a clinical management board which brought together the clinical directors and other senior leaders and had a role of providing advice to the Board of Directors and the trust executive group
- There was a leadership forum which was chaired by the Chief Executive and met twice a year with a focus on transformation of services, leadership and development.
- All Nurse Directors and the Chief Nurse carried out clinical shifts on wards every month.
- We found 84% of staff had an appraisal including medical staff.
- At the time of inspection, the average staff sickness rate was reported as 4.4% against a trust target of 4%.
- Staff spoke positively about the leadership at the trust. They told us that senior leaders were visible; they were very positive about the Chief Executive and it was evident that he visited areas of the trust regularly. Staff told us about regular email communication they received from the Chief Executive.
- The NHS staff survey (2015) found the percentage of staff that got support from their immediate managers was worse than the national average.
- The National Training Scheme Survey from the General Medical Council 2015 assessed the trust as performing as expected in 12 of the 13 indicators and worse than expected for inductions.

Culture within the trust

- A culture of innovation and improvement was evident throughout all levels of the organisation.
- Staff spoke positively about the culture, although movement of nursing staff to cover shortfalls had affected morale in some areas.
- The trust had implemented the Sheffield Microsystem Coaching Academy (MCA), supported by the Health Foundation. This was designed to train coaches within the Sheffield healthcare system to help front line teams make improvements and build quality improvement capability. We saw examples of this in practice. The project won a Changing Culture Award in 2014, and the Head of Quality Improvement won the Leadership Academy, Coach of the Year Award.
- Workshops on customer care had been attended by over 1,200 staff and a 5% reduction in complaints about staff attitude had been identified.
- The NHS staff survey (2015) found the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months was better than the national average.

- In the dental hospital, many of the staff described the environment as feeling like a family with a general consensus of there being a strong team spirit and sense of belonging to provide a high standard of patient care.

Fit and Proper Persons

- The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust had a policy and procedure in place for the Fit and Proper Person that was ratified by the Trust Board on 21 October 2015. The policy covered all executive and non-executive directors and all directors who formed part of the Trust Executive Group.
- We reviewed the personnel files of all the executive and non-executive directors and found they were fully compliant with the requirements of the Fit and Proper Persons Requirement. All executive and non-executive directors had a Disclosure and Barring Scheme check including those employed prior to implementation of the FPPR. There was an annual declaration of ongoing compliance and clear procedures and checks for new applicants.

Public engagement

- The trust had a patient partnership department led by the Head of Patient Partnership. We identified some innovative patient experience engagement activity, such as the use of art therapy, pet therapy and a 'listening wall' for patients to say what they would like to improve the clinical environment.
- There was an active council of governors.
- There had been consultation for areas of the hospital being refurbished. For example, staff had talked with groups for people living with dementia to inform development of the dementia ward at Northern General Hospital.
- Refurbishment of the Huntsmann block at Northern General Hospital had also involved a survey of what patients wanted, plans were shared and carers were consulted. Following feedback, a 'changing places' toilet was included in the refurbishment of Hunstman block at the Northern General Hospital. There was also one available at the Royal Hallamshire

Hospital. These facilities are designed so people with profound and multiple learning disabilities and their carers can access appropriately designed toilet and changing facilities, including hoists. There are 821 designated toilets available nationally.

- There was a monthly patient experience committee, chaired by the Deputy Chief Nurse with representation from each care group. Membership included a representative from the local Healthwatch team and patient governors. The meeting included a patient experience case study.
- The trust had adopted different methods of engaging with patients for the friend and family test. They had introduced an automated telephone call to patient, use of text messages and postcards. The method varied according to the population.
- There was a patient story at the Patient Experience Committee.. Voice recordings and videos were used with patient's consent.
- Wards received a report of patient feedback which included comments and videos. Review of the feedback was included in the annual clinical assurance toolkit.
- The active recovery service had a patient experience group. Feedback from patients was used to improve services.

Staff engagement

- The NHS staff survey (2015) found the trust's score of 3.74 was below (worse than) average when compared with trusts of a similar type.
- Results from the NHS staff survey (2015) showed out of 32 questions, 10 results were similar to other trusts, five were better and 17 were worse than average when compared to other similar trusts.
- The trust had introduced 'Listening into Action'. As part of this, the trust completed a pulse check asking staff 15 questions, for example, 'managers and leaders seek my views about how we can improve our services' and 'communications between senior managers and staff is effective.' The 2015 results were better than the trust's 2014 results and better than the average of healthcare organisations.
- We saw some examples of positive staff engagement. For example, staff in the emergency department had developed a "you said we did" board for staff engagement; we saw examples of changes as a result of this. 'Big Breakfast' and 'Afternoon Tea' events were held in critical care departments for staff to discuss any concerns, ideas and talk with the senior leaders in the directorate and hospital.
- The trust had a workplace health scheme which ran in partnership with external organisations.

Innovation, improvement and sustainability

- Sheffield Teaching Hospitals NHS Foundation Trust is one of seven hospitals that is part of the 'working together' partnership to share best practice and improve patient care. This became an acute care collaborative vanguard project in November 2015.
- NIHR Devices for Dignity (D4D) Healthcare Technology Co-operative was hosted by the trust. D4D works across multiple NHS, higher education, charity, patient and industry organisations to develop technology solutions to unmet clinical needs.
- The Sheffield Microsystem Coaching Academy (MCA), supported innovation and improvement within the trust. There was an improvement team which staff could be seconded into as improvement facilitators for up to two years. The team supported operational teams to implement improvement projects. This was seen to be innovative and supported the focus on sustainable improvement. Examples of [projects including reduction of outpatient waiting times and do not attend rates for patients with cystic fibrosis. Improvement training for staff is also provided across the trust.
- The trust had a strong research focus and strategic links with external organisations. The trust hosted the National Institute for Health Research,Collaboration for Leadership in Applied Health Researchand Care. The trust had a Research, Education and Innovation Committee that reported into the Trust Executive Group and then into the board.
- There were 14 academic directorates at the trust. These were identified as 'flagship' directorates involved in research. There was application and selection process before they were recognised as an academic directorate. There was trust support for staff to undertake clinical research.
- The trust had a number of initiatives that had been nationally recognised as good practice. For example, the active recovery team was an innovative service. It was the first in the England to provide this model of care and had been cited by the Royal College of Physicians as an exemplar of good practice. Another example was the duty floor anaesthetist role in theatre developed in Sheffield which was going to be used by the Royal College of Anaesthetists as a beacon of good practice.

Overview of ratings

Our ratings for Royal Hallamshire Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	☆ Outstanding	Good	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	☆ Outstanding	☆ Outstanding
Overall	Good	Good	Good	Good	☆ Outstanding	Good

Overview of ratings

Our ratings for Northern General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	☆ Outstanding	☆ Outstanding
Overall	Good	Good	Good	Good	Requires improvement	Good

Our ratings for Weston Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
End of life care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Requires improvement	Requires improvement	☆ Outstanding	Requires improvement	Good	Requires improvement

Overview of ratings

Our ratings for Charles Clifford Dental Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dental services	Good	Good	Good	☆ Outstanding	Good	Good
Overall	Good	Good	Good	☆ Outstanding	Good	Good

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Community health inpatient services	Requires improvement	Good	☆ Outstanding	Good	Good	Good
Community End of Life Care services	Good	Good	Good	Good	Requires improvement	Good
Community heath dental services	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Sheffield Dialysis Unit	Good	Good	Good	Good	Good	Good
Overall Community	Good	Good	Good	☆ Outstanding	Good	Good

Our ratings for Sheffield Teaching Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and Diagnostics.

Outstanding practice and areas for improvement

Outstanding practice

Community dental service

- A collaboration between the Sheffield Community Dental Services, NHS commissioners, Dental Public Health consultants and local general dental practitioners led to the development of the Residential Oral Care Sheffield service for residents living in care homes. This collaboration was cited as good practice by the British Society for Disability and Oral Health. This service now covers 80 out of the 88 residential care homes who participate in the scheme in the city of Sheffield.
- The clinical lead was instrumental in developing a national benchmarking tool used by other community dental services and NHS dental commissioners for describing the complexity of patients treated by community dental services. An evaluation of the outcomes of the pilot project was delivered at the National Association for Dentistry in Health Authorities and Trusts in 2014.
- Collaboration between the Clinical Lead of Sheffield Community Dental Services and the Head of Psychotherapy Services within Sheffield NHS Foundation Trust developed a dental nurse led Pain and Anxiety Service. This led to a reduction in the numbers of patients needing intra-venous sedation for dental treatment and the overall waiting times for intra-venous sedation.
- Sheffield Community Dental Service provided a service for the Sheffield homeless under the auspices of the 'Archer Project at the Cathedral'.
- Sheffield Community Dental Service had developed a communication tool known locally as 'the widget sheets' enabling children with autistic spectrum disorders and other communication difficulties to accept dental treatment. An evaluation of this audit tool was published in the peer reviewed international scientific publication 'Journal for Disability and Oral Health in 2014.
- The development of a number of nationally recognised clinical benchmarking tools by Sheffield Community Dental Service was a result of exceptional leadership provided by the current Clinical Lead of the Service.

Community Adults

- The active recovery service was a responsive service, which aimed to reduce un-necessary hospital admissions and facilitate the timely discharge of more complex patients from hospital. The team was multidisciplinary and multiagency with health and social care working closely together. The service had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess resulting in reduced length of stay for patients and improved patient flow within the hospital.
- The Single Point of Access (SPA) service managed referrals from patients and health professionals into all community health services. The service used a call routing system to direct patients to the right professional from the start. The team had extensive local knowledge and specialist expertise and were able to access to up to date information on service capacity. This meant that they could ensure patients were seen by the right professional at the right time at a venue of their choice.
- We thought the person centred care planning was outstanding. The aim of this was to provide support for patients considered to be at high risk of hospital admission at an early stage. Community nurses and GPs worked together to develop patient and carers confidence in managing their own health. The community matron supported this. There were locality champions for person centred care planning in each of the four localities.

Northern General Hospital

- The patient care and experience delivered by staff in the Bev Stokes Day Surgery Unit was outstanding, particularly in relation to patients living with learning disabilities and dementia.
- The duty floor anaesthetist role in theatre developed in Sheffield was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- The development of a relative's room in the theatre complex.

Outstanding practice and areas for improvement

- On GICU /GHDU there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services.
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in critical care.
- The use of the Enhanced Recovery After Thoracic Surgery (ERAS) programme had resulted in marked improvements in the quality of care for patients on CICU.
- The laboratory team had introduced a 'Patient Safety Zone' project into the inpatient wards and in the community. The aim was to reduce labelling errors. Disturbance or distraction while taking blood samples has been identified as a major risk factor for errors. This initiative had been introduced to improve patient safety. Pathology staff showed us lots of publicity material, including branded biro pens.
- In laboratory medicine, we observed large screens above the bench dealing with urgent samples. It contained a full list of patients waiting for results in the accident and emergency (A&E) department. The same screens were on display in A&E. This meant laboratory staff could see exactly who was waiting in A&E and gave context and 'humanity' to the samples they were analysing. Urgent results for A&E samples were available in one hour because of the use of this management tool.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for A&E patients; results were ready within 20 minutes.
- Geriatric medicine had historically been part of acute medicine but was now combined with community services.

