Sheffield Hallam University

Evaluation of the Sheffield Enhanced Primary Care Programme

Final Report (Draft for Consultation)

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Glossary

A&E	Accident & Emergency - now officially called Emergency Department (ED)
ANP	Advanced Nurse Practitioner
BP	blood pressure
CCG	Clinical Commissioning Group
EMIS	a medical records system
EPC	Enhanced Primary Care
EPCC	Enhanced Primary Care Contract
EPCP	Enhanced Primary Care Programme
GP	General Practitioner
HSCIC	Health and Social Care Information Centre
IAPT	Improving Access to Psychological Therapies
ICM	Integrated Care Management or Interprofessional Care Management
IMD	Index of Multiple Deprivation
MH	mental health
MIG	Medical Interoperability Gateway
NGH	Northern General Hospital
OMG	Operational Management Group
OOH	out of hours
PCP	Primary Care Pharmacy
PMCF	Prime Minister's Challenge Fund
SCC	Sheffield City Council
SEPCP	Sheffield Enhanced Primary Care Program
SPA	Single Point of Access
STH	Sheffield Teaching Hospitals
SWOOH	Social Work Out of Hours
SystmOne	A medical records system

Executive Summary

Background

This is an evaluation of the Sheffield Enhanced Primary Care Programme (SEPCP) funded in the second wave of the Prime Minister's Challenge Fund. The fund is intended to *"… help improve access to general practice and stimulate innovative ways of providing primary care services."* The SEPCP was the largest component of Wave 2 at £9,311,248.

The SEPCP provided a comprehensive package that engaged with 87 Sheffield GP Practices with 16 different schemes (see Table 2). Some schemes were new initiatives while others extended existing innovations. The programme represented a process of spread and adoption of innovations designed in primary care to enable the six key goals (mapped to the schemesSection 4.1.1): A. Care closer to home; B. Increased availability of GP appointments for adults and children in practices and satellite units across the city; C. Further integration of health and social care services; D. Improved transitions between services with better communication across the traditional providers of care, in and out of hours; E. Better utilisation of technology in care processes; to improve communication and information sharing across providers; F. Locally based innovations to address the needs of some marginal local communities and support people to manage their own care
The benefits expected include:

1. Changing how patients use the primary care system
2. Increasing patient self management
3. Reducing the use of secondary care
4. Service redesign and workforce development.

Methodology

A mixed methods approach was used which incorporated:

- interviews with programme managers, scheme leads and GPs
- an analysis of quantitative activity data provided by schemes - where this was possible
- an analysis of survey data from patients who used the Satellite Units.

Of the 16 schemes, anonymised patient-level quantitative data was available for 3 schemes (Satellite Units, PCP, Social Workers Out of Hours), aggregate usage statistics for another 3 schemes (Acute Same Day, Roving GP, Web GP), and so economic evaluations could be completed for those 6 schemes. Five schemes were discussed during the qualitative interviews (Satellite Units, PCP, Social Worker Out of Hours, Roving GP and SPA). Five schemes self-evaluated (Acute Same Day, Roving GP, WebGP, Roma and IAPT).

As a result of changes within NHS data agreements with the transfer of responsibility from HSCIC to NHS Digital there is a serious problem attributing any of the activity (e.g. appointments) to patient outcomes (e.g. hospital admissions or A&E visits) because of the lack of access to population and HES data. However, the activity data provided does allow us to draw conclusions and recommendations about how Satellite Units, PCP and Social Work Out of Hours are perceived by GPs and patients. This represents all sectors but does not provide conclusive evidence of the effectiveness of reducing the burden on A&E.

Successes

The following schemes have been accepted and adopted by GPs and are recognised as contributing to programme goals (and have data associated with the investment).

- As of 30 November 2016, Satellite Units (Section 4.1) had provided an additional 24,448 appointments and had 90% approval ratings from the patients. Although, GPs reported that many appointments were not urgent, less than 1% were considered inappropriate. 3.3% of appointments led to direct hospital admission. Responses from the Family & Friends questionnaires collected from Satellite Unit users suggest that 30% of patients would have gone to A&E without the Satellite Units. The patient data also highlights that patients viewed the Satellite Units as an extended-hours service rather than an urgent service. The very high proportion of patients who are living in the most deprived areas suggest that this extended access provided a solution to the constraints of working/ everyday life and therefore access to a GP. The Satellite Units were officially extended with Government funding in Autumn 2016.
- The Primary Care Pharmacy (PCP) scheme (Section 4.2) recorded 18,044 individual activities and calculated that this released 3,171.25 hours of GP time and provided specialist expertise in medicines-management. The pharmacy provision is an extension of the team practices reported in some surgeries and groups where multi-professional practice is well established and forms a good model for new ways of working. Scheme managers reported that it improved working relationships that spilled over into the rest of the working week.
- The Acute Same Day Service extended an existing programme and provided an additional 30,068 appointments of which 23,732 were utilised. The vast majority of these 'acute' appointments resulted in prescriptions and 1 in 6 of these patients reported that they would have gone to A&E, fewer than with the Satellite Units.

Both Satellite and Acute Same Day appointments demonstrates the widely recognised evidence that increased capacity will quickly fill and, this increase in capacity doesn't necessarily discriminate for those with urgent healthcare needs and/or model any transformational change in the way GP's provide service.

Besides PCP, there are other schemes which were intended to change ways of working into a more collaborative model with multi-disciplinary teams. Like PCP some of these schemes had a pre-existing remit and GPs recognised and used these services. But, for some, there were confusions about the additional offer and this is reflected in uptake of the schemes. Perhaps more time and effort would have been needed to familiarise GPS with the new schemes. And their lack of knowledge about schemes is reported in this and the Supplementary Reports.

- Extensions to the Single Point of Access (Section 4.5.2) included: 1) Increased clinical triage; 2) access to psychiatric liaison and; 3) specialist mental health support. The difference between these three individual pathways as separate schemes was not understood well and activity data was difficult to untangle from the pre-existing service. In the monthly activity reports had lower than expected numbers of requests and the qualitative data suggests that GPs may not be using the service as effectively as they could and/or are unaware of what referrals pathways are available. Further communication of the offer from SPA to GPs is

critically needed to facilitate the signposting and access to constantly changing range of health and social care provision.

- The Social Work Out of Hours Scheme (in partnership with Sheffield City Council) was designed to reduce hospital admission for healthcare for the patients or respite-relief for their carers. GPs who used this scheme spoke well of it but the scheme was ended by the withdrawal of one of the 3rd sector partners. The scheme supplied 131 assessments with GPs making 50% of the referrals and other primary care services providing the other half. The eligibility criteria for this service was restricted to social and respite need and 50% of GP-referrals were refused. The high rejection rate was not seen in other referral routes.
- IAPT is well-regarded nationally as a mental health treatment pathway. The Community Nurse Project enabled community nurses, dual trained as IAPT Psychological Wellbeing Practitioners, to provide integrated physical and mental health interventions to people who are housebound. This scheme self evaluated.
- Roving GP (City Wide Rapid Access Team) was developed from earlier testing of the approach. It was expanded as part of the scheme to help GPs manage home visits for vulnerable patients. The data provided by the scheme estimates that 330 hospital admissions were avoided. This is a self-reported measure by GPs provided by the service and there is no ojective means of confirming this data.. The GPs that participated, value it highly although many GPs who weren't in the scheme expressed a preference to manage their own demand for home visits.

In addition there was the piloting of a community health and literacy programme in 6 Practices for a marginalised Roma-Slovak population that was successful in improving communication and health literacy in this demographic group.

Economic Evaluation

The Return on Investment (ROI) calculations were severly hampered by the restrictions on linking up scheme acticity to HES and/or population-level data. The Primary Care Pharmacy, Acute Same Day and Roving GP all reported a positive return on investment. Although, we caution that we cannot verify Primary Care Pharmacy and Roving GP calculations. Once they were operating at 90% capacity (GP appointments have reached this level) the Satellite Units produce an ROI of 0.81. Given that the users of the Satellite Units data suggests some unmet need the ROI could be expected to show some additional cost to the system. WebGP was not cost effective with the data provided but, as with all the schemes, linking data might have identified benefits and this analysis could not take into account the long-term benefits of alcohol, obesity and smoking awareness programmes..

Challenges and Limitations

There are some important challenges and limitations and these are to be expected in a project of this scale and complexity and should constitute further learning opportunities.

- The Programme was complex with 87 GP Practices and 16 schemes.
- There was insufficient organisational development of pathways . to engage all GPs effectively with all new .schemes. Some were confused about the complex offer and this limited the number of patients who could benefit in some schemes.

