Draft Primary Care Strategy For Sheffield

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How has the primary care strategy been developed?

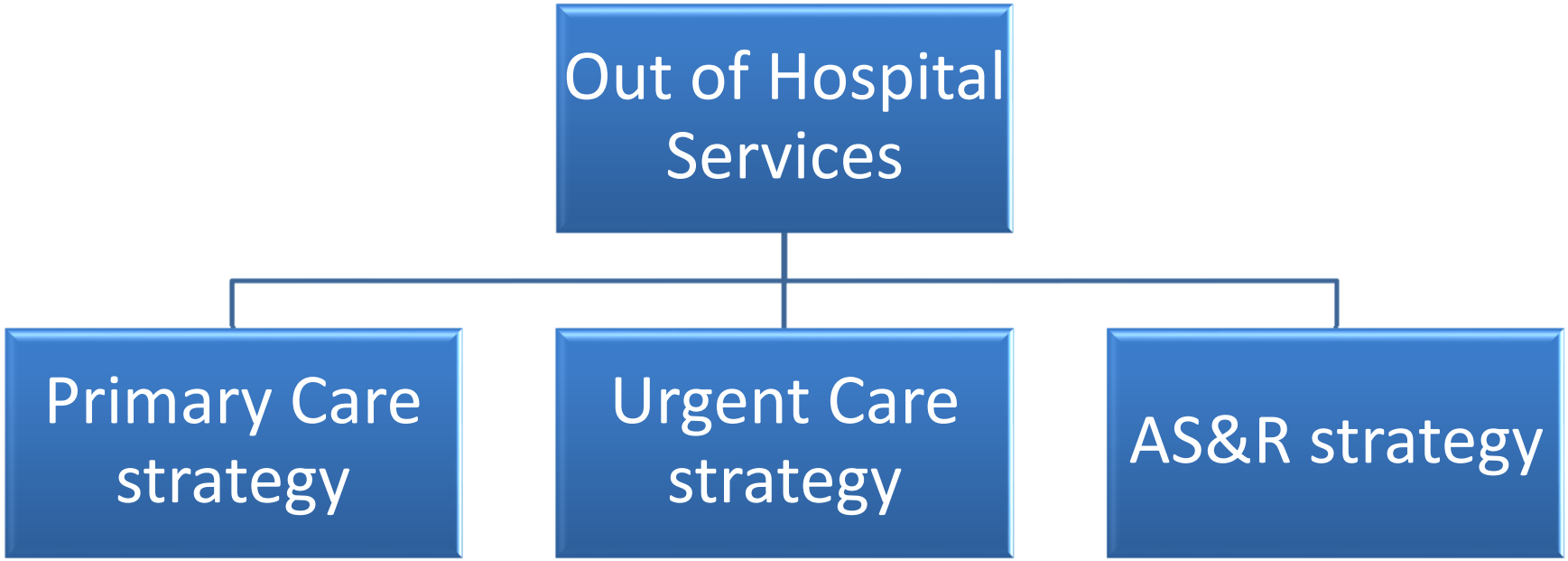
Why does primary care need to change in Sheffield?

- Increasing volume of demand for all primary care services from worried well through to complex co-morbidities
- Increasing proportion of patients with complex needs; increasing physical and mental health co-morbidity
- Increasing undefined grey area of provision between primary and secondary care
- Many practices are reporting they are in crisis
- GPs leaving the profession early, including practice partners; difficulties in recruitment
- Increasing workload and demand is taking its toll emotionally and financially
- Patient care is in danger of being compromised if the status quo continues
- Part of wider system changes – Out of Hospital Strategy
- Health inequalities across the city persist

Changes in primary care are part of a wider system change

- All parts of health and social care are experiencing increased demand and health inequalities persist
- Realisation that current system encourages a ‘fortress mentality’
- Explicit policy to develop ‘place based systems of care’ and person-centred care