Royal Hallamshire Hospital

- Staff in theatre had introduced a learning disability pathway. An operating list was dedicated to patients with a learning disability, if the patient needed more than one procedure this was carried out on the same operating list under the same general anaesthetic.
- The use of duty floor anaesthetist role in theatre, developed in Sheffield, was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for minor injury patients; results were ready within 20 minutes
- Histopathology was using cross-site digital pathology to speed up processing time for frozen sections.
- On GICU and NICU there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in Critical care.
- The one to one team and specialist midwife clinics gave greater assurance that high risk women continued to have a choice on the care they received in pregnancy.
- The rapid access clinic reduced readmissions of babies with feeding problems.
- The GRIP project responsible for getting research into practice improved services for maternity and gynaecology.
- The termination of pregnancy service gave women continuity of care in an appropriate caring environment. The seven day service gave women choice and improved accessibility.
- The use of the Enhanced Recovery programme in both maternity and gynaecology improved the service for women.

Weston Park Hospital

- Specialised cancer services provided a patient-centred holistic approach to patient care where the whole multidisciplinary team worked together to ensure the patient's experience of the service was the best that it could be.
- The teenage cancer unit had a number of innovations which had been paid for out of charitable funds. These included a 'couples retreat' for end of life patients and their partners. They could spend time away from home and explore issues about coming to the end of life.

Outstanding practice and areas for improvement

Community end of life care

- The intensive home nursing service provides support for patients and their families in the last days and hours of life. Relatives consistently praised the service and the staff who provided it.

Community inpatients

- Feedback we received from patients was consistently positive about the way nursing and therapy staff treated them. Patients told us that staff go the extra mile. Staff and patients confirmed that the unit had a flexible approach to care.
- Patients were supported emotionally. Activities such as singing, arts and crafts were arranged to prevent social isolation and boredom.

Charles Clifford Dental Hospital

- An holistic approach to individual patient's requirements was modelled within CCDH, and anxious patients had the option of utilising cognitive behavioural therapy (CBT), acupuncture, hypnosis, inhalation, or intravenous or oral sedation to assist with their dental treatments.
- Staff were sensitive to the needs of vulnerable patients, making reasonable adjustments to ensure that effective two-way communication was achievable to allow patients to be fully empowered to make decisions about their treatment options.
- The service worked with a local dental unit to provide an out of hours (17:00 – 20:00) oral surgery Consultant led clinic for patients who were unable to be released from work within core hours, enabling them to attend one evening each week.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure patients do not wait longer than the recommended standard for assessment and treatment in the emergency department.
- The trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.
- The trust must monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department.
- The trust must ensure the safe storage of intravenous fluids.
- The trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.
- The trust must ensure that guidance is followed in the documentation of foetal heart rate monitoring's.
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at Weston Park Hospital.
- Ensure that guidance is followed in the documentation of foetal heart rate monitoring's. In 86% of 39 CTG records there was no data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not always documented on the monitoring, in accordance with trust guidance (Intrapartum foetal monitoring - CTG, 5.5, 5.6).
- The trust must ensure divisional risk registers reflect issues in the emergency department and demonstrate evidence of actions and reviews.
- The trust must ensure there is a clear strategy for the end of life care which is implemented and monitored.
- The trust must ensure that staff implement individualised, evidence based care for patients at the end of life.
- The trust must ensure that DNACPR records are fully completed.
- The trust must ensure that, where concerns are raised and investigated, the reviews are undertaken promptly to ensure any necessary actions are implemented in a timely manner.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12: Safe care and treatment Care and treatment must be provided in a safe way for service users. How it was not being met: Patients waited longer than the recommended standard for assessment and treatment in the emergency department; patient's vital signs were not taken and recorded consistently as part of the initial assessment in the "pit stop area" in the emergency department; 95% of patients were not admitted, transferred or discharged within four hours of arrival in the emergency department.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg. 12 (1) (g) There must be proper systems in place to ensure the safe management of medications. How it was not being met: Intravenous fluids were not always stored safely and securely, oxygen was not prescribed, drug fridge temperatures were not always accurately monitored or maintained.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Reg.17. Good Governance

Systems or processes must be established and operated effectively to :

a) assess, monitor and improve the quality and safety of services

c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided

How it was not being met:

In 86% of 39 CTG records there was no data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not always documented on the monitoring, in accordance with trust guidance (Intrapartum foetal monitoring - CTG, 5.5, 5.6).

The risk register for the emergency department did not reflect the identified risks.

There was no end of life care strategy. DNACPR records were not completed fully and accurately.

Some reviews had taken longer than expected and this meant findings and actions were not always implemented in a timely manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.

This section is primarily information for the provider

Requirement notices

How it was not being met:

Nursing staffing levels were below the planned level at Weston Park Hospital with shifts having fewer registered nurses than required on duty.

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee
13th Julv 2016

Report of: Policy & Improvement Officer

Subject: Draft Work Programme 2016/17

Author of Report: Alice Nicholson, Policy and Improvement Officer
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A draft work programme for 2016/17 is attached at appendix 1 for the Committee's comment, consideration, discussion, prioritisation and agreement.

The future work programme identifies a proposed scrutiny style for each item listed. There are a high number of agenda items, including carry forward from last year, this approach can limit the ability to focus on a small number of issues in depth. This means that the Committee should prioritise which issues will be included on formal meeting agendas, whether a single agenda item in-depth approach, multi items of less depth or for information only. This may include considering added value of follow-on items. In undertaking prioritisation and rationalisation of topics for the work programme the Committee may wish to reflect on the prioritisation principles attached at appendix 2 to ensure that scrutiny activity is focussed where it can add most value.

The draft work programme 2016/17 includes a proposed task group, a more in-depth and in the round approach. A possible topic for the group is suggested along with a proposal to integrate with the Quality Accounts activity.

The Scrutiny Committee is being asked to:

- Comment/feedback on proposed one-off agenda items for 2016/17
- Identify priorities, confirm scrutiny style, for one-off/single agenda items for future agendas
- Consider/agree suggested task group approach, topic and integrating with Quality Accounts activity

Category of Report: OPEN

Appendix 1

Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee

Draft work programme 2016/17

Last updated: 4th July 2016

Please note: the draft work programme is a live document and so is subject to change.

Possible Topic	Reasons for selecting topic	Date	Proposed scrutiny style	Priority
Draft Work Programme	*Committee to agree work programme 2016/17*	*Jul-16*	*Ongoing agenda item*	
CQC inspection reports - Sheffield Teaching Hospitals NHS Foundation Trust	*Opportunity for the Committee to examine the recent Care Quality Commission inspection report and raise questions*	*Jul-16*	*Agenda item for discussion and consideration*	
Quality Accounts 2015/16 - sub group report	*For information - responses to NHS Trust QAs*	*Jul-16*	*Report for information*	
Joint Health Overview and Scrutiny Committee (JHOSC) - Commissioners Working Together Programme	Update on JHOSC set up the request of NHS England & NHS Sheffield CCG; the Chair Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee or nominee to attend JHOSC for identified service changes under Commissioners Working Together Programme	Jul-16 and Sep-16 and ongoing	Ongoing agenda item for information and discussion when required	
Sustainability & Transformation Plan (STP)	To consider the local service response to NHS plan – 5 year forward view – footprint is South Yorkshire & Bassetlaw; focus on patient engagement in plan, patient expectations.	Sep-16	Single agenda item – discussion and consideration or combined with Public Health Strategy	

Appendix 1

Possible Topic	Reasons for selecting topic	Date	Proposed scrutiny style	Priority
Dementia Strategy	Raised as a public question 23.03.2016 for inclusion in work programme – work in progress to determine when and scope	TBC	Single agenda item – discussion and consideration	
Delays to Hospital Discharging	This issue has been raised at various points in the work of Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee. Now national evidence in report of National Audit Office - Discharging older patients from hospital, May 2016.	Nov -16	Single agenda item - discussion and consideration or NAO report for information	
CAMHS	There is an NHS procurement of CAMHS Tier 4 - full NHS timeline for each package not known yet - South Yorkshire will be one package; a topic of interest to the Committee a previous Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee Task Group reported March 2014	TBC	TBC	
Public Health Strategy	To consider the Director of Public Health Annual Report. Public Health is a core aspect of Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee activity. Public health and its wider determinants underlay tackling health inequalities.	Sep-16	Single agenda item – discussion and consideration or combined with STP	
Health & Wellbeing Board	The terms of reference are currently under review, this item could consider new terms of reference and the 5 outcomes of Sheffield Health & Wellbeing Board.	TBC	Agenda item – discussion and consideration or for information	
PREVENT	The PREVENT task group of Safer and Stronger Communities Scrutiny and Policy Development Committee recognised that there was a particular aspect of PREVENT that needed further consideration and was more suited to Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee, that of radicalisation vulnerability & mental health.	Jan-16	Single agenda item – discussion and consideration	
Task group topic	**Reasons for selecting topic**	**Date**		

Appendix 1

Possible Topic	Reasons for selecting topic	Date	Proposed scrutiny style	Priority
A&E – patient experience	Members of the Committee raise anecdotal evidence of poor patient experiences. A recent CQC inspection of Sheffield Teaching Hospitals NHS Foundation Trust gives an overall rating 'requires improvement' for urgent and emergency services at Northern General Hospital. The suggested task group could consider this in-depth - see task group	Jan-17	Part year Task Group	
Quality Accounts – performance	Sub group of Committee Members to carry out work on Quality Accounts on behalf of the Committee. Building on previous years QA approach integrate with patient experience	Sep- 16 & Jan-17	Sub-group or include in full year task group	
Task group – main topic for 2016/17: Examining performance with patient experience/performance – including Quality Accounts – with a focus for example on A&E;	A proposal for a task group that examines performance, gathers evidence of patient experience. To integrate with Quality Accounts activity, a further enhanced approach on previous years; a QA focus on a topic e.g. A&E – 'frame around 'patient experience'. Expansions could look at: the A&E mental health experiences of young people – the transition from children's to adult provision. Other patient experience themes raised are: a lack of reasonable adjustments in hospital; health inequalities – understanding what they are i.e. Mental Health, disability, economy, BME experience.	Now to Mar-17	Full year Task Group	
Follow on to schedule from 2015/16				
Primary Care Strategy - CCG (Katrina Cleary)	*This item is for information - At its meeting in March 2016 the committee considered Access to GP and requested that this be forwarded when available*	*Jul-16*	*Agenda item for information*	
PMCF evaluation	At its meeting in March 2016 the committee considered Access to GP and requested that this be presented/forwarded when available	TBC	Agenda item for information	