- There were insufficient communication pathways to, between, and from GPs to the PCS prior to and during the Project. Future schemes would benefit from more extensive programme-level communication and formative organisation learning (i.e., tell people what is happening).
- There was a problem with data completeness and the nature of what data was recorded in all schemes. And, the evaluation team were unable to collect and collate data on outcomes and impact across the target populations.
- This evaluation was severely hampered by the national turbulence around NHS data but there is a chronic inability at CCG level to understand the restrictions and lack of skills at the scheme level around data. This includes sharing, extraction, analysis, and linkage. Even before the switch from HSCIC to NHS Digital existing NHS data rules would have required that these schemes have data sharing agreements which were not always in place.
- Interoperability of the IT systems resulted in read and write functionality on SystmOne but read only for EMIS. This problem was seen in the national evaluation as well. The evaluation team have no further data about the life of this element of the program.
- An economic evaluation requires good data of both the schemes activity and for the entire population of the region served. This was not available at this time.
- Future schemes would benefit and should be underpinned by an integrated care model to reduce problems associated with service fragmentation and allow GP's and others to recognise and use the range of providers across the primary and community services.
- Many GPs reported in interviews that they would prefer to manage the care of local patients within their own surgeries and using their own staff. Some practitioners saw the opportunity to collaborate across practices as a beneficial outcome of the SEPCP. See the Supplementary Report for the full analysis.
- Programme delivery, typically short term, made effective Process Evaluation and data clarification very challenging which limited the level of shared critical thinking.

Recommendations

There are a number of key recommendations to both the Sheffield CCG and to PCS that are made on the basis of the evaluation activity and outcomes. These were shared with the SEPCP Board and those that received their endorsement have been retained as a means to continue learning about systems change and transformation and to learn lessons to support further programmes. Further findings and analysis about the specific perceptions and key factors about retaining GP involvement is contained in the Supplementary Report. This highlights the need for reliable referral and feedback processes for new schemes that are co-designed **with** GPs. This would ensure that innovations are piloted before rolling out as a standardised offer across community and primary care.

- Across primary care there is a limited capability around data. Specific expert advice is needed to identify relevant, valid, reliable and possible data related to outputs and outcomse. This would result in a convincing evidence-base to facilitate transformational change across community and acute care. 'Experts' should include patient representation to identify the desired outcomes relative to quality of life and well-being.
- Further investment in leadership capacity was recognised as a continuing need across the services and specific reference to systems leadership and improvement capability is likely to facilitate learning and organisational change.

- A central referral service (here offered by SPA) for health and social care removes the burden from GPS to to keep up with the changes in how community and social care are provided and who is providing the service (e.g. 3rd sector contracts). As the NHS outsources and integrates services, the systems and process offered by central referral services are going to be increasingly needed.
- Locality managers have been influential in sharing understanding and supporting the evaluation , providing a the broader perspective on the culture and current ways of working in primary care. Their knowledge could be shared further to support systems-learning and developing the interface with community and secondary care and their influence at CCG level could be further enhanced.
- The majority of GPs recognise their own ways of working and have less knowledge and skill (and some would say power) to influence integrated care planning. Workforce development in primary care with general practitioners may include a range of organisational learning initiatives including:
    - sharing of successful local innovation
    - the establishment of evidence of successful innovations
    - mobilisation of knowledge based on research evidence
- Future roll-outs should be staged such that the most innovative practices are recruited first, followed by those who buy-in once some evidence of benefit is provided. Data from this evaluation could be used to design an approach strategy to more effectively engage GPs in future change.
- Demand management strategies for complex case management are working well for a number of innovative primary care groups and resulting in better access for patients. These initiatives are local and need evidencing - particularly in relation to the impact on demand for out-of hours care and then dissemination regionally and nationally.

Conclusions

- These schemes have helped to improve access to general practice by providing an 8 til 10 service across the city, piloting a locality-based Satellite delivery, and reporting on early activity and cost benefit. The extension of the funding nationally for these schemes demonstrates government priorities for primary care.
- These schemes did initiate and/or extend innovative ways of providing primary care services, Including:
    - The Satellite Unit appointments may be filling unmet need for more deprived populations and in young families.
    - The Roma as a new model of practice
    - Pharmacy as an integrated professional offer
    - Broadening of the SPA offer to include mental health and social care provision outside of secondary care.
    - Roving GP offered as a solution to a greater number of practices to manage the demand of housebound patients.
- These schemes have added new appointments by extending the hours of access and increasing the number of appointments during the day. This increase in service adds cost which may not continue to be available.
- Engagement in the programme has made more GPs think about the way they work and most impotantly how they work with community services.

- Similar future projects need to be aware of the need for, and cost in, the up-front expense of data collection systems bringing any needed expertise from the beginning.

Plain Language Summary

Purpose

1. This is an evaluation of the Sheffield Enhanced Primary Care Programme (SEPCP) funded in the second wave of the Prime Minister's Challenge Fund. The fund was intended to "*… help improve access to general practice and stimulate innovative ways of providing primary care services.*" The SEPCP was the largest component of Wave 2 at £9,311,248.

2. 87 Sheffield GP Practices were offered 16 different schemes: some new initiatives while others extended existing innovation to enable the six key goals: A. Care closer to home; B. Increased availability of GP appointments for adults and children in practices and satellite units across the city; C. Further integration of health and social care services; D. Improved transitions between services with better communication across the traditional providers of care, in and out of hours; E. Better utilisation of technology in care processes; to improve communication and information sharing across providers; F. Locally based innovations to address the needs of some marginal local communities and support people to manage their own care

Method

3. We used information from interviews with programme managers, scheme leads and GPs, along with data collated by the schemes. We looked for patterns in all this data to report on the overall success and limitations of the Programme. This analysis was designed to achieve an understanding of overall effectiveness of the schemes in the Programme.

   Patients and the public have been consulted via a specific SEPCP patient and public involvement panel recruited from the city-wide Citizen's Reference Group. The panel represents a range of service users and interested stakeholders, some of whom have had long-standing involvement with Sheffield CCG

4. The recent establishment of NHS Digital has meant that scheme information could not be matched with Hospital Episodes Statistics (HES). HES is the main source of data to identify, at patient level, which part of the NHS that any patient uses. Instead, we used patient self-reports of what a they would have done without the scheme. This limits the confidence we can have linking the Programme schemes with other NHS service but our findings are consistent with similar programmes in England.

5. To achieve a cross -scheme perspective the interview data sampled a range of opinions and perceptions about how the EPCP was designed and what objectives were met (see Supplementary Report).

Findings from the Evaluation

6. Scheme by scheme, the following activity data (and rarely, outcomes) were seen:

   6.1. Satellite Units - Between October 2015 and November 2016 24,448 appointments have been provided with a 90% approval ratings from the patients. Although, GPs reported that many appointments were not urgent, less than 1% were considered inappropriate. 3.3% of appointments led to direct hospital admission. Responses from the Family & Friends questionnaires collected from Satellite Unit users suggest that 30% of patients would have gone to A&E without the Satellite Units. The patient data also highlights that patients viewed the Satellite Units as an extended-hours service rather than an urgent service. The very high proportion of patients who are living in the most deprived areas suggest that this extended access provided a solution to the constraints of

working/ everyday life and therefore access to a GP The Satellite Units were officially extended with Government funding in Autumn 2016.

6.2. The Primary Care Pharmacy (PCP) scheme recorded 18,044 individual activities and calculated that this released 3,171.25 hours of GP time and provided specialist expertise in medicines-management. The pharmacy provision was a prexisting practice in some GP surgeries. This scheme extended the offer of pharmacy support to all. Different professionals working together was welcomed in some new practices. The Scheme managers reported that it improved working relationships that spilled over into the rest of the working week.

6.3. The Acute Same Day Service extended an existing programme and provided an additional 30,068 appointments of which 23,732 were utilised. The vast majority of these acute appointments resulted in prescriptions and 1 in 6 of these patients reported that they would have gone to A&E which is a smaller proportion than in patients who used the Satellite Units. Both Satellite and Acute Same Day appointments demonstrates the widely recognised evidence that increased capacity will quickly fill and, this increase in capacity doesn't necessarily discriminate for those with urgent healthcare needs and/or model any transformational change in the way GP's provide service.

6.4. The Social Work Out of Hours Scheme (in partnership with Sheffield City Council) was designed to reduce hospital admission for healthcare for the patients or respite-relief for their carers. GPs who used this scheme spoke well of it but the scheme was ended by the withdrawal of one of the 3rd sector partners. The scheme supplied 131 assessments with GPs making 50% of the referrals and other primary care services providing the other half. The eligibility criteria for this service was restricted to social and respite need and 50% of GP-referrals were refused.

6.5. Extensions to the Single Point of Access included: 1) Increased clinical triage; 2) access to psychiatric liaison and; 3) specialist mental health support. The difference between these three individual pathways as separate schemes was not understood well and activity data was difficult to untangle from the pre-existing service. The qualitative data suggests that GPs may not be using the service as effectively as they could and/or are unaware of what referrals pathways are available. Further communication of the offer from SPA to GPs is critically needed to facilitate the signposting and access to constantly changing range of health and social care provision.

6.6. The Roma-Slovak scheme piloted a community health and taught people how to use primary care in 6 Practices with large numbers of people from marginalised populations. It was self-evaluated and reported success in improving communication and health literacy in this group. Importantly, the scheme employed community members as workers in order to culturally sensitise the service. Locally, we have been told that this scheme has generated other health improvement opportunities with community services, particularly relating to children's health.

6.7. Roving GP (City Wide Rapid Access Team) was developed from earlier testing of the approach. It was expanded as part of the scheme to help GPs manage home visits for vulnerable patients. The data provided by the scheme estimates that 330 hospital admissions were avoided (but this can't be verified with any other data). The GPs that participated, value it highly although many GPs who weren't in the scheme expressed a preference to manage their own demand for home visits.