Out of Hospital Services for Sheffield



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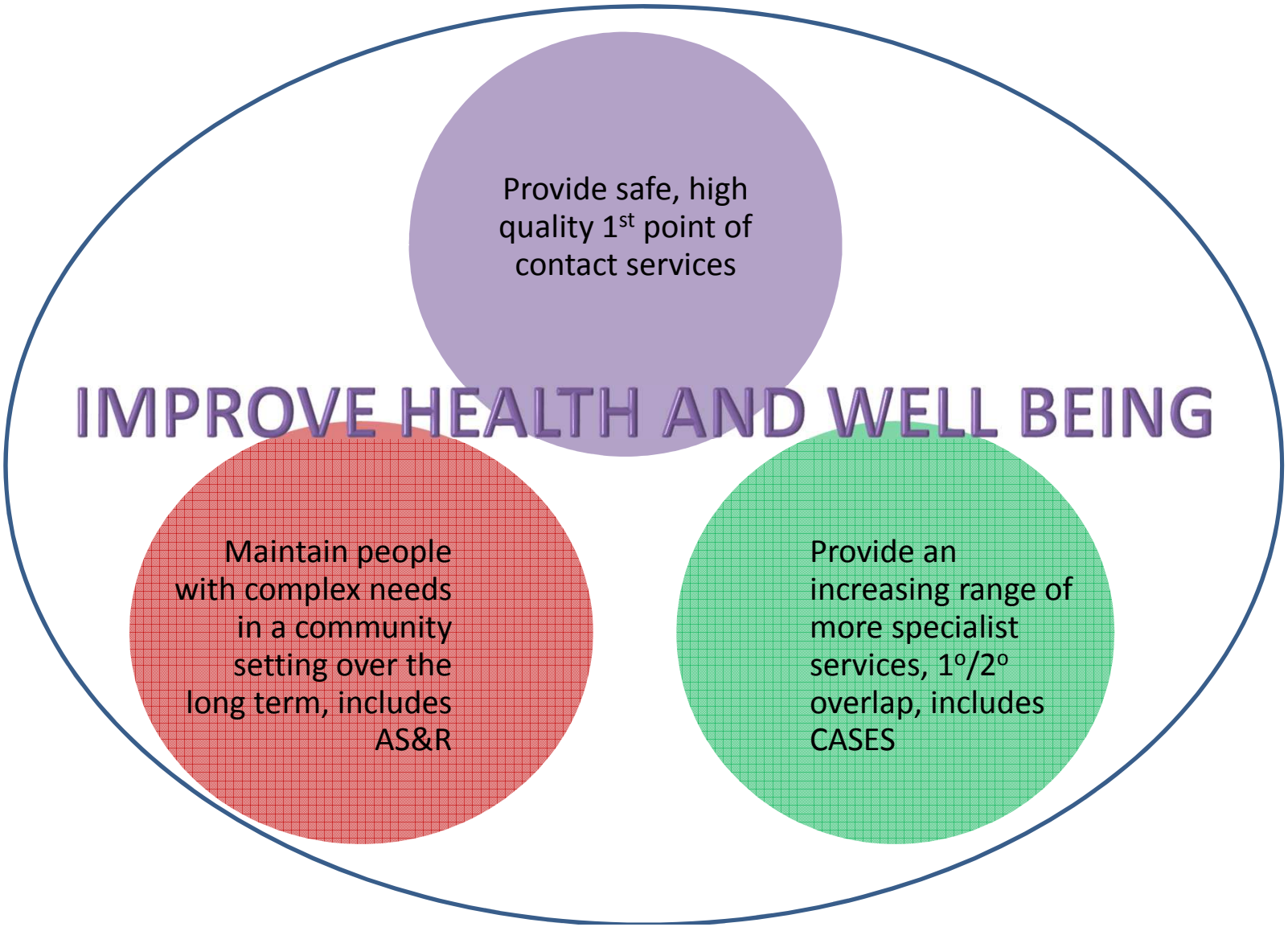
What do we want primary care to do – next 5-10 years?



What needs to happen to build capacity – providing safe, high quality 1st point of contact services?

Assumption: It doesn't take a qualified GP to see all the presentations they currently see

- Free GP time up from less complex work so they can concentrate on managing more complex patients; allow GPs to be expert medical generalists
- Use the existing community pharmacist workforce to better effect
- Develop a workforce that can manage the less complex work – nurses, pharmacists, physician's associates, HCAs
- Educate people to use resources differently and with a greater emphasis on self care