Appendix 1

Possible Topic	Reasons for selecting topic	Date	Proposed scrutiny style	Priority
Better Care Fund	Following consideration of the Better Care Fund at its meeting in November 2015, the committee wanted to look at it again in the future, focusing on whether the programme is achieving its intended outcomes and financial savings	TBC	Agenda item for discussion and consideration	
Adult Social Care Performance	At its meeting in January 2016, the Committee welcomes the approach being taken to improve adult social care performance, and requested that the Director of Adult Services provide a further update in a year's time.	Jan-17 (or Mar/Apr 17)	Agenda item - discussion and consideration or for information	
Quality Care Provision for Adults with a Learning Disability in Sheffield	In January 2016, the Committee considered improvements and action plans following reviews of Council and Care Trust learning disability services. The Committee requested a further update on progress in 12 months from the Director of Adult Services	Jan-17 (or Mar/Apr 17)	Agenda item – discussion and consideration or for information	
Carers' Strategy	At its meeting in September 2015 the committee considered the developing Carers' Strategy and requested that the final version of the Carers' Strategy and Action Plans be presented to the Committee for comment.	TBC	TBC	
Home Care task group - response to report	recommendations to Cabinet 9th March 2016 - response due no later than December 2016	Jan -16	Agenda item for discussion and consideration or for information	
Adult Safeguarding	A protocol was agreed March 2016 – this item to provide updates as and when required and facilitate feedback to the board	TBC	TBC	
Training				
Adult Safeguarding	A training/ awareness session for all members of the Committee to be scheduled outside of set meetings – to enhance scrutiny role in Adult Safeguarding in line with protocol.	Oct - 16	N/A	

Sheffield Council Scrutiny
Selecting Scrutiny topics

This tool is designed to assist the Scrutiny Committees focus on the topics most appropriate for their scrutiny.

- **Public Interest**
  The concerns of local people should influence the issues chosen for scrutiny;

- **Ability to Change / Impact**
  Priority should be given to issues that the Committee can realistically have an impact on, and that will influence decision makers;

- **Performance**
  Priority should be given to the areas in which the Council, and other organisations (public or private) are not performing well;

- **Extent**
  Priority should be given to issues that are relevant to all or large parts of the city (geographical or communities of interest);

- **Replication / other approaches**
  Work programmes must take account of what else is happening (or has happened) in the areas being considered to avoid duplication or wasted effort. Alternatively, could another body, agency, or approach (e.g. briefing paper) more appropriately deal with the topic

Other influencing factors

- **Cross-party -** There is the potential to reach cross-party agreement on a report and recommendations.

- **Resources**. Members with the Policy & Improvement Officer can complete the work needed in a reasonable time to achieve the required outcome

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Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 13th July 2016

Report of: Policy & Improvement Officer

Subject: Quality Accounts 2015/16 – Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee submissions

Author of Report: Alice Nicholson, Policy and Improvement Officer
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A sub-group of Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee was tasked with considering NHS Quality Accounts 2015/16. Attached for information are the comments/submissions for publication of four NHS trusts that provide service to the Sheffield community and St Luke's Hospice.

The Scrutiny Committee is being asked to:

- For information only

Category of Report: OPEN

Local Overview and Scrutiny comment on Sheffield Children's NHS Foundation Trust Quality Report 2015/16

3rd May 2016

Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee welcome the opportunity to consider your draft Quality Account in line with NHS (Quality Accounts) Regulations 2010. We view it as a valuable aspect of health service provision scrutiny that looks at the things that are important to the public of Sheffield.

The Committee are pleased to see year on year document presentation improvements. We would like to see three year performance trend throughout with the inclusion of comparator year data and that objectives/priorities do not fall off or out of the report if not achieved.

The Committee welcome the healthier food priority and improving services for children and young people with learning disabilities priority for 2016/17. We would like to see this as a wide ranging public health priority across the whole Trust, including primary child health care, for example health visitor service, and staff healthy eating.

The Committee are pleased with the success the document is reporting on the 16-17 years mental health service. We have some concern the number of Serious Incidents has increased on the previous year and note the missed target for diagnostic waits.

The Committee look forward to a report next year on the outcome to increase the number of staff receiving a well-structured appraisal. We would have liked to have seen reporting of NHS Staff Survey indicators KF21 & KF26 for the Workforce Race Equality Standard

Local Overview and Scrutiny Formal Comment on Sheffield Health and Social Care NHS Foundation Trust Quality Account 2015/16

9th May 2016

Comment for publication:

Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee welcome the opportunity to consider your draft Quality Account in line with NHS (Quality Accounts) Regulations 2010. We view this as a valuable aspect of health service provision scrutiny that looks at the things that are important to the public of Sheffield and make the following comments:

The Committee would like to see three year performance trend throughout with the inclusion of comparator year data and that objectives/priorities do not fall off or out of the report if not achieved. Pleased to see Quality Objectives for 2016/17 reflect CQC improvement requirement, it is appropriate continuing to focus on these.

We welcome the improvement in waiting times reported 2015/16 and that the Trust has achieved most of their targets. The reference to working to improve services out of hours over the last 12 months is positive; look forward to the Trust sharing the evidence of impact on the service users.

The Committee note patient related incidents have increased and the CQC assessment required this as an area for improvement. We observe a variable performance with an increase in number of incidents but reduction in most serious incidents and look forward to seeing the outcome of conclusions being implemented from the serious incident procedures review, with a degree of reassurance for the public.

We are pleased to see 93% of staff appraised in last 12 months. The Committee welcome presentation of three year staff experience trend data and would like to see a breakdown by ethnicity.

Local Overview and Scrutiny comments on Sheffield Teaching Hospitals NHS Foundation Trust Quality Report 2015/16

May 2016

Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee welcome the opportunity to consider your draft Quality Report in line with NHS (Quality Accounts) Regulations 2010. We view this as a valuable aspect of health service provision scrutiny that looks at the things that are important to the public of Sheffield.

The Committee note the Quality Report as a document is dual purpose and encourage the publication of two versions for different audiences. The sharing of priorities in October was welcomed and working further together on the process timetable will facilitate full comment on all aspects of the Quality Account for next year.

The Committee welcome progress made on the handling of complaints and improving complainant satisfaction. For next year's priorities we are pleased to see the inclusion of further work to improve safety and quality of care, as well as arrangements to improve End of Life Care and look forward to getting feedback on these in due course. The Committee also welcome improvements in the patient experience at Weston Park; we hope that this will include the roof terrace, as this is important to patients and families. We would like to see progress continuing to be made in key areas not selected yet as a priority – Frailty Unit and SAFER bundle. In particular, progress in speeding up discharge including tackling delays in the prescription/pharmacy process.

The Committee are pleased to see some improvement in number of on day cancellations but welcome further progress. We especially want to see progress to 'Optimise Length of Stay, commitment of all to change, to enable discharge quicker and encourage further improvement through local co-production such as Right First Time. In reviewing Quality Performance Information 2015/16 we are disappointed with the readmission rate; and look forward to seeing next year the outcome of the work on understanding why this is happening, including a look at a more detail age breakdown or indication of whether it is age related.

The Committee note that the percentage of patients who waited less than 62 days from urgent referral to receiving their treatment for cancer is below national standard and there has been deterioration in performance over last 3 years. We hope there are plans in place to improve this.

The Committee are pleased to note in response to our previous comments that, for transparency 'Never Events' are included in the Quality Report. It is good to see the improvements in results from staff survey, we are concerned with areas that have deteriorated and express concern at the disparity between white and BME experiences in the Work Race Equality Standard (WRES) particularly standards KF21 and Q17b, we look forward to seeing anticipated improvements.

Local Overview and Scrutiny Formal Comment on St Luke's Hospice, Sheffield Quality Account 2015/16

10th May 2016

Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee are pleased to provide the following comments on the Quality Account 2015/16 for St Luke's Hospice, Sheffield:

Overall the Committee are very pleased to see St Luke's constantly seeking to improve. We can see that your priorities build on previous progress and extend the service offer for the people of Sheffield. St Luke's Hospice is an example of Sheffield working for Sheffield and excellent practices. Following on from last year's Quality Account we would have liked to have seen further feedback on the innovative 'is there one thing' service user feedback approach.

The Committee welcome your response to our comment last year about the diversity of the city. We are pleased to see analysis of BME population accessing St Luke's, the service it provides for the population of Sheffield.

The success of 2015/16 priorities is encouraging: for 'Improving Access' priority we would have liked to see publication of evidence to support the statement of knowing it works; we are pleased to see you adopt community engagement approaches that are beyond reach of some healthcare providers, particularly work placements, engaging with schools and the support for volunteers, there is an impressive number of volunteers at St Luke's Hospice; we are pleased to see the increased use of laundry and food delivery and will be interested to see how this progresses over this next year, the 'Ask the Chef' initiative is an excellent innovation, with the added value of reducing social isolation for carers; the Enhanced Community Palliative Support Services (EnComPaSS) management system is noted and we are interested in feedback on its impact and outcomes and look forward to seeing the evaluation referred to.

Feedback on Draft Quality Accounts 2015-16

Feedback from (name of organisation):

1. **Comments for publication:**
   This is likely to include your assessment against the Department of Health's suggested headings:

   - Do our priorities reflect the priorities of the local population?
   - Are there any important issues we have missed in our Quality Accounts?
   - Have we demonstrated that we have involved patients and the public in the production of the Quality Accounts?
   - Is our Quality Accounts clearly presented for patients and the public?

   [Max: 1000 words]

We note your feedback form and provide the following for publication:

Sheffield City Council Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee welcome the opportunity to consider your draft Quality Report in line with NHS (Quality Accounts) Regulations 2010. We view it as a valuable aspect of health service provision scrutiny that looks at the things that are important to the public of Sheffield.

The Committee note the document is dual purpose and encourage the publication of two versions for different audiences.

The Committee felt unsure how far a judgement could be made of appropriateness of the Quality Account for benefit for the people of Sheffield and would welcome more area breakdown of data across the Yorkshire Ambulance Region, including the 'you said, we did' section.

The Committee would welcome more outcome focussed information, perhaps more analytical to support the descriptive information, notably in regard to Quality Indicators to understand the patient experience and improving quality for people.

The Committee are very pleased there is a positive picture for mental health pathways and the inclusion of data that demonstrates this outcome.

The Committee note there are variations in response time performance within the Yorkshire Ambulance Service area of provision.

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Briefing for Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 13th July 2016

Report of: Policy & Improvement Officer

Subject: Joint Health Overview and Scrutiny Committee 2016 – Commissioners Working Together Programme

Author of Report: Alice Nicholson, Policy and Improvement Officer
alice.nicholson@sheffield.gov.uk
0114 273 5065

NHS England and NHS Sheffield CCG formally requested that local authorities in the 'Commissioners Working Together' programme area establish a Joint Health Overview and Scrutiny Committee to consider proposed substantial variations to local health services. Council agreed on 4th March 2016 to participate in this. There is limited information to report at this point, the detail of the service changes are anticipated for presentation at the next meeting on 8th August 2016. No papers are attached to this briefing, the papers for the first meeting held on 23rd May can be found here .