6.8. IAPT is a well-regarded nationally as a mental health treatment programme. and the scheme was design to provide a service inside 10 GP Practices. The Community Nurse

Project enabled community nurses, dual trained as IAPT Psychological Wellbeing Practitioners, to provide integrated physical and mental health interventions to people who are housebound. This scheme self evaluated

6.9. The WebGP scheme estimated that it prevented 397 GP consultations by providing online information that patients could directly access to meet their healthcare queries.

6.10. In addition there was the piloting of a community health and literacy programme in 6 Practices for a marginalised Roma-Slovak population. The programme was successful in improving communication and the way people use the NHS.

7. An economic evaluation found

7.1. a financial benefit for the Primary Care Pharmacy, Acute Same Day and Roving GP schemes although we caution that none of the reported decreases in A&E attendance could be verified for the two schemes using this an an outcome.

7.2. Once the uptake on Satellite Unit appointments reached 90% the return on investment was good (£81 saved for every £100 spent). As the scheme appears to be filling some unmet need for evening and weekend appointments for the working poor this could be regarded as a good investment.

8. There are some important challenges and limitations and these are to be expected in a project of this scale and complexity and should constitute further learning opportunities should schemes be continued or further programmes be planned

8.1. The Programme was probably too complex with 87 GP Practices and 16 schemes.

8.2. Further development of pathways of referral and processes would enable GPs to access all schemes, reducing confusion and increasing the benefit to patients, for example using SPA to facilitate access to a range of health and social care provision.

8.3. Programme monitoring and contract requirements are needed to provide evidence of activity *and* outcomes.

8.4. Scheme staff often struggled to collect the additional information needed for an evaluation. This is a nation -wide problem and not restricted to these schemes. Evaluation was also severely hampered by the national turbulence around NHS data with the recent establishment of NHS Digital.

8.5. Future schemes would benefit and should be underpinned by an integrated care model to reduce problems associated with service fragmentation and allow GP's and others to recognise and use the range of providers across the primary and community services.

8.6. Future schemes would benefit from more extensive programme-level communication and formative organisation learning (i.e., tell people what is happening).

8.7. There is marked variation in the receptiveness of the primary care workforce to respond to change. There needs to be better mechanisms to engage GPs in these types of service changes and different types of working.

9. Many GPs reported in interviews that they would prefer to manage the care of local patients within their own surgeries and using their own staff. Some practitioners saw the opportunity to collaborate across practices as a beneficial outcome of the SEPCP. See the Supplementary Report for the full analysis.

10. This evaluation was severely hampered by the national turbulence around NHS data. There is no culture of data and this includes sharing, extraction, analysis, and combining data between services. An economic evaluation requires good data of both the schemes activity and for the entire population of the region served. This was not available at this time.

11. Recommendations

11.1. Across primary care there is a limited capability around data. Specific expert advice is needed to identify relevant, valid, reliable and possible data to use in evaluating new initiatives.

11.2. Commit to developing more leaders in the GP community who can consult on changes in primary care.

11.3. A central referral service for health and social care (here offered by SPA) removes the burden from GPS to keep up with the changes in who and how community and social care are provided.

11.4. Locality managers have good ideas and can provide a primary care perspective alongside GPs

11.5. Some GPs need and want to develop leadership skills that would help them to change the way they work and reduce the pressures on them.

11.6. Future roll-outs should be staged such that the most innovative practices are recruited first, followed by those who buy-in once some evidence of benefit is provided. Data from this evaluation could be used to design an approach strategy to engage GPs more effectively in future change.

11.7. Work with experts when identifying successes for schemes to ensure that they are relevant, valid, reliable and possible as this will result in convincing evidence for change across community and acute care

12. Conclusions

12.1. These schemes have helped to improve access to general practice by providing an 8 til 10 service across the city, piloting a locality-based Satellite delivery, and reporting on early activity and cost benefit. The extension of the funding nationally for these schemes demonstrates government priorities for primary care.

12.2. These schemes did initiate and/or extend innovative ways of providing primary care services, Including:

12.2.1. The Satellite Unit appointments may be filling unmet need for more deprived populations and in young families.

12.2.2. The Roma as a new model of practice

12.2.3. Pharmacy as an integrated professional offer

12.2.4. Broadening of the SPA offer to include mental health and social care provision outside of secondary care.

12.2.5. Roving GP offered as a solution to a greater number of practices to manage the demand of housebound patients.

12.3. These schemes have added new appointments by extending the hours of access and increasing the number of appointments during the day. This increase in service adds cost which may not continue to be available.

12.4. Engagement in the programme has made more GPs think about the way they work and most impotantly how they work with community services.

12.5. Similar future projects need to be aware of the need for, and cost in, the up-front expense of data collection systems bringing any needed expertise from the beginning.

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Table and Figures

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1.0 Introduction

In October 2013, the Prime Minister announced a new £50 million Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services. The first wave of twenty pilots was announced in April 2014. Further funding of a second wave of £100m for 2015/16 was announced by the Prime Minister on 30 September 2014.

Several key quotes from the Prime Minister's Challenge Fund (PMCF) website describe what the PMCF is expected to achieve: and the funding announcement stated that the PMCF would

> *"help improve access to general practice and stimulate innovative ways of providing primary care services."*
>
> *"A wide variety of innovative ideas are being tested including extended opening hours, more ways for patients to access services and new services to better support patients with complex needs."*
>
> *"The fund will also support GPs to play an even stronger role at the heart of more integrated out-of-hospital services that delivers better health outcomes, more personalised care, and excellent patient experience."*

In other PMCF documents and presentations, the emphasis is on improving access – specifically out-of-hours options. The underlying belief is that restricted access to GP services increases hospital use so 7-day working, and a longer work day in GP Practices, should decrease hospital admissions and, presumably, A&E visits.

In funding these projects, the Government asked NHS England to lead the process of inviting practices to submit innovative bids and overseeing the pilot schemes. Primary Care Sheffield[1] was successful in its bid and this is an evaluation of the Sheffield Enhanced Primary Care Programme (SEPCP) which was the largest component of Wave 2 at £9,311,248.

The original remit was to report on the extent to which different elements of the Sheffield Pilot have resulted in a reduced or re-distributed demand on primary care services using both quantitative and qualitative data collection and analysis. In response to the interim report, the EPCP Board agreed that the voice of General Practitioners was also needed to ensure that the evaluation offered a balanced perspective and a qualitative investigation of ' the factors that affect the uptake of schemes and services 'has included narrative sampling of GP's perceptions and views related to the EPCP. The quantitative element planned to; linking data from the different elements of the PMCF with actual acute care service provision (Hospital Episodes Statistics (HES)) data. But, changes to health-data access meant this was impossible.

Therefore this report presents findings associated with the SEPCP where activity has been analysed for outcomes and effectiveness against programme goals and an associated simple cost comparison is all that is available.

[1] Primary Care Sheffield is a GP led, social purpose company spanning the majority of Sheffield Practices, that aims to improve patient care through a unified supportive approach to General Practice in the city.

2.0 Background to EPCP Programme

The SEPCP coversall patients in 87 GP practices, organised into 4 localities within the NHS Sheffield Clinical Commissioning Group (CCG). This amounts to 580,000 patients.

Two levels of participation were available, Level 1 and Level 2. Level 1 provided no additional funding to GPs (EPCC Scheme) but access to the rest of the scheme. Level 2 provided £5 per patient on the practice list as of census date. Payments to GPs were based on list-size and their level of contribution to staffing Satellite Units was also based on list-size.

The SEPCP programme was established in April 2015 and rests strongly on the ideas and learning of the Right First Time programme team. A range of activities that occurred between 2013 and 2015 was used as a basis for the PMCF bid and 16 schemes of work were established. Figure 1 shows the governance structure and Table 1 lists the name of the scheme and acronym of the scheme used in this report. Primary Care Sheffield was established to manage this programme of work.