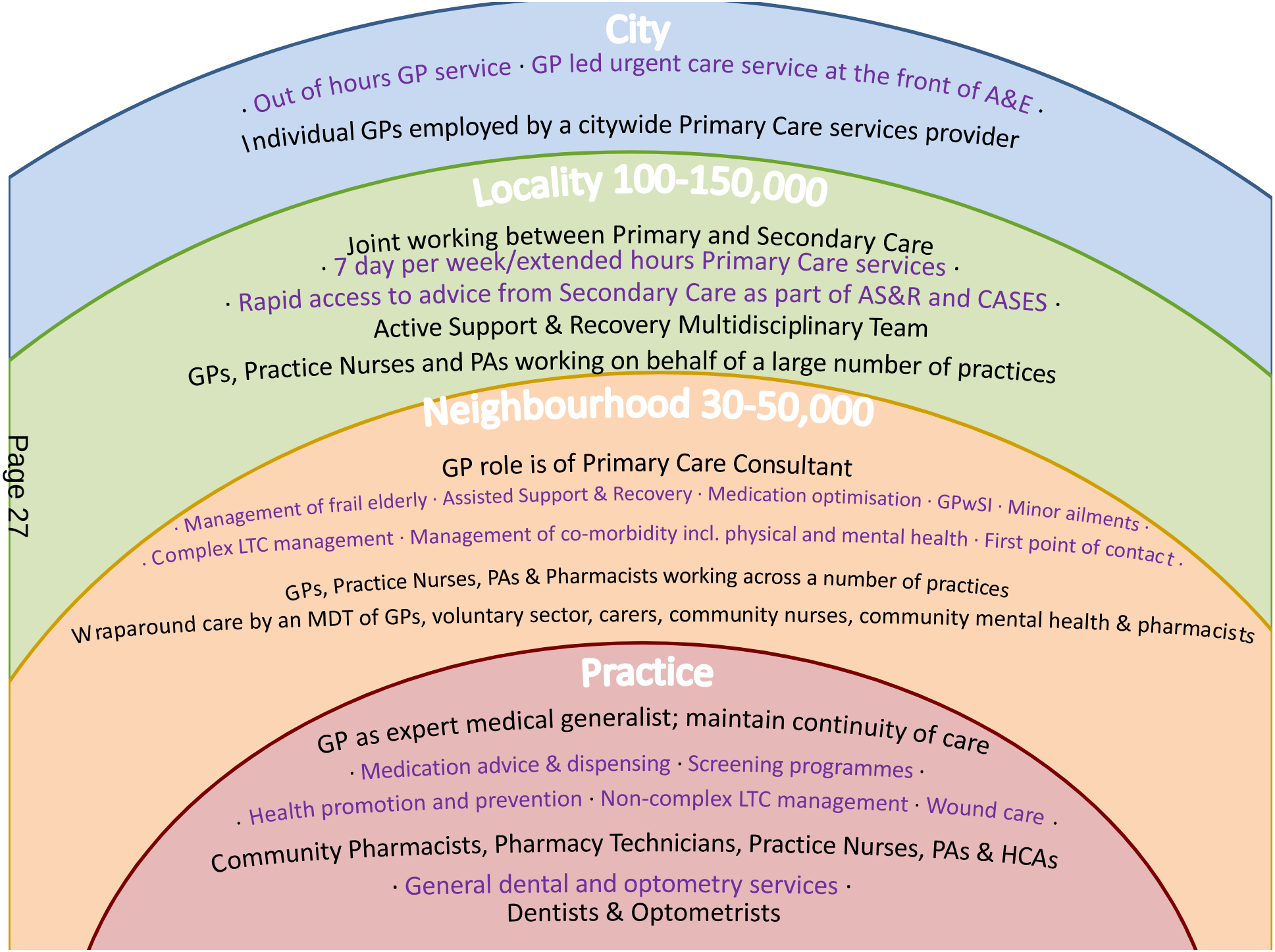
What needs to happen to build capacity – maintaining people with complex needs in the community?

- GPs to work as Primary Care Consultants – the joint decision maker **with the patient** in the care and support of patients with complex needs; repatriate work most appropriate to be managed by GPs to primary care
- Make better use of the health, social care and voluntary services already there; work as a multi-agency team providing flexible packages of support to patients and carers
- Wrap around resources to be organised and coordinated across populations of 30,000-50,000

What needs to happen to build capacity – provide an increasing range of services in the primary/secondary care overlap?

- Build further knowledge and skill within the primary care workforce; primary and secondary care to work jointly in community based settings
- Pool specialist skills, using all professions, across groups of practices
- **Contract** for secondary care services to be provided in a community based setting:

This should be a merging of primary and secondary care approach and skill; applying specialist treatment in the community but in the context of all needs of the patient


City
· Out of hours GP service · GP led urgent care service at the front of A&E ·
Individual GPs employed by a citywide 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 ·
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 Primary Care Consultant
· Management of frail elderly · Assisted Support & Recovery · Medication optimisation · GPwSI · Minor ailments ·
· Complex LTC management · Management of co-morbidity incl. physical and mental health · First point of contact ·
GPs, Practice Nurses, PAs & Pharmacists working across a number of practices
Wraparound care by an MDT of GPs, voluntary sector, carers, community nurses, 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 optometry services ·
Dentists & Optometrists

What needs to change in primary care to enable this?

- Use current resources to best effect; community pharmacists under-utilised at present; primary and community based services do not work in an integrated way
- Have a clear implementation plan for developing a primary care workforce fit for purpose
- Have a clear implementation plan for enabling inter-operability of IT systems across multiple providers

What does this mean for practices?

- Greater skill mix and more integration indicates services provided over a wider footprint
- Practices to collaborate/join forces to establish Primary Care Home/Multi-Specialty Community Provider
- Practices to work much more in partnership with community, voluntary and secondary care
- GPs, practice nurses, community nurses, community pharmacists will work differently
- CCG will look to practices to provide for a community according to the needs of that community
- Some services will need to be provided at a neighbourhood, locality or city wide level; CCG will be looking for a strong primary care provider offer at all these levels

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