The Scrutiny Committee is being asked to:

- This briefing is provided for information only

Category of Report: OPEN

Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee 13th July 2016

Report of: Policy & Improvement Officer

Subject: Sheffield CCG Primary Care Strategy 2016

Author of Report: Alice Nicholson, Policy and Improvement Officer
alice.nicholson@sheffield.gov.uk
0114 273 5065

At its meeting 23rd March 2016 Healthier Communities and Adult Social Care Scrutiny and Policy Development Committee considered Access to GP and requested that the Primary Care Strategy be forwarded when available.
The attached is a report to the Sheffield CCG board 4th June 2016.

The Scrutiny Committee is being asked to:

- The document is provided for information only

Category of Report: OPEN

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Primary Care Strategy for Sheffield

Governing Body meeting

D

26 May 2016

Author(s)	Becky Meadows
Sponsor	Katrina Cleary, CCG Programme Director Primary Care

Is your report for Approval / Consideration / Noting

Approval

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

A detailed implementation plan will follow if the primary care strategy is approved; this will have resource implications.

Audit Requirement

CCG Objectives

Which of the CCG's objectives does this paper support?

1. To improve patient experience and access to care
2. To improve quality and equality of healthcare in Sheffield
3. To work with Sheffield City Council to continue to reduce health inequalities in Sheffield
4. To ensure there is a sustainable, affordable healthcare system in Sheffield.

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached?
Yes, EIA attached.

PPE Activity

How does your paper support involving patients, carers and the public?
Information from Speaking with Confidence, National Voices, Healthwatch, Sheffield Fairness Commission and the BMA survey results included in their 2015 paper, Responsive, safe and sustainable has been used to develop the strategy. As a result an underpinning element of the strategy is the person-centred care approach – ensuring people are motivated to manage their own health needs and empowering them to get support to address non-medical determinants of health (housing, employment, transport, benefits etc). If implemented the strategy will mean significant changes to the way services are delivered – a public engagement and education programme will be needed to support the successful implementation of this and the wider out of hospital strategy.

Recommendations
The Governing Body is asked to approve the strategy

Fit for the Future

A Strategy for Primary Care Services in Sheffield

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Executive summary

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

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

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

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

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

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

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

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

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

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

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

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

Our vision

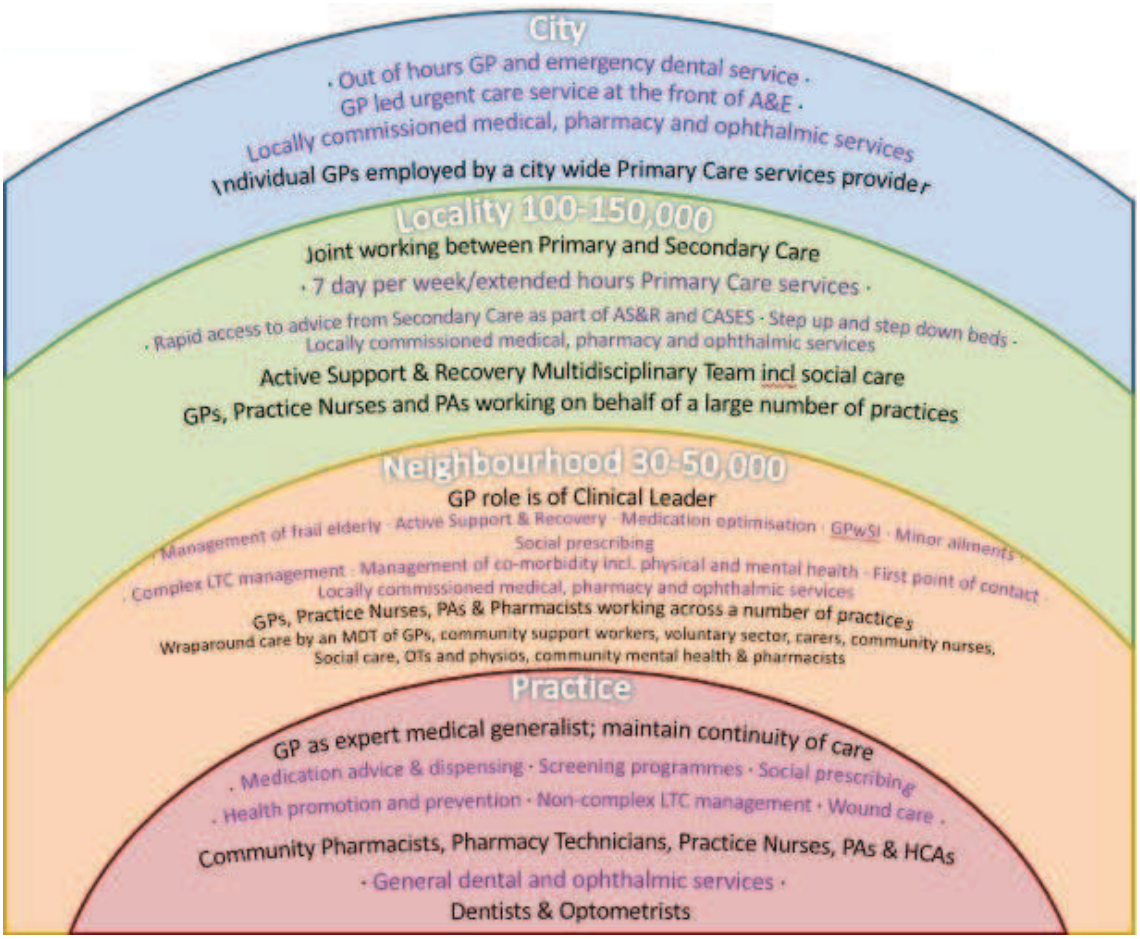
We know there will be big improvements in people's health and well-being if the existing services already rooted in local communities – health, social care, voluntary sector, police, education and others – work in a more collaborative way. There is a growing recognition that organisational boundaries have prevented healthy collaboration in the past and that this culture is now shifting. Collaboration between services covering populations of 30-50,000 people is recommended in a number of national documents[1]; we refer to this as a neighbourhood and it forms a key part of our strategy.

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

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

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

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



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

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

1. The strategic context and case for change

1.1 The strategic context: Out of hospital services

The purpose of the health and social care sector is to improve the health and well-being of the local population. Sheffield CCG and Sheffield City Council have a leadership role to play in signalling the changes that need to be made and in enabling the system to make the necessary changes through the intelligent use of commissioning. The organisations are working jointly to define a system of services that will deliver the highest quality health and social care for people living in Sheffield[2]. As part of this work the CCG has set out a strategy for Care Outside of Hospital[3] which takes a whole system approach to the planning and delivery of all care services provided in a community or primary care setting.

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

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

- Managing greater volume of demand by using workforce skills more appropriately; keeping the most skilled resource for the patients in greatest need and maximising the use of resources across different size population groups according to need.
- Maintaining and seeing patients at home or in a community setting rather than in a hospital[4].
- Working as a single team across organisational boundaries.

[2] Transforming Sheffield Structure, consultation draft, March 2016.
[3] Care Outside of Hospital: An Overarching Strategy, Idris Griffiths. Sheffield CCG Governing Body, January 2016.
[4] The Clinical Assessment Service, Education and Support model (CASES) is one of the vehicles for delivering this part of the strategy.

1.2 The case for change – national and local drivers

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

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

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

National drivers for change

These drivers are well documented[5] and can be summarised as:

- The number and proportion of older people in the population is increasing; the health and social care needs of older people are often more complex.
- There are more people being diagnosed with long term conditions and a greater proportion of people living with co-morbidity; this increases the demand for services and demands a different type of service provision.
- Greater prevalence of mental health needs and co-morbidity of physical and mental health illness.
- The healthcare expectations of the population are changing in line with greater consumer choice, 24/7 access, fast response times and better informed consumers.
- The approach to healthcare provision is shifting away from a paternalistic model with a greater onus on patients taking a more active role in the care of their own health; the Collaborative Care and Support Planning (CCSP) or person-centred care approach[6].
- Significant differences in health outcomes for different population groups; a persistence of health inequalities.
- Funding levels have decreased in real terms; the same resources are being spread more thinly requiring more efficient use of funds available.
- Greater integration between health and social care commissioners as a result of the Care Act and introduction of the Better Care Fund (BCF).

[5] Five Year Forward View, NHS England, October 2014 and General Practice Forward View, NHS England, April 2016.
[6] Stepping Forward. Commissioning Principles for Collaborative Care and Support Planning. Professor Nigel Mathers, RCGP Clinical Innovation and Research Centre, 2015.

- Changes in technology are enabling improved survival rates, more complex conditions to be managed in a community or home setting and alternative ways of seeing and assessing patients.
- There are significant workforce issues in many parts of healthcare and this is keenly felt in primary care where fewer GPs are entering the profession and more are leaving it early[7]; there are too few practice nurses and a lack of dedicated training and career structure; physician's assistants courses are in their infancy.
- A combination of workload and workforce pressures and, in some cases, reductions in funding, are pushing some general practices to consider closure[8].
- A shift in culture towards patient centred care (see Appendix A).

Local drivers for change

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

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

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

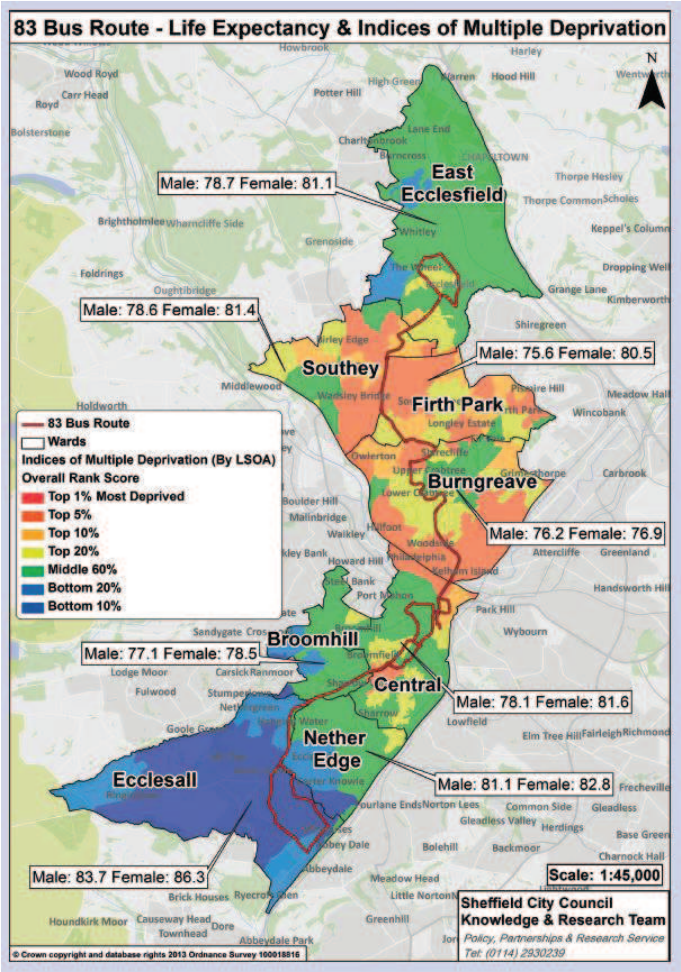
- Be of a consistent standard and quality
- Engage with and be accessible to anyone, regardless of their social circumstances
- Offer the same level of service to people with mental ill health and disability as is available to the rest of the population
- Have the right workforce, IT and buildings to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

Local drivers – demographics and health outcomes

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

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

[7] Responsive, safe and sustainable. Towards a new future for general practice, British Medical Association, 2015.
[8] General Practice Forward View, NHS England, April 2016.