Figure 1 Governance of the SECPC Programme

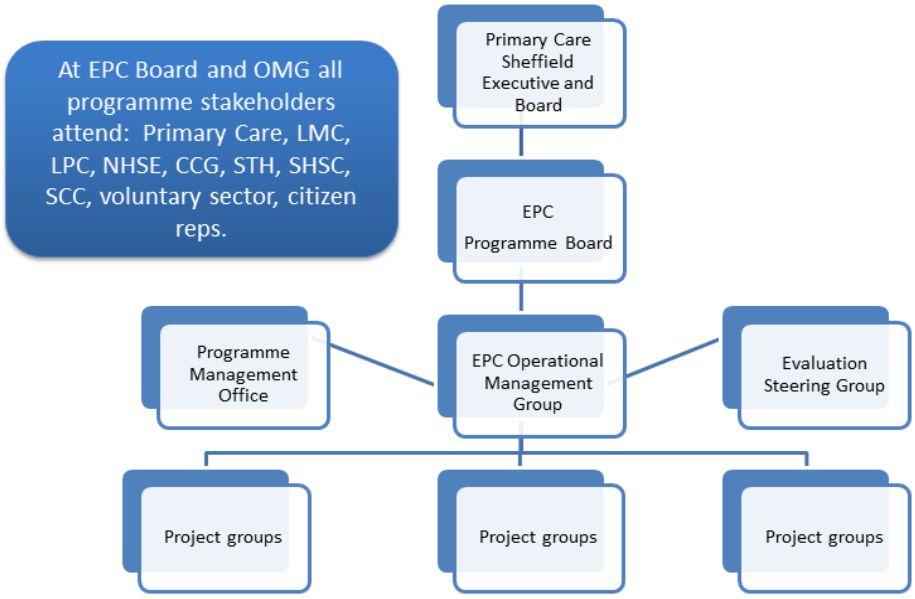


Table 1 Schemes of Work

Num	Original Schemes in Programme - Name	Acronym	Section
1	Enhancing Primary Care Contract	EPCC	4.1
2	Satellite Units (4 sites)	Satellite Units	4.2
3	Primary Care Pharmacy Scheme	PCP	4.3
4	Social Workers Out of Hours Assessment and crisis response home support	SW OHH	4.5
5	Roma Advocacy and Health Project	Roma	4.6.1
6a	Single Point of Access – Increased Clinical Triage	SPA (triage)	4.6.4
6b	Primary care access to psychiatric liaison	SPA (PrimaryPsych)	4.6.4

Num	Original Schemes in Programme - Name	Acronym	Section
6c	Weekend Specialist mental health support	SPA (Weekend MH)	4.6.4
7	Expansion of the Florence system to primary care	Florence BP	4.6.5
8	City Wide Rapid Access Team	Roving GP	4.6.2
9	City Wide Acute, Same Day Service.	City Wide Acute	4.4
10	Training Community Nurses to provide IAPT interventions	Community IAPT	4.6.6
11	WebGP	WebGP	4.6.3
12	Use of the Medical Interoperability Gateway (MIG)	MIG	4.6.8
13	Integrated Care Management Teams	ICM Teams	4.6.9
14	Community Volunteer Scheme	Comm Volunteer	4.6.7

2.1 Remit

The Prime Minister's Challenge Fund emphasises improving access to GPs - specifically out-of-hours options with the, unspoken, underlying belief that restricted access to GP services increases hospital use, particularly after 5pm and at weekends. Extending this idea further the SEPCP was established to enhance access to local community-based and primary care services, and to manage more care in out-of-hospital settings. The aim of the programme was to invest in, and pilot, a range of mainstream general practice initiatives, building capacity to meet current demand for the management of complex needs and urgent care. At the establishment of the SEPCP (https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/wave-two/about-wave-two-pilots/#3) the aim was:

> "Working together through the access fund, general practice in Sheffield will improve access to urgent primary care appointments for 580,000 patients, reducing avoidable emergency admissions and unnecessary attendance at A&E."

The 16-scheme project is split into two tiers, with practices able to choose their level of engagement. Level one includes an acute same day service, additional pharmacy support, and secure data sharing across primary care, secondary care, mental health and social care. Level 2 includes all of these, with the addition of a rapid access GP team, out of hours urgent care provision through four satellite units, wrapped around services which will provide GPs with additional out of hours support from social care and mental health services, Roma advocacy and health support for practices with a high Slovak Roma population, and access to self-management tools and signposting for patients through Web GP. The majority of practices have committed to the second level (77) with six committing to level one. All 16 projects were intended to be operational by the end of October 2015.

From October 2015, the scheme provided increased access to primary care services seven days a week with appointments 6pm–10pm weekdays, and 10am-6pm at weekends from four satellite units, three of which are being set up specifically through this initiative and one as an extension to an existing out-of-hours service.

Six goals were described in the SEPCP remit:

1. Care closer to home"
2. Increased availability of GP appointments for adults and children in practices and satellite units across the city (particularly targeted at areas of high A&E utilisation)
3. Further integration of health and social care services
4. Improved transitions between services with better communication across the traditional providers of care, in and out of hours
5. Better utilisation of technology in care processes; to improve communication and information sharing across providers
6. Locally based innovations to address the needs of some marginal local communities and support people to manage their own care

It is within the scope of this evaluation to map these goals onto the schemes and the contracted outcomes from the schemes as well as evaluate the individual schemes.

3.0 Methodology

The Programme Board wanted the evaluation to identify patient health outcomes and impact of the programme at systems level; i.e. the extent to which the schemes alleviated pressure on primary care. Given the need to understand how the change has occurred as well as what difference the programme has made within the timescale we used both quantitative and qualitative evaluation methods. Our preferred methodology, as proposed within the tender, would have been to combine a retrospective matched control analysis with a series of targeted interviews of the programme leads and specific stakeholder engagement and public involvement via the Citizen's Reference Group.

Early meetings with the Programme Board confirmed that all schemes commissioned via the EPCP programme were within scope and that the programme logic of the evaluation needed to include separate and discrete activity of the schemes as entities of the whole. It was beholden on the individual schemes to provide activity (output data) for the additional or new service.. The qualitative portion of the evaluation had co-operation and proceeded well.

In this, and other evaluation projects, we have found that the NHS has a low capacity to collect and collate service data and we found that number of schemes collected data that was not useful or did not manage the data collection element of their contract. It is extremely difficult to add additional data collection fields to existing data systems and the problem is compounded by limited data skills in most services. The programme team were responsible for the collection of performance reporting and this data has been used where it is available.

But the quantitative portion was further affected by recent changes to health-data access with the transfer of responsibility from (Health and Social Care Information Centre (HSCIC) to NHS Digital. All data sharing agreements had to be replaced and the process was still ongoing as this report was being prepared. In addition, rule changes prevent some of the data linkage that had previously been permitted. Therefore, the quantitative component of this evaluation is limited in scope as is the economic evaluation arising from it.

Predictably the programme was very complex and the evaluation programme logic assumed that population level data could be used: accessed and used to validate systems changes and specifically the outputs of each scheme. This included the direct impact on other elements of the system: ED attendances, hospital admissions, re-admissions and length of stay. The other element which became increasingly important was the need to understand the complex feedback and pressure on the primary care providers. See Appendix 1 for the levels of direct investment into general practice relative to the costs associated with schemes. Schemes were both intending to increase access to primary care, whilst at the same time reducing pressure of work on individual GPs.

As is typical with a complex programme like this there have been some changes to the original schemes and the schemes began and finished at various times. Appendix 1 and Table 2 list the individual schemes.

Table 2 Outlines the nature and level of analysis for each scheme in this report.

Section	Scheme Name	Data Provided or Collected and Extent of Evaluation	Scheme Related interviews
4.0.1	Enhancing Primary Care Contract	- number and level of Practice collaboration provided	GP interviews
4.1	Satellite Units (4 sites)	- output data provided - survey of users provided	Interviewed programme leads and GPs
4.2	Primary Care Pharmacy Programme (PCPP)	output data provided	Scheme leader
4.3	Social Workers Out of Hours Assessment and crisis response home support	- output data provided	Scheme leader
4.4	City Wide Rapid Access Team	- final scheme report provided	GP leader /Programme Board
4.5.1	Roma Advocacy and Health Project	- final report provided by scheme - see Appendix 3	Scheme leader
4.5.2	Single Point of Access (SPA)– Increased Clinical Triage, Signposting	- no data available	Scheme leader
4.5.2	SPA - Primary care access to psychiatric liaison	- no data available	Scheme Lead
4.5.2	SPA - Weekend Specialist mental health support (general and older adults)	- no data available	Interviewed under SPA-scheme lead
4.5.3	Expansion of the Florence system to primary care	- no data available and project ongoing	Not available
4.5.4	City Wide Acute, Same Day Service. 'Roving GP'	- final dashboard provided	GP leader /Programme Board
4.5.5	Training Community Nurses to provide IAPT interventions for housebound patients	- self-evaluated, see Appendix 3.	Scheme lead
4.4.6	WebGP	- no data provided - was to be part of national review	Programme leader reported
4.5.7	Community Volunteer Scheme	- remit revised and project still ongoing.	Scheme leader
4.5.8	Interoperability and use of the Medical Interoperability Gateway (MIG)	- no data provided	Programme lead reported
4.5.9	Integrated Care Management Teams	- no data provided	Not available

3.1 Qualitative Analysis

The specific question we sought to address in this part of the evaluation process was: **' What factors affect General Practitioner adoption of the EPCP schemes and services?'**

In discussion with representatives of the PCS, the SEPCP Board and individual scheme leads[2] we recognised that the programme consisted of many schemes that had been developed in primary care as local pilot projects in response to local patient and population demand. These initiatives were being scaled up for adoption across the city as required (i.e. Roving GP). In addition, new methods of delivery were being trialled; based on national guidance and outcomes of the Phase One EPCP (Satellite Units and Pharmacy Scheme). Finally, there was an aspiration within SEPCP to enable further integrated service by including schemes delivered by Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield City Council including public health provision and by commercial providers in the SEPCP. The SEPCP incorporated elements of disease self-management practices (i.e. Florence), autonomous inter-professional working (i.e. Pharmacy and Social Work Out of Hours) and specific programmes of health-literacy to improve population health (i.e. Roma/Slovac scheme) as well as improving primary care access. The complexity of the programme was inevitably going to present a challenge to GPs who were more accustomed to the holistic management of patients within their own surgery or locality groups. It was therefore considered expedient to ask about the individual schemes, for the purpose of evaluating the range of investment in the SEPCP but also to undertake an analysis that would evidence the range of factors to be considered in systems transformations of this type, that depend on the adoption of new ways of working in primary care.

Approach- In collaboration with Primary Care Sheffield Programme Board we explored the most effective way of meaningfully capturing the GP voice (opinion and perceptions), given the known barriers that include, time constraints, workforce pressures and the scale of the workforce (87 practices included in the PMCF programme). We explored and rejected a survey questionnaire due to shared concerns about completion rates and distortion of the data. In addition we were advised by Sheffield locality managers, of inherent difficulties of accessing GPs via their own practices, for the purpose of an evaluative interview but also the potential for accessing them via a planned appointment in three of the four Satellite Unit (The North Locality Satellite Unit was staffed by locum doctors and so not appropriate for inclusion in the sampling frame). This led us to develop a recruitment strategy that involving identifying a sample of general practices and then interviewing a general practitioner from that practice with interviews conducted either in their place of work or in a satellite session where they had been allocated an evening or weekend sessions.

Sampling and recruitment - We used a purposive sample[3] sampling approach to ensure inclusion of the following characteristics:

- Demographic factors; age , gender and working role

[2] Interviews with available scheme leads within SEPCP were undertaken and reported in the interim report (Appendix 1)

[3] A purposive sample is a non-probability sample that is selected based on characteristics of a population and the objective of the study

- Practice configuration; equally across the city, in four localities, group practices both large and small
- Partners and salaried GPs with relevant involvement and experience in the programme

Recruitment was a staged process. We started from a list of GP practices organised by locality and used a 1 in 4 sampling technique to identify 21 potential participants. We cross referenced these against programme information to ensure that within the proposed sample there was comprehensive coverage across and inclusion of all schemes. For example - we ensured that we included at least one of the 6 practices using the Roma/Slovac Scheme. We contacted the practice manager in each of these practices by email and requested an interview with a GP from that practice. We followed up emails with a telephone call where practice managers did not respond. Fourteen of the 21 practices identified in the initial sample responded and we recruited one GP from each practice.

To increase the sample and reduce the time burden on individual practices, we worked with one of the PCS managers to organise interviews through the satellite units. She cross referenced the list of selected GP practices with the satellite staffing programme to identify when a GP from that practice was working in a satellite unit, during either an evening or a weekend session and then booked a double appointment (30 minute) slot in that session for the interview. She also set up additional GP interviews through the satellite service.

Data Collection- We conducted fourteen telephone interviews in satellite sessions and ten in the GP's own practice. Three members of the evaluation team (SFD, HP, SP) were involved in the interviews. The interviews were semi-structured using a topic guide to guide data collection.
The topic guide (see appendix 1) included questions related to their overall understanding of the SEPCP, the motivation of their General Practice to join the programme and feedback on adoption of the 16 schemes. Additionally we captured their views and experiences of using the scheme and the ways in which they felt that it had contributed to meeting the needs of their practice population and how well it had operated in their practice context.
Interviews lasted approximately 20 minutes.

Ethics and information governance.

A copy of the study information sheet and topic guide, together with a consent form, was sent to each GP prior to interview. Recorded verbal consent was obtained at the beginning of the interview. Ethical approval for the evaluation was granted by SHU faculty ethics committee.

During the lifetime of the project, all research data emanating from the project were stored safely and securely on the University's dedicated networked storage system for research data.. At the end of the project, an anonymised version of the data will be made available via the University's Research Data Archive (http://shurda.shu.ac.uk) under a Creative Commons license. It is SHU policy to preserve research data for at least 10 years since the last time any third party has downloaded the data.

Data Analysis- All interview data were digitally recorded and fully transcribed under contract by a commercial company. Framework analysis was used as a pragmatic approach[4] to qualitative data analysis involving a systematic process of sifting, charting and sorting the material into key issues and themes. This allowed the integration of a priori issues into the emerging data analysis and provided a clearly defined analytical structure that contributed to the transparency and validity of the results. We followed the five data management steps for data analysis: familiarisation, constructing an initial thematic framework, index and sorting, reviewing data extracts and data summary and display. Three members of the research team were involved in the analysis process and we were supported by a research assistant. To ensure rigour and ensure consistency across the analytic processes, we agreed brief descriptors for all the themes and met regularly throughout the analytic process.

We analysed the data in two ways. Firstly we constructed a framework of deductive themes that enabled us to analyse GPs' perception of each individual scheme and address the main objective of the evaluation. We indexed and sorted each of the interviews in relation to these deductive themes and then populated the framework with data extracts and summaries. This element of the analysis is reported in the main evaluation, supporting the quantitative analysis and providing description of the scheme from the perspective of the GPs in the programme.

The second analysis was a detailed interrogation of the data within a framework of four inductively derived themes. Analysis in relation to this set of themes was supported by a series of detailed and critically reflective discussions within the research team, drawing on their collective theoretical and academic expertise, and wider discussion of the data and the analytic insights with the PPI group, established to work on the evaluation. During that PPI meeting, we explored the meaning of the interview data in the context of the EPCP with the group members (4 present along with the programme manager). The findings of this analysis are presented in this supplementary report.

[4] Ritchie J, Spencer A. Qualitative data analysis for applied policy research. In: Bryman A, Burgess R, editors. Analyzing qualitative data London: Routledge; 1994.

3.2 Quantitative Analysis

3.2.1 Data Provided by Each Scheme

We expected to have data provided by each of the service providers as per their contracts with PCS (see Appendix 1). Service providers were asked to supply data **without** identifiers (i.e., no name, address, or date of birth). Data was stored on a secure server that meets Home Office specifications for security. The following table lists the data received for each scheme in the order in which they are included in the report.

Table 3 Scheme Data

Scheme	Quantitative Data Content	Economic Evaluation
4.2 Satellite Units	- anonymous data from a SystmOne data collection database created for this scheme - anonymous data from SystmOne responses to Family & Friends survey	- calculated cost of avoided A&E, walk-in centre, or next day GP visit - limited as not able to link to secondary care data
4.3 Primary Care Pharmacy	- data from a bespoke data-collection Excel spreadsheet	- calculated cost of GP time saved.
4.4 Acute Same Day	- usage counts from the last performance report to the Programme Board	- calculated cost of avoided A&E, walk-in centre, or next day GP visit - limited as not able to link to secondary care data
4.5 Social Work Out of Hours Assessment	- data in the "dashboard" from the last performance report to the Programme Board	- limited as not able to link to secondary care data
4.6.1 Roma	- no data provided	- evaluated by others
4.6.2 Roving GP	- usage counts from the last Performance Report	- evaluated by others - calculated cost of avoided hosptial admissions
4.6.3 WebGP	- usage counts from the last Performance Report	- limited data provided - calculated cost of GP appointments saved.
4.6.4 Additions to Single Point of Access	- data could not be disaggregated from overall SPA data	
4.6.5 Florence	- no data provided	- no data provided - still ongoing
4.6.6 IAPT	- no data provided	- evaluated by others
4.6.7 Community Volunteer Scheme	- no data provided	- no data provided

4.6.8 Interoperability	- no data provided	- no data provided
4.6.9 Integrated Care Management Teams	- no data provided	- no data provided

3.2.2 Statistical Analysis

Upon receipt of the data it was directed into the Statistical Package for the Social Sciences (SPSS) Version 24. The data files were checked for completeness and range, routing and logic checks were undertaken. Data was also categorised and answers were grouped and coded for ease and clarity of analysis. The clean data files were then subject to statistical analysis using SPSS software and analysed using descriptive frequencies and distributions, cross-tabulations and correlations. Multivariate analysis was undertaken in the Friends and Family project.

3.2.3 Economic Analysis

The economic evaluation provided analysis of financial, output and outcome data within an impact and Value for Money (VFM) framework. The VFM framework was rooted in logic model models for each project and informed by guidance on evaluating impact and additionality ('3R's' guidance[5] and the HM Treasury Magenta[6] and Green[7] Books and Value for Money[8] and Assessment Guidance[9]). Logic models provide a simplification of the relationship between: resources, what activities take place (e.g. creation of Satellite Units), what these activities provide/produce (e.g. appointments) and what results from the activities (e.g. reduced A&E attendances).

The impact and VFM analysis included the measurement of:

- **inputs**: the financial resources that have been used
- **outputs** achieved, for example the number of patient appointments
- cost **efficiency**, the cost per output achieved
- **net additional outcomes/impacts** achieved, for example changes in hospital A&E or outpatient episodes for beneficiary populations; the original aspiration was to use linked hospital data to quantify the level of additionality; however, the evaluation was unable to access this data so qualitative perception data was used
- the cost **effectiveness** of outputs in delivering outcomes; Where cost effectiveness compares the relative cost of a given scheme per impact compared against the status quo. So for example what is the unit cost per reduced hospital A&E attendance
- **monetising net additional outcomes**
- **Return on Investment:** a comparision between the input costs and the value of net additional outcomes.