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

Local drivers – pressures in general practice

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

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

[9] Sheffield Fairness Commission report 'Making Sheffield Fairer' available at http://www.sth.nhs.uk/clientfiles/File/Enclosure%20J3%20-%20Fairness%20Commission%20Report.pdf

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

More detailed information on the primary care workforce in Sheffield is provided in Appendix C. The workload pressures experienced by GPs in Sheffield are being felt across the country; a study published in the Lancet[10] of over 100,000,000 general practice consultations showed that the number of consultations per person per year has increased by 10.5% between 2007/08 and 2013/14. A separate study[11] found that the number of consultations in general practice increased by more than 15% from 2010/11 to 2014/15; the biggest growth in activity was in contacts with people over the age of 85.

1.3 Development of the primary care strategy

For a number of years Sheffield Clinical Commissioning Group (CCG) has been engaging with local people who have told us that[12]:

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

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

[10] Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007-14, The Lancet, April 2016.
[11] Understanding pressures in general practice, The Kings Fund, May 2016.
[12] From Speaking with Confidence Briefing, Communications and Engagement Team, NHS Sheffield CCG.

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

2. The current picture of Primary Care provision in Sheffield

2.1 General Practice services

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

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

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

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

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

2.2 General Pharmaceutical services

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

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

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

2.2.1 Developing joint working between general practice and community pharmacy

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

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

2.3 General Ophthalmic services

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

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

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

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

2.4 General Dental services

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

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

2.5 Co-commissioning of primary care services

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

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

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

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

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

2.5.1 Changes to primary care contracts

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

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

3. A primary care service for 2021

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

3.1 What do we need from a primary care service?

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

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

We want to see a primary medical service that retains the core values of general practice, as identified by a group of Sheffield GPs at a seminar in October 2015[14]:

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

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

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

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

[13] From deliberative events with patients to inform: Responsive, safe and sustainable. Towards a new future for general practice. BMA, 2015.
[14] From Sheffield CCG Future of Primary Care Seminar held on 13 October 2015.

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

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

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

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

AS&R: Active Support and Recovery

CASES: Clinical Assessment Service, Education and Support model

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

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

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

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

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

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

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


City
· Out of hours GP and emergency dental service ·
GP led urgent care service at the front of A&E ·
Locally commissioned medical, pharmacy and ophthalmic services
Individual GPs employed by a city wide Primary Care services provider
Locality 100-150,000
Joint working between Primary and Secondary Care
· 7 day per week/extended hours Primary Care services ·
· Rapid access to advice from Secondary Care as part of AS&R and CASES · Step up and step down beds ·
Locally commissioned medical, pharmacy and ophthalmic services
Active Support & Recovery Multidisciplinary Team
GPs, Practice Nurses and PAs working on behalf of a large number of practices
Neighbourhood 30-50,000
GP role is of Clinical Leader
· Management of frail elderly · Active Support & Recovery · Medication optimisation · GPwSI · Minor ailments ·
· Complex LTC management · Management of co-morbidity incl. physical and mental health · First point of contact ·
Locally commissioned medical, pharmacy and ophthalmic services
GPs, Practice Nurses, PAs & Pharmacists working across a number of practices
Wraparound care by an MDT of GPs, voluntary sector, carers, community nurses, OTs and physios, community mental health & pharmacists
Practice
GP as expert medical generalist; maintain continuity of care
· Medication advice & dispensing · Screening programmes ·
· Health promotion and prevention · Non-complex LTC management · Wound care ·
Community Pharmacists, Pharmacy Technicians, Practice Nurses, PAs & HCAs
· General dental and ophthalmic services ·
Dentists & Optometrists

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

3.3 Working in neighbourhoods

Active Support and Recovery and People Keeping Well

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

Population groupings of this size are being favoured across the country as the size allows for professionals to know each other, know the patients, know the local voluntary sector services available and easily access resources within their neighbourhood[15]. Active Support and Recovery (AS&R) will be one of the services on offer. Those patients with more complex needs living within the neighbourhood would work closely with a team of health, care and voluntary sector

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

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

3.4 Empowering clinicians

The role of GPs – practice level

GPs are shown as having a role within every layer; to do this we see GPs operating more as clinical leaders and expert medical generalists[16]. At the less complex end of need, GPs would no longer directly provide the service but would oversee other professionals providing those services on their behalf. This model is already in operation in most practices where the practice employs nurses and healthcare assistants to carry out some of this work and this is likely to continue on this basis (management of less complex long term conditions, health checks, screening, vaccinations etc.)

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

The role of GPs – neighbourhood level

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

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

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

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

needs of individual patients. GPs would be able to work more closely with patients and their carers to determine the type and level of input required but would not then be responsible for mobilising this input, which is often reported as being time-consuming and frustrating by GPs working within the current arrangements and a poor use of their time. GPs would continue to lead on the care of those patients with complex long term conditions, co-morbidities and/or the frail elderly who are on their registered list; the care of these patients would originate with the registered practice and their continuity of care would be maintained through this on-going relationship. This service is described in detail in the emerging AS&R strategy paper[17].

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

The role of GPs – locality level

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

The role of GPs – city wide level

GP out of hours services are currently commissioned on a city wide basis and this will continue. The Urgent Care strategy signals the intention to establish a GP led urgent care service at the front of A&E which would be available to the city wide population[18].

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

The role of the wider general practice team

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

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

[17] AS&R Strategy as set out in the AS&R Scoping Document, Sheffield CCG, October 2015.
[18] Urgent Care Strategy in development. For consideration at Sheffield CCG Governing Body meeting, June 2016.

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

The role of community pharmacists

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

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

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

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

For community pharmacists to take on these roles they would need to work much more closely with GP practices and would need to have access to patients medical records. Some practices have started to employ pharmacists directly[19] and this is one option available to primary care providers. However, it would also be practical for independently contracted community pharmacists to work in close partnership with their nearest GP practices which will signal the need for system wide changes; these are considered in more detail in section 4.

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

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

The role of optometrists

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

The role of dentists

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

Oral surgery was reported as the biggest cause of elective admission to hospital for children aged between 5 and 9 in 2014[20], pointing the way for a greater focus on prevention and for closer working between CCG the and providers of general dental services in the city.

3.5 Neighbourhoods and the voluntary sector

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

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

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

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

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

VCF and other organisations in Sheffield were recently invited to form, develop and manage Collaborative Partnerships (CPs), via a pseudo-framework[21], covering geographic areas of the city of between 20,000 and 30,000. 11 CPs have now been formed all of which have general practices as partners. Once on the framework the CPs can provide PKW services. The Council and the CCG will approach CPs on the framework when investing in neighbourhood based preventative health and wellbeing services.

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

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

3.6 Empowering patients

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

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

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

The People Keeping Well (PKW) initiative will form part of the offer of services within each neighbourhood and uses a proactive, preventative, community based approach made up of a mix of the following six elements[22]:

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

[21] 'Pseudo-Framework' is the commercially compliant title for a framework contract that is flexible enough to periodically re-open to new and changed partnerships.
[22] See Appendix G for further detail

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

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

Case Study

Elsie[23] is an 84yr old lady who lives alone. She has poor eyesight, severe mobility problems and suffers from Crohn's disease. Due to her health conditions Elsie was housebound and was beginning to struggle to manage her small flat independently. Elsie was referred to a Community Support Worker (CSW) by her GP because she reported being isolated and was struggling with her home.

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

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

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

[23] Patient's name has been changed.

4. Achieving the vision – Providers

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

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

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

4.1 General Practice

From listening to local practices we believe that there is a real appetite to make radical change and address some of the pressures primary care providers have been reporting for some time. There will be room for the development of more specialist roles, better utilisation of existing clinical skills and the opportunity to have clearer career paths within the primary care setting across a wide range of disciplines. The role of the GP as a Clinical Leader within the neighbourhood will enable them to provide leadership on the care of complex patients without having to also be the hub that mobilises this care.

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

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

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

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

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

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

The recently published General Practice Forward View[24] has committed to supporting practices financially through a 3 year programme, Releasing Time for Patients, with the aim of freeing up 10% of GPs' time. The programme will spread successful innovations adopted in practices across the country including the ten high impact actions.

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

4.2 Pharmacists

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

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

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

5. Achieving the vision – implementation for Commissioners

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

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

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

5.1 Patient education and engagement

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

"We should encourage people to think of non-medicalised remedies first. If they don't work then people should go to their GP.[25]"

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

5.2 Information Technology

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

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

Strategic Ambitions

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

- To enable Integrated Care.

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

- To empower staff across care settings to work together in the best interests of their patients through shared electronic care records within a common user interface.
- To connect staff with their customers, partners and patients through agile communication and collaboration tools securely, anytime and anywhere.
- To "give care professionals and carers access to all the data, information and knowledge they need", i.e. make available real-time digital information on a person's health and care by 2020 for all NHS-funded services, and comprehensive data on the outcomes and value of services to support improvement and sustainability – as stated in the national Personalised Health Care 2020 plans[26].
- To "bring forward life-saving treatments and support innovation and growth" – make England a leading digital health economy in the world and develop new resources to support research and maximise the benefits of new medicines and treatments, particularly in light of breakthroughs in genomic science to combat long-term conditions including cancer, mental health services and tackling infectious diseases – as stated in the national Personalised Health Care 2020 plans.
- To "support care professionals to make the best use of data and technology" – in future all members of the health, care and social care workforce must have the knowledge and skills to embrace the opportunities of information – as stated in the national Personalised Health Care 2020 plans.

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

City wide working

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

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

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

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

General Practice IT

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

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

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

5.3 Primary care workforce

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

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

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

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

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

development[27]. The schemes they have set up will go partway to addressing the projected gaps in the workforce and they are reliant on their CCG partners to work with constituent practices to encourage and facilitate uptake of the training opportunities on offer. The Advanced Training Practices network has been set up to promote the training schemes available and, where these are not being taken up, the CCG has a role to understand and address the reasons for this.