[5] ODPM (2004), Assessing the impacts of spatial interventions: regeneration, renewal and regional development, 'The 3Rs guidance', London, Office of the Deputy Prime Minister.
[6] HM TREASURY (2011), The Magenta Book: Guidance for Evaluation . London, TSO.
[7] HM TREASURY (2003), The Green Book: Appraisal and Evaluation in Central Government. London, TSO.
[8] HM TREASURY (2006), Value for Money Assessment Guidance. London, TSO.
[9] ENGLISH PARTNERSHIPS (2008), Additionality Guide - A Standard Approach to Assessing the Additional Impact of Projects, Third Edition.

4.0 Review of Each Scheme

4.1 Overall Participation by Practices

At the beginning of the Programme 87 GP Practices were available to participate with some closures and mergers of practices over the term of the evaluation. It is estimated that the 'turn-over' of GP changes was around 9% (8 practices were variously affected). Only 4 practices did not participate at all. A further 4 only participated at level 1. Thus the majority of practices participated and "by signing the contract they committed to standardising delivery of primary care in core contracted hours (08:00-18:30) and to engaging with the 'enhanced services being developed through PMCF Sheffield."[10] . The focus of this engagement was on contributing staff to the Satellite Units, providing extended Practice hours and taking up the services offered by the Primary Care Pharmacy Programme. Some schemes, such as the Roma scheme, were targeted where there was the most need (i.e. high Roma population) while others such as WebGP were national schemes offered to all practices.

4.1.1 Mapping Each Scheme onto the SEPCP Remit

The Prime Minister's Challenge Fund emphasises improving access to GPs - specifically out-of-hours options. Extending this idea further the SEPCP was established to enhance access to local community-based and primary care services, and to manage more care in out-of-hospital settings. Six goals were described in the SEPCP remit (below) and mapped onto the individual schemes (Table 4):

a. Care closer to home"
b. Increased availability of GP appointments for adults and children in practices and satellite units across the city (particularly targeted at areas of high A&E utilisation)
c. Further integration of health and social care services
d. Improved transitions between services with better communication across the traditional providers of care, in and out of hours
e. Better utilisation of technology in care processes; to improve communication and information sharing across providers
f. Locally based innovations to address the needs of some marginal local communities and support people to manage their own care

[10] PMCF Business Care Summary Description February 2016

Table 4 Mapping Each Scheme onto the SEPCP Goals

		A	B	C	D	E	F
1	EPCC		y				
2	Satellite Units		y				
3	PCPP						
4	SW OHH	y			y		y
5	Roma			y			y
6a	SPA (triage)				y		
6b	SPA (psychiatric)	y					
6c	SPA (Weekend MH)	y		y	y		
7	Florence BP	y				y	
8	Roving GP	y					
9	City Wide Acute		y				
10	Community IAPT	y		y			
11	WebGP	y				y	y
12	MIG				y	y	
13	ICM			y	y		
14	Community Volunteer						y

All the SEPCP goals were covered by 2 or more schemes. The 'care closer to home' goal was covered by the most schemes (7) although most of these schemes are small in scale. The largest in terms of volume of activity were the Satellite Units (Section 4.2), the Primary Care Pharma (Section 4.3), and Acute Same Day Appointment Schemes (Section 4.4).

The benefits expected from each scheme were articulated in the contracts (see Appendix 1). These benefits were content analysed to ensure overall match with PMCF goals and any extensions to the pre-existing remit. The analysis produced 4 themes which have been mapped back to the schemes. This provides an overview of the complexity of the programme and the requirements of each scheme to deliver one or more aspects of the whole system change.

Of note is the scheme requirement 'to release GP time' that does not appear in the original remit of the SEPCP programme. Whilst this is understandable it does appear in the contracted benefits for some schemes (see Table 5 below).

Table 5 Content Analysis of the benefits expected# from the schemes

Theme	Wording in contract - stated benefit (scheme*)
A. How patients use the primary care system	– improved in hours access (9) – improved overall access (2, 5) – Redistributed urgent in-hours demand (2, 9)

Theme	Wording in contract - stated benefit (scheme*)
	– Reduced demand (8, 11) – Release GP time (3, 5) – Improved access to MH liaison in and out of hours (6b) – improved links between primary care & 3rd sector (5) – improved access, including mental health and social care (6a) – - reduced walk-in centre use (2, 8)
B. Increasing patient self-management	– improved self-care/management (7, 11) – *possibly related* – Improving access for housebound patients with a mix of physical and mental health needs (10)
C. Reducing the use of Secondary Care	– manage chronic conditions better (3, 4) – improved social care liaison (4) – improved mental health in and out of hours (6b, 6c, 10) – reduced A&E visits (2, 4, 5, 6b, 6c, 8) – reduction in Walk in Centre Attendances (2, 8) – Improved appropriate access for a specific population (5)
D. Service Redesign and Workforce Development	– Improved linkage of Primary Care to 3rd sector (5) – Mapping of Services (13) – Providing time, facilitation and practical support for Practice Development and federated working (1) – Reduce prescribing spend (3) – Reduced duplication and save clinician time (12) – Reducing practice demand for patient cohort (7) – Strategic practice engagement at scale (1) – System and Workforce development (13) – Testing benefits of working with clinical pharmacists (3) – Workforce development (10) – Patient Safety (12) – Improved Communication and collaboration (12) – Practices Working together (8) – Improve the joining up of services and improved access to them (6A)

benefits were listed in the contracts for each scheme.

* Number of Scheme matches Table 4

The lack of an overall integrated care model onto which these benefits were mapped meant that most schemes operated in isolation. Nor were robust outcome measures for these 'benefits' considered and many can't be measured from existing data. (e.g., " roviding time, facilitation and practical support for Practice Development and federated working")

There is an overarching emphasis, which strengthened over the year, on improving access by specifically offering out-of-hours options for patients. It is quite clear from the 'benefits' analysis reported in Table 5 that the underlying belief is that restricted access to GP services for urgent care

increases secondary care visits. The follow on logic is that that 7-day working and a longer work day, etc., should decrease hospital admissions and A&E visits. This is certainly consistent with the view that is being presented nationally.

In the subsequent sections we will eview each scheme.

4.2 Satellite Units

£831,677 - 01 October 2015 to 30 June 2016. Level 2 Engagement

4.2.1 Introduction

Satellite Units are a national initiative and a focus of the PMCF. The aim was to provide **urgent** primary care appointments, out of hours (evening, Mon-Fri 06:00-22:00 and weekends 10:00-18:00). The Satellite Units work alongside the existing walk in centre and the GP Collaborative Service. Each unit is staffed by two receptionists, an advanced nurse practitioner and a GP.

Objectives

- To increase access to General Practice
- To address the increasing GP workload and capacity on a daily basis
- To ensure a manageable day for all staff and allow today's workload to be done today
- To reduce unscheduled admissions
- To ensure primary care develops to support and integrate with city wide transformation programmes

Four new satellite units opened on the 1st of October 2015, three based in existing GP practice premises (Crookes practice, Sloan Medical Centre, Woodhouse Health Centre) and one based within the existing GP Collaborative premises (North). gpGP cover is by locum GPs in the North locality. Appointments are booked by GP surgeries using SystmOne or over the telephone, and via 111 and the out-of-hours service. There was a low uptake of Nurse Practitioner appointments:

1) 30 November 2015 Woodhouse and Crookes removed Saturday afternoon and Sunday Advanced Nurse Practitioner (ANP) shifts and
2) In January 2016 all weekend ANP shifts were removed and replaced with Practice Nurse appointments.

4.2.2 Qualitative Findings

GPs recognised the benefits of 'Satellite Units' to patients with urgent problems: to offer additional access that in turn reduced pressure on their surgeries in the late afternoon and the following day. This spill-over effect (seeing patients in the evenings and weekends) is a recognised benefit to GP work loading and was generally welcomed.

> "*it's improved access for people who have obviously got acute on the day problems, because that's really what it should be used for. In theory they would have been seen anyway"* GP interview

> *"I suppose it's reduced potentially the pressure on us, particularly at the end of the day in terms of phone calls at quarter to six when you might already have a late visit. It's reduced that pressure, because you've got another outlet for them to go to*" GP interview

"*where's the evidence to say that people need routine access to GPs at the weekend. We have them at the collaborative[11] 24/7 so why do we need another three hubs?.*" GP interview

"*it's good to be able to book patients in in the afternoon to be seen at night rather than having to defer them to the next day or advise them to go into the city when they probably won't go.*" GP interview

The units provide access to out of hours (evening and weekend) and there was frustration at the mis-use of appointment for non-urgent need. The benefits of Satellite Units were recognised by GP's who wanted to use additional services to manage patients with urgent needs. This is in contrast to those patients who have difficulty accessing day-time appointments for other reasons. There was a notable disparity between GPs' understanding of what constitutes 'urgent' need and this affected the referrals to OOH appointments. Misuse of the appointments was a regular frustration, particularly in relation to the EPCP core purpose.

"*I've had a surgery tonight mainly of coughs and rashes and things that didn't need to be seen this evening. And I think if the GP surgeries concerned had resources to see these patients during the day, I think they'd have been better managed there.*" GP interview

"*Sometimes I'm getting patients with, they shouldn't be here maybe, they don't have acute problems. But if it's used properly I think it will reduce pressure on the surgery, and reduce pressure on accident and emergency in the hospital.*" GP interview

"*the problem with the satellite is we find that it is, and this is my own experience and talking to my colleagues in the practice, we see a lot of people dumping patients that they don't necessarily want to see. I mean if people are booking those appointments at nine o'clock in the morning, you have to question why they're not seeing that patient themselves.*" GP interview

Satellite Units offered more appointments and increase capacity over the period but many GPs reported that they would rather manage their own patients if they could offer slots and if not then the resource is useful. Of GPs interviewed many were able to manage demand and reported a low usage of the Satellite Units, suggesting that the use was for a marginal group of users who could not be accommodated in surgery.

"*because the vast majority of our appointments are on the day and we guarantee people here appointments if they ring before 10.30. So we use it [the hub] rarely. But it still can be very useful, particularly when an afternoon call comes in and somebody needs to be seen that day.*" GP interview

"We haven't actually used them very much I don't think. Why we haven't, I'm not quite sure. I've used them once, I think and as far as I'm aware, none of the other doctors have used them at all."

[11] The GP Collaborative is an existing centralised GP out of hours service based at Northern General Hospital. At the beginning of this project approximately one-quarter of practices were in the collaborative.

Demand from non-native speakers and patients without private transport. GPs are critically aware of patient vulnerability and / or more marginal need. They experienced the Satellite Units as additional appointments but for some patients the access to Satellite Units was not perceived as enabling personalised care. Patient opinion collected in the Friends and Family survey (see section 4.2.3) has not picked this up although the GPs did identify that patients using the Satellite Units were less urgent and it is possible that this opinion relates to GPs choosing to prioritise some patients who need specific knowledge of their patients and a continuing barrier to access for some patient groups.

> "*We've tried to use that quite a few times obviously when we're full and we've got patients wanting appointments and things, because it's quite a fair distance for them to travel from our practice, and because it's normally a late appointment time as well"*. GP interview

> *"It's after six o'clock; a lot of them [patients] are refusing to use it. We have used it a few times, and it's been useful in that way. But I a lot of the patients have said they don't want to use it, and insist on coming and sitting and waiting here as an extra really*." GP interview

> "*these clinics aren't particularly set up for non-English speakers, because you don't know which GP you're booking into. So that's quite a significant thing for where we are in Sheffield: quite a high number of our patients don't have fluent English"* GP interview

4.2.3 Quantitative Findings

Data came from appointment data the Systm1 OOH module (database) set up specifically for the Satellite Units. Each patient who attended was also asked to complete the Family and Friends Questionnaire. This anonymous questionnaire was collected by the Satellite Units and sent to PCS for entry by PCS staff into an Excel database.

The Satellites continuued operating after the SEPCP funding finished and data is available for 14 months (Oct 2015 to Nov 2016).

Satellite Appointment Data

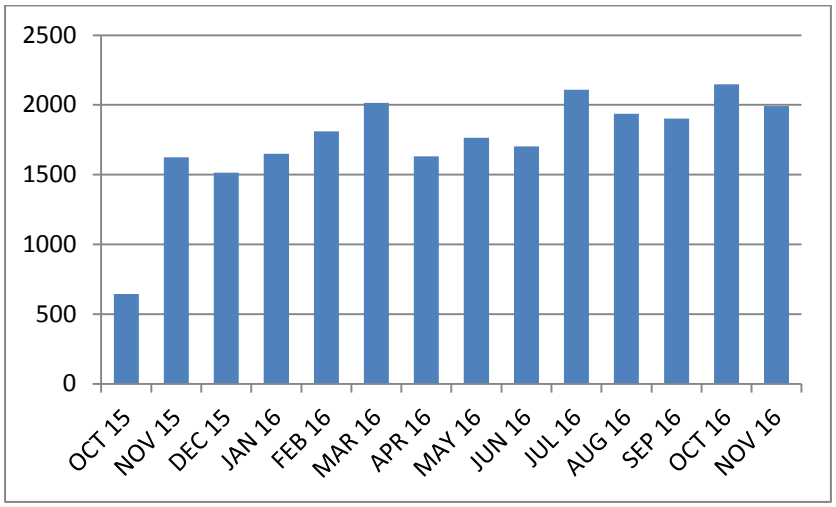
There were 24,448 appointments over the 14 months for 19,701 different patients. The appointments resulted in 29,629 outcomes (i.e. clinical advice, prescription issued, etc.). 98.5% of the appointments were for patients registered with Sheffield GPs. Table 6 provides the number per Satellite Unit.

Table 6 Number of Satellite Unit appointments per Hub Oct 2015 to Nov 2016

Satellite Unit	Number	Percent
Crookes Satellite Unit	4206	17.2%
North Satellite Unit	5510	22.5%
Sloan's Satellite Unit	4864	19.9%
Woodhouse Satellite Unit	5850	23.9%
Out of Hours (GP Collaborative)	3848	15.7%
unassigned	170	0.7%

Use of the service built steadily over the 14 months of this evaluation (Figure xx) averaging 2018 appointments per month over Jul-Nov 2016.

Figure 2 Appointment Satellite Unit uptake Oct 2015 to Nov 2016



Demographics of the Satellite Unit Patients

The patients ranged in age from newborn to 101 (see figure 3). The mean patient age was 32.04 years but clearly the greatest number of users are in the under 5's (nearly 20%) and young adults (age 20-35) at 25% (see following Table 8). Only 7.8% of patients were over age 70.

Figure 2 Frequency of visits by age of the patient

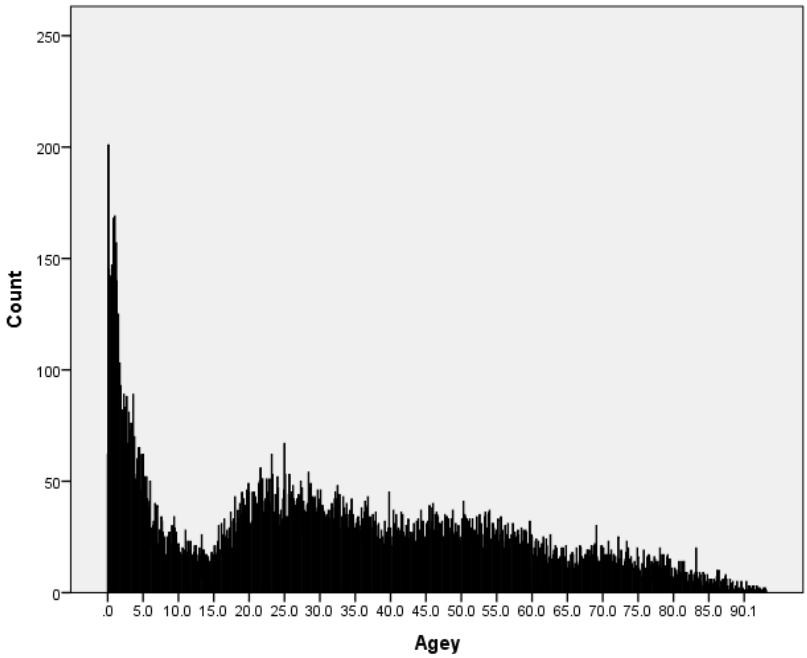
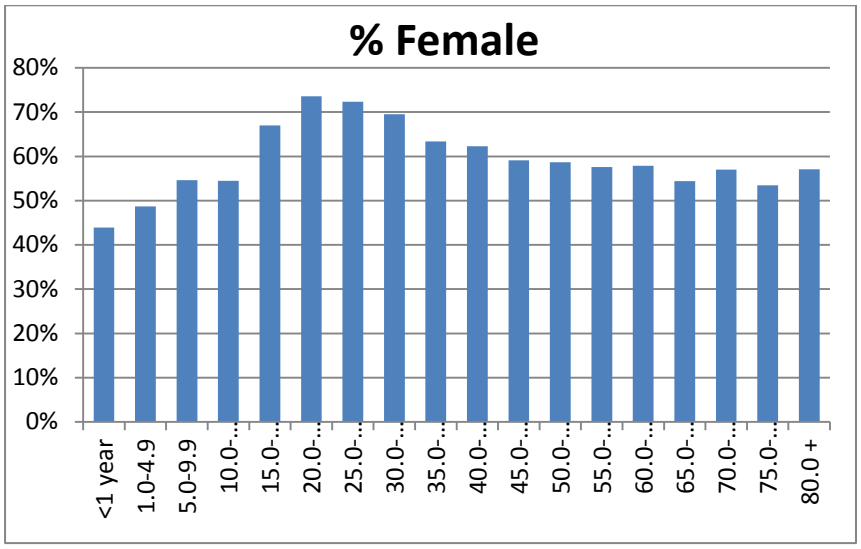


Table 7 Age of the patient in Satellite Unit Appointments

Age Group (years)	N	%
<1 year	1434	5.9
1.0-4.9	3200	13.1
5.0-9.9	1489	6.1
10.0-14.9	841	3.4
15.0-19.9	1430	5.8
20.0-24.9	1979	8.1
25.0-29.9	2043	8.4
30.0-34.5	1755	7.2
35.0-39.9	1449	5.9
40.0-44.9	1317	5.4
45.0-49.9	1438	5.9
50.0-54.9	1393	5.7
55.0-59.9	1158	4.7
60.0-64.9	854	3.5
65.0-69.9	768	3.1
70.0-74.9	712	2.9
75.0-79.9	589	2.4
80.0 +	599	2.5

Overall the patients were 60% female (see Figure 4) with only 4 patients (3 adults and 1 baby) having no recorded gender. In young adulthood more than 70% of the patients are female which is a pattern seen primary care as women are socialised to engage in peventative practices such as smears. However, these appointments were screened for urgent care needs so routine healthcare provision should not be an explanation for the preponderance of females. Another explanation may be that women still carry the majority of childcare needs and that out of hours timing allows them to find childcare from friends and family. Particularly for those in low-paying jobs for whom a medical appointment means an unpaid half or full day from work..