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

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

5.4 Contracting – financial and quality

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

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

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

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

Quality

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

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

Current quality measures[29] for primary care focus on assurance, value for money and inputs and there will continue to be a place for this where the measures are supported by an evidence base. However, health providers, commissioners and the public will also want to be able to assess service quality based on outcomes for patients. The National Voices paper (2012) and the new integrated health platform require us to refocus and shift our perception of how quality is measured and what this shift may look like in order to deliver the services that best meet the needs of our population. The CCG recognises that outcome measures will need to be developed locally and in a way that takes into account the specific needs of a local population.

Determining what quality measures to use in primary care and the unintended negative consequences resulting from some of the current quality measures has been the subject of much discussion[30]. What is clear is that assurance processes would benefit from being streamlined and/or lighter touch for those practices meeting current criteria.

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

[28] Next steps towards primary care co-commissioning, NHS England 2014.
[29] These include the Quality and Outcomes Framework, Care Quality Commission, NHS England and CCG inspections and appraisals and revalidation.
[30] See for example How to assess quality in primary care, BMJ, November 2015; The quality of care in general practice – capturing opinions from the front line, The Kings Fund, October 2010; Quality assessments in general practice – have we gone too far? E Ng, BMJ, September 2015.

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

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

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

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

5.5 Primary care estate

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

The table[31] of Sheffield GP practice premises below shows that Sheffield has a high proportion of small practices operating from converted premises:

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

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

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

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

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

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

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

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

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

Primary Care Transformation Fund (PCTF)

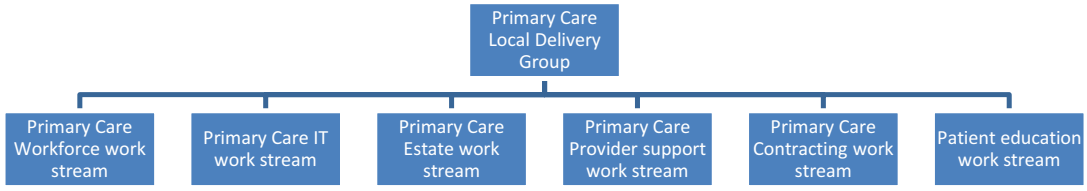
The Primary Care Transformation (formerly Infrastructure) Fund (PCTF) is a four-year investment programme to help general practice make improvements in premises and technology. It is part of the additional NHS funding, announced by the Government in December 2014, to enable the direction of travel set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

CCGs have been invited to propose schemes for 16/17 that support delivery of their primary care strategy. . NHS England have published criteria in line with the General Practice Forward View[32] against which bids will be assessed which include improving the quality of the Primary Care Estate, improving the utilisation of fit for purpose assets and supporting joint working across groups of practices. Schemes will need to be transformational and promote greater access to services, support 7 day access and have the full financial commitment of the CCG in terms of revenue costs.

5.6 Strategy implementation and resourcing

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

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



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

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

6. Conclusion

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

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

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

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

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

Fit for the Future

A Strategy for Primary Care Services in Sheffield

Supporting Appendices

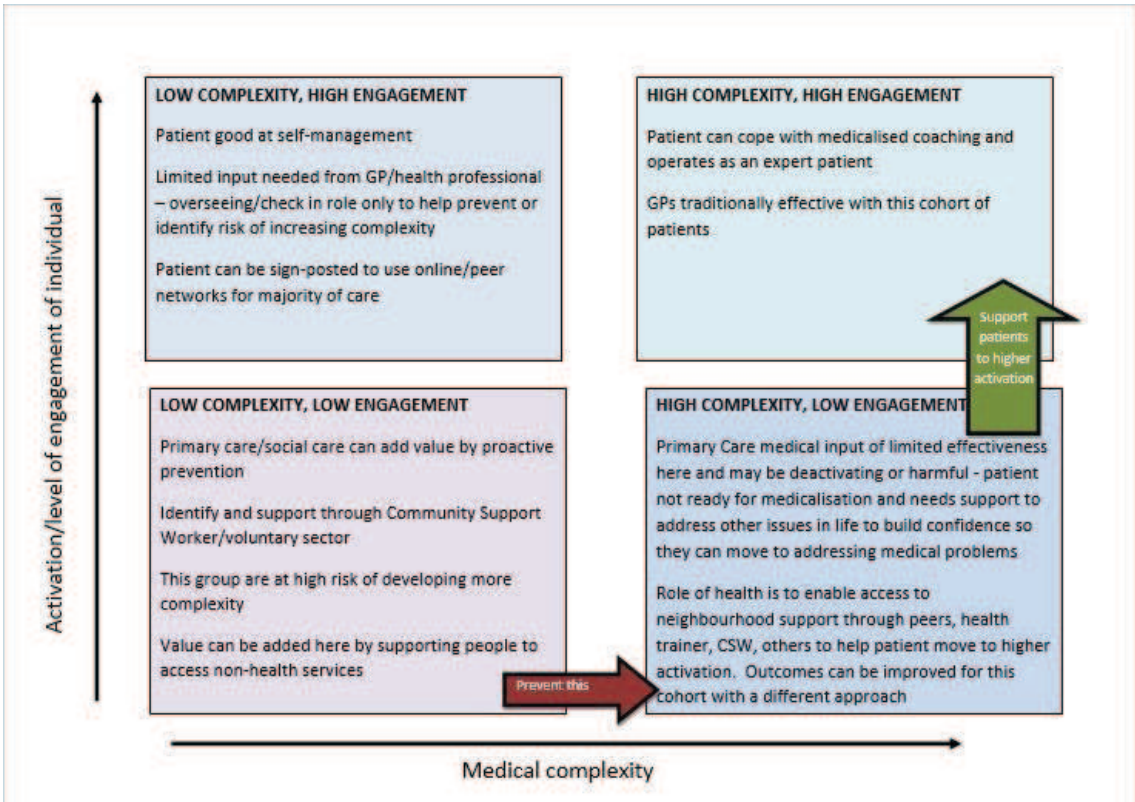
APPENDIX A – Patient centred care approach

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

> "There is now general consensus amongst policy makers, professional bodies, health charities and NHS managers that safe and effective care can only be achieved when patients are 'present, powerful and involved' at all stages."
>
> Stepping Forward. Commissioning Principles for Collaborative Care and Support Planning. Professor Nigel Mathers, RCGP Clinical Innovation and Research Centre, 2015.

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

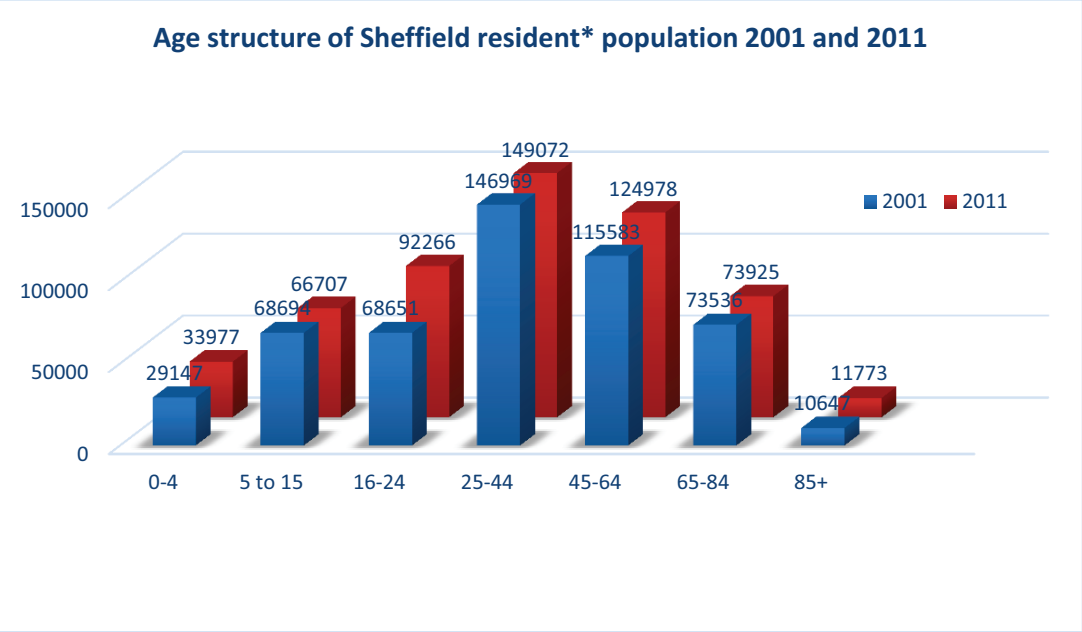
The following model has been observed by Dr Ollie Hart, a GP in Sheffield who is actively involved in implementing person-centred care across Sheffield. It proposes a method to map patient need to the health and social care teams who might be best placed to lead the care of the patient at that time.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


LOW COMPLEXITY, HIGH ENGAGEMENT
Patient good at self-management
Limited input needed from GP/health professional – overseeing/check in role only to help prevent or identify risk of increasing complexity
Patient can be sign-posted to use online/peer networks for majority of care
HIGH COMPLEXITY, HIGH ENGAGEMENT
Patient can cope with medicalised coaching and operates as an expert patient
GPs traditionally effective with this cohort of patients
Support patients to higher activation
LOW COMPLEXITY, LOW ENGAGEMENT
Primary care/social care can add value by proactive prevention
Identify and support through Community Support Worker/voluntary sector
This group are at high risk of developing more complexity
Value can be added here by supporting people to access non-health services
HIGH COMPLEXITY, LOW ENGAGEMENT
Primary Care medical input of limited effectiveness here and may be deactivating or harmful - patient not ready for medicalisation and needs support to address other issues in life to build confidence so they can move to addressing medical problems
Role of health is to enable access to neighbourhood support through peers, health trainer, CSW, others to help patient move to higher activation. Outcomes can be improved for this cohort with a different approach
Prevent this
Activation/level of engagement of individual
Medical complexity

APPENDIX B

Demographic and health outcomes data

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



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

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

The likelihood of presenting with multiple long term conditions increases with age and the complexity of such cases creates additional burden on primary care services. Nationwide, the number of people with one long term condition is projected to remain relatively stable, however those with multiple long term conditions (i.e. more than 2) is set to rise from 1.9million in 2008 to 2.9million in 2018.[1] In Sheffield, approximately 11% of the population reported that they have multiple long term conditions[2] and the average complex patient has 7 inpatient admissions per year across 3 different conditions[3]. Studies into multiple long-term conditions are few, but the evidence that does exist suggests that collaborative and integrated care models, with comprehensive continuity of care, leads to better quality care both for mental and physical health[4].

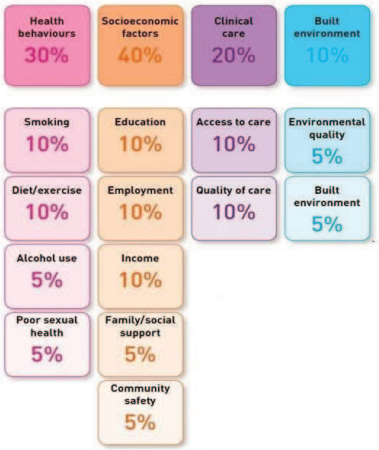
[1] Department of Health 'Long Term Conditions Compendium of Information 3rd edition'. Gateway reference 17485
[2] NHS England, GP Patient Survey 2014/15
[3] NHS England 'Commissioning for Value: Integrated Care Pathways Sheffield CCG February 2015'. NHSE Gateway ref 03066
[4] The Kings Fund, 'Managing people with long-term conditions' (2010)

The Marmot Indicators in Sheffield[5] show that the city is significantly worse than the England average for life expectancy and healthy life expectancy. The life expectancy for both men and women in Sheffield has not improved over the last 10 years and remains at 78.8 years for men and 82.4 years for women (compared to the national average of 79.4 years for men and 83.1 years for women). There are also significant differences in life expectancy for disabled people and for those suffering with mental ill health. The Sheffield Fairness Commission[6] found that people with serious mental disorders die 20 years younger than people with no mental health diagnosis.

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

Health outcomes are determined by a number of factors including clinical care[7], as shown in the diagram below. It is estimated that 20% of health outcomes are attributable to high quality and timely clinical care, with 10% of this from access to care, and 10% from quality of care received. Since the vast majority of NHS patient contact takes place in primary care, this sector plays a significant role in the healthcare contribution to improving health outcomes and reducing health inequalities. For example, in Sheffield there are significantly more people than average diagnosed with cancer through an emergency admission to hospital, with poorer health outcomes as a consequence. Whilst health behaviours and socioeconomic factors contribute significantly to this, variability in access to and quality of primary care is also important.

Determinants of health outcomes



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

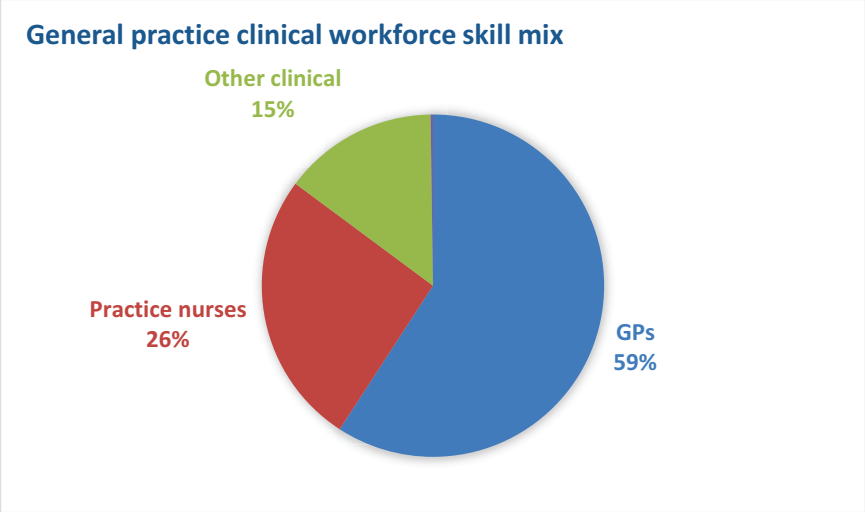
[5] Marmot Indicators for Local Authorities in England 2015 Institute of Health Equity (University College London) – www.instituteofhealthequity.org
[6] Sheffield Fairness Commission report 'Making Sheffield Fairer' available at http://www.sth.nhs.uk/clientfiles/File/Enclosure%20J3%20-%20Fairness%20Commission%20Report.pdf
[7] Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute

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

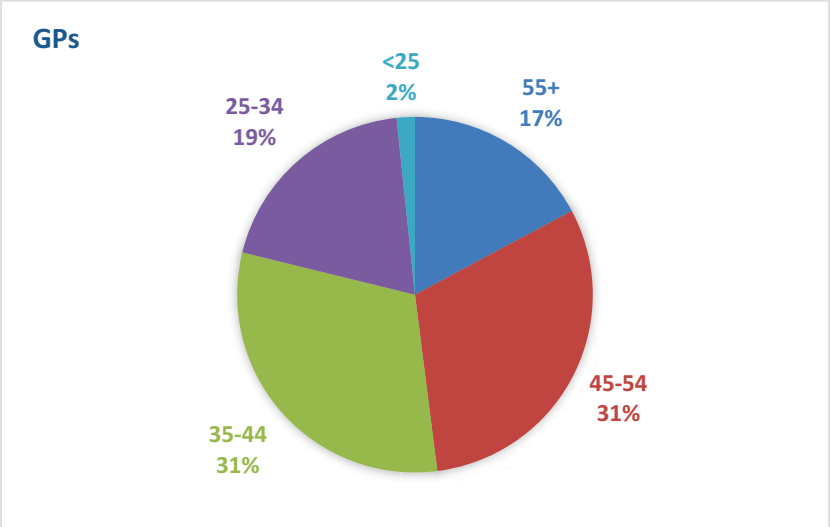
Inequalities are also found in the provision of services to people suffering from mental ill health, particularly in the assessment and treatment of any physical health problems they may present with. The Sheffield Fairness Commission received evidence that 75% of people who committed suicide in Sheffield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

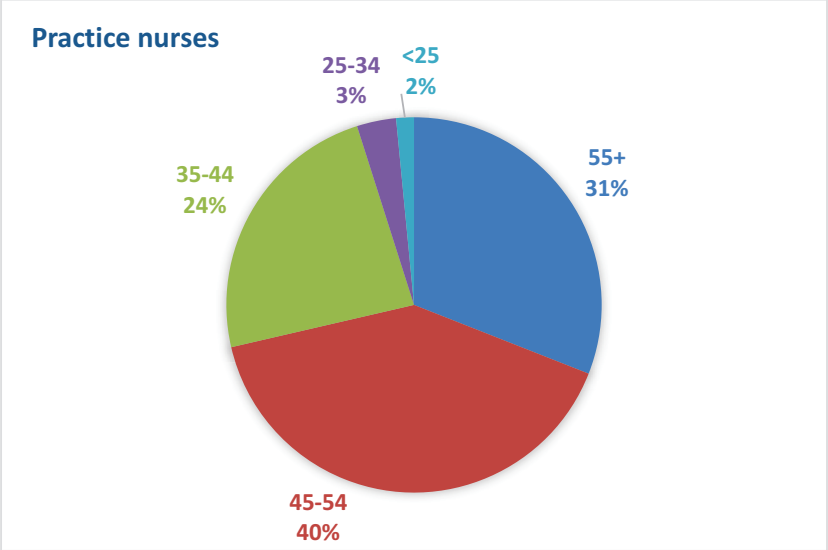
APPENDIX C

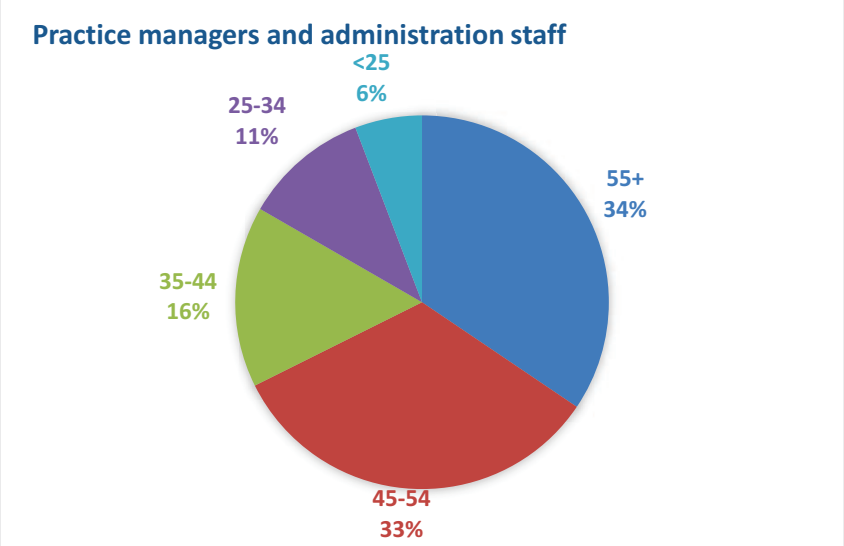
Primary care workforce data collected by Health Education Yorkshire and Humber (HEYH) from October-December 2015 (from 71 Sheffield practices) shows that the skill mix in general practice remains 'GP heavy' and reveals a high proportion of the general practice workforce are within 5-10 years of retirement;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



Age profiles for general practice staff:




Practice nurses
25-34
3%
<25
2%
55+
31%
35-44
24%
45-54
40%


Practice managers and administration staff
<25
6%
25-34
11%
55+
34%
35-44
16%
45-54
33%

APPENDIX D

Development of the strategy – stakeholder engagement

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

  Healthwatch; GPs, pharmacists and community nurses working across Sheffield; Local Medical Committee (LMC); Local Pharmaceutical Committee (LPC); Local Optometric Committee (LOC); Royal College of General Practitioners (RCGP); Primary Care Sheffield (PCS); Professional Network Lead for Pharmacy; Sheffield Teaching Hospital Foundation Trust (STHFT); Sheffield Children's Hospital Foundation Trust (SCHFT); CCG GPs, Clinical Directors, Chief Nurse and nursing staff, Medicines management staff, Locality Managers and Directors; Professor of General Practice, University of Sheffield; NHS England.

- A series of stakeholder engagement and one to one meetings with primary care stakeholders including various GP leaders, Primary Care Sheffield (PCS), City Wide Localities Group (CWLG) and CCG Lead Managers (HR, Communications and Engagement, IT, Medicines Management & Finance), NHSE, Public Health, Sheffield City Council, Healthwatch, Our Healthier Communities and Adult Social Care Scrutiny Committee.

- Presentation and discussion at each Locality Clinical Council.

- The establishment of a Local Delivery Group for Primary Care, responsible for overseeing the implementation of an agreed Primary Care Strategy.

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

APPENDIX E

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

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

Impact of the project to date:

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

APPENDIX F

Changes to primary care contracts 2016/17

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

General Medical services

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

General Pharmaceutical services

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

The proposed contractual changes are currently being consulted on; concerns have been raised about them by the Pharmaceutical Services Negotiating Committee (PSNC). PSNC have published a set of service proposals[8] that describe how pharmacy services could develop within the context of government drives for efficiency. The proposals include the introduction of a care package, which would see repeat dispensing becoming a default option where medicines are needed on a long-term basis, patient registration at pharmacies, and pharmacies offering enhanced medicines optimisation services. The consultation will continue to be monitored by the CCG.

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

General Ophthalmic services

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

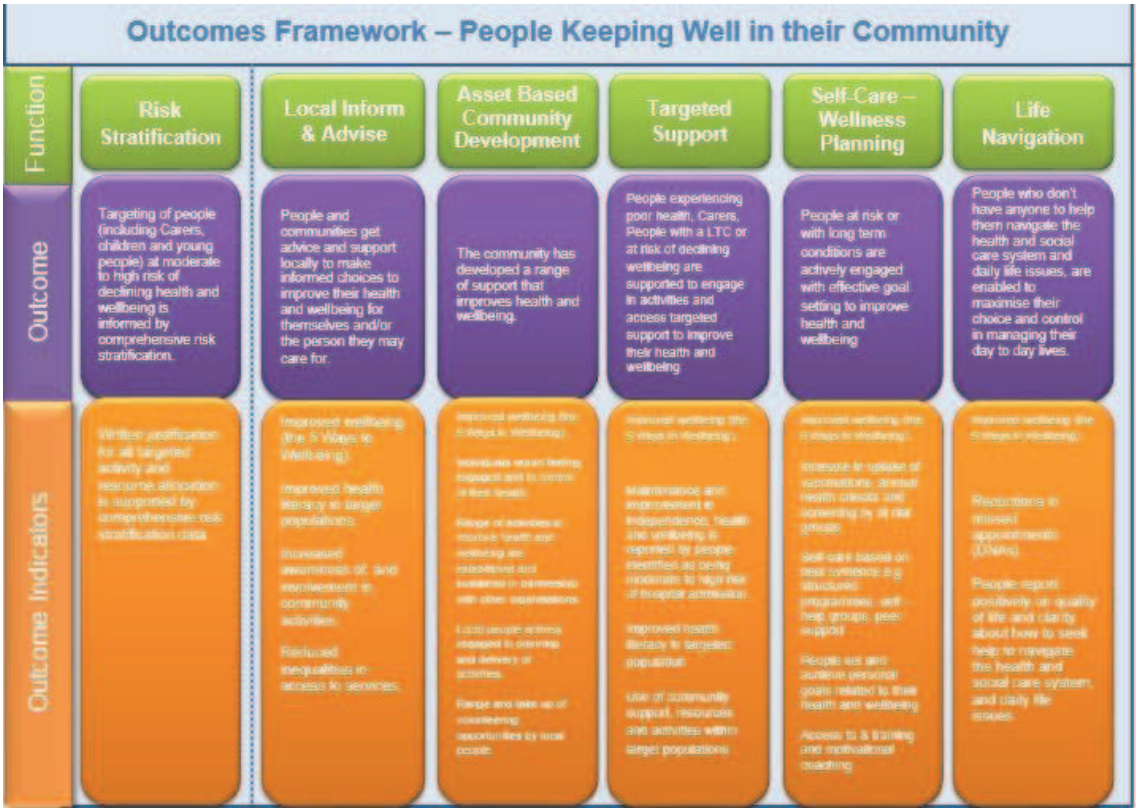
General Dental services

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

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

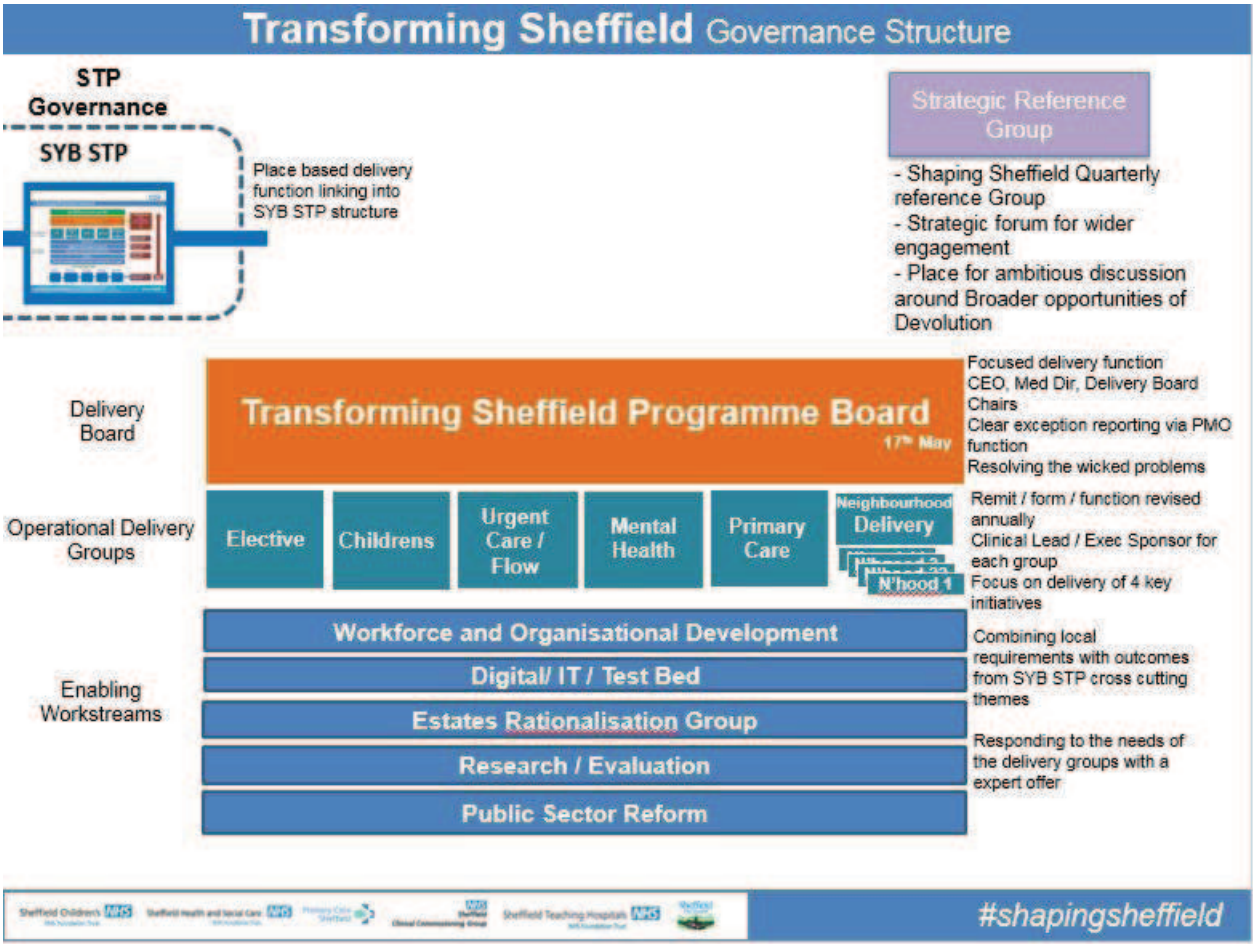
whether the contract will be implemented. This continues to be debated at a national level. Whatever mechanism is eventually used, the direction for general dental services is for more focus on prevention and more complex dental care in a primary care setting rather than on contracting for units of dental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

APPENDIX G


Outcomes Framework – People Keeping Well in their Community
Function
Outcome
Outcome Indicators
Risk Stratification
Local Inform & Advise
Asset Based Community Development
Targeted Support
Self-Care – Wellness Planning
Life Navigation
Targeting of people (including Carers, children and young people) at moderate to high risk of declining health and wellbeing is informed by comprehensive risk stratification.
People and communities get advice and support locally to make informed choices to improve their health and wellbeing for themselves and/or the person they may care for.
The community has developed a range of support that improves health and wellbeing.
People experiencing poor health, Carers, People with a LTC or at risk of declining wellbeing are supported to engage in activities and access targeted support to improve their health and wellbeing
People at risk or with long term conditions are actively engaged with effective goal setting to improve health and wellbeing
People who don't have anyone to help them navigate the health and social care system and daily life issues, are enabled to maximise their choice and control in managing their day to day lives.
Written justification for all targeted activity and resource allocation is supported by comprehensive risk stratification data
Improved wellbeing (the 5 Ways to Wellbeing)
Improved health literacy in target populations
Increased awareness of, and involvement in community activities
Reduced inequalities in access to services
Improved wellbeing (the 5 ways to wellbeing)
Range and take up of volunteering opportunities by local people
Improved wellbeing (the 5 ways to wellbeing)
Maintenance and improvement in independence, health and wellbeing, as reported by people identified as being moderate to high risk of hospital admission
Improved health literacy in targeted population
Use of community support, resources and activities within target populations
Improved wellbeing (the 5 ways to wellbeing)
Increase in uptake of vaccinations, annual health checks and screening by at risk groups
Self-care based on real evidence e.g. structured programmes, self-help groups, peer support
People set and achieve personal goals related to their health and wellbeing
Access to a training and motivational coaching
Improved wellbeing (the 5 ways to wellbeing)
Reductions in missed appointments (DNAs)
People report positively on quality of life and clarity about how to seek help to navigate the health and social care system, and daily life issues.

APPENDIX H

Proposed model for the Sheffield Transformation Programme



NHS
Sheffield Clinical Commissioning Group

Equality Impact Assessment

Title of policy or service:	Primary Care Strategy	
Name and role of officer/s completing the assessment:	Becky Meadows on behalf of Katrina Cleary	
Date of assessment:	11 May 2016	
Type of EIA completed:	**Initial EIA 'Screening'** ☒ ***or*** **'Full' EIA process** ☐	*(select one option - see page 4 for guidance)*

1. Outline	
Give a brief summary of your policy or service • Aims • Objectives • Links to other policies, including partners, national or regional	Strategy sets direction for primary care services in Sheffield for next 5-10 years. Purposes of strategy are to: • Contribute towards improving health and wellbeing of people in Sheffield; • Ensure primary care services are sustainable and fit for future purpose; • Establish collaborative working between health, social and voluntary sector across neighbourhoods, extending scope of services provided in a primary and community setting. Primary care strategy is part of out of hospital plans and sits alongside urgent care and AS&R strategies. Enabling groups for Transforming Sheffield and STP for SY&B will feed into the implementation plans that come out of the primary care strategy – workforce, IT, estates, patient education and engagement and new contracting mechanisms.

Identifying impact:

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

2. Gathering of Information This is the core of the analysis; what information do you have that might *impact on protected groups, with consideration of the General Equality Duty*.					
(Please complete each area)	**What key impact have you identified?**			**For impact identified (either positive and or negative) give details below:**	
	Positive Impact	**Neutral impact**	**Negative impact**	**How does this impact and what action, if any, do you need to take to address these issues?**	**What difference will this make?**
Human rights	☐	☒	☐		
Age	☒	☐	☐	Strategy aims to provide better coordinated care for frail elderly	Services will be tailored to needs of individual – less confusion and quicker response times for patients
Carers	☒	☐	☐	Neighbourhood working will mean easier access to the right social and voluntary sector services	More support for carers and services tailored better to the people they care for
Disability	☒	☐	☐	Strategy aims to address gap in health outcomes for people with disabilities	Better access to primary care services
Sex	☐	☒	☐		
Race	☒	☐	☐	Strategy aims to improve access to services for all minority groups	Neighbourhoood working is more likely to identify and outreach to those who are not currently accessing services
Religion or belief	☒	☐	☐	Strategy aims to improve access to services for all minority groups	Neighbourhoood working is more likely to identify and outreach to those who are not currently accessing services
Sexual orientation	☐	☒	☐		
Gender reassignment	☐	☒	☐		
Pregnancy and	☒	☐	☐	Strategy aims to provide a wider	Easier access to pregnancy and

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

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

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

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

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

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

Elaine Barnes signature:	

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