Figure 3 Proportion of females in each age group - all patients Oct 2015 to Nov 2016



The patients from the poorest 5th of the population use nearly 40% of the appointments (Table 9).

Table 8 IMD 2015 Pentile

pentile	**N**	**%**
best	4330	17.7
2nd	3500	14.3
3rd	4163	17.0
4th	3288	13.4
worst	9092	37.2
missing	75	0.3

*business hours 09:00-17:59; early evening 18:00-19:59; night time 20:00-08:59

The original data contained 116 ethnicity categories which were reduced to 24 categories. Unfortunately, except for mixed and unknown, most non-white categories had too few patients for any subanalysis and so the categories were further reduced to be in line with Census classifications (see Table 10). The service does seem to be used by more non-whites than their prevalence in the population would suggest. Although, 42% of patients label themselves as 'mixed or other' and for 20% the ethnicity information is not stated accurately or missing making this characteristic difficult to analyse.

Table 9 Ethnic category of Satellite Unit Patients

Ethnicity	N	%
White	6419	26.3
Mixed multiple ethnic groups	10157	41.5
Asian Asian British	2074	8.5
Black African Caribbean Black British	433	1.8
Other ethnic group	424	1.7
Not stated	1720	7.0
Missing	3221	13.2

Outcomes from the Satellite Unit Appointments

82% of appointments were the only time the patient used the service and a further 13.8% of appointments were for patients seen twice (see Table 11a).

Table 11a Health Care Providers classification of the outcome of the appointment

Number of outcomes from appointment		
patient only seen once in 14 months	16,196	82.2%
patients seen twice in 14 months	2723	13.8%
patients seen three times in 14 months	548	2.8%
patients seen 4-16 times in 14 months	233	1.2%

There were only 28 people who attended 7 or more times over the 14 months. This is a very small number and we cannot draw firm conclusions about frequent users from these few people. Two practices had 7 frequent users each - one is a large practice and the other small. For both practices the frequent appointments were spread over the entire 14 months. Amongst the 28 people, 57% were male and there was an even distribution across the age groups. This is not consistent with the overall age and sex pattern of the rest of the appointments. There were also proportionately more people from the least deprived IMD quintile than in all the users.

Less than 1% of appointments were deemed inappropriate and the non-attendance rate of 1.8% was well below the national average (see Table 11b)..

Table 10b Outcome of the Satellite Appointment

Outcome	N	%
Admitted to Hospital	664	2.2%
Ambulance arranged	16	0.1%
Referred to A&E	417	1.4%
significant event/complaint	15	0.1%
prescription issued	3743	12.6%
Call back if no better	3567	12.0%
Follow-up appointment needed	875	3.0%
Needs urgent appointment with own GP	623	2.1%
To ring own GP if no better	12,143	41.0%
Needs routine appointment with own GP	25.3	8.4%
no follow-up required	4388	14.8%
inappropriate appointment	133	0.4%
Did not attend	542	1.8%

As an acute measure of urgency these categories were combined into:

urgent: admitted to hospital; ambulance arranged; referred to A&E; significant event/complaint; needs urgent appointment with own GP

managed - no follow-up: prescription issued; no follow up required

non-urgent, needs further follow-up: call back if no better; needs routine appointment with own GP; to ring own GP if no better; follow-up appointment needed

inappropriate

did not attend

Table 12 suggests that only a tiny proportion of Satellite Unit appointments were inappropriate or missed appointments (2.2% in total). Six percent were deemed urgent and two-thirds were non-urgent but needed follow-up. The pattern is similar across every day of the week . and there is an even lower non-attendance rateon weekends than on weekdays.

Table 11 OOH urgency - recode of OOH follow-up

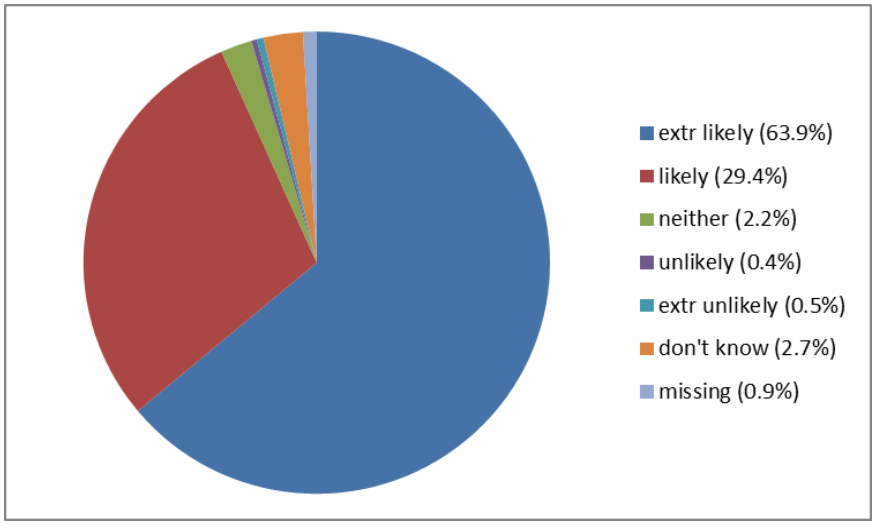
	N	%	Weekday %	Weekend %
urgent	1735	5.9%	6.0	5.6
managed - no followup required	8131	27.4%%	25.3	31.1
non-urgen but needs further followup	19,088	64.4%	65.8	62.0
did not attend	542	1.8%	2.2	1.2
inappropriate	133	0.4%	0.6	0.1

Family and Friends Survey Findings

The satellite appointments were extremely well received by the patients with 93% of respondents to the survey indicated that they were 'extremely likely' or 'likely' to recommend the service to friends & family if they needed similar care or treatment (see Figure 6).

The demographics of the survey respondents are given in Table 13. There is a problem with the design of the questionnaire as it did not specify that the responses were for the patient rather than the person filling out the questionnaire. This is evidenced with the response to the question "If you had not had this appointment what alternative would you have sought?"of which one choice was "Children's A&E" for which one could expect the patient was a child. But, only 87 out of 163 (53%) who reported their alternative was "Children's A&E" were in the 0-15 age group. Therefore one should assume that the respondents are a mixture of patients and carers.

Figure 4 Responses to the question "How likely are you to recommend our service to friends & family if they needed similar care or treatment?"



Regardless of this, we can discuss the demographics of the people who completed the survey. Two thirds of respondents were female which is consistent with the Satellite Unit patient record data. Eighty percent of respondents were under age 55 and again, this matches the Satellite Unit data.

Table 12 Basic Descriptors of the Family & Friends Survey Respondents - n (%)

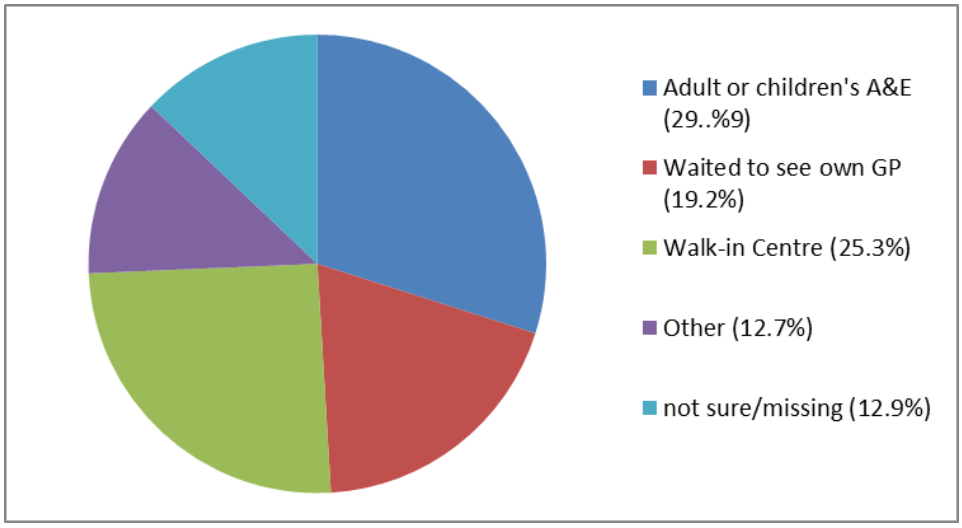
Characteristic	N (%)
Sex	
Female	1393 (65.7%)
Male	654 (30.8%)
Missing	73 (3.4%)
Age Group	
0-15	267 (12.6%)
16-24	307 (14.5%)
25-34	492 (23.2%)
35-44	373 (17.6%)
45-54	260 (12.3%)
55-64	163 (7.7%)
65-74	106 (5.0%)
85-84	129 (6.1%)
85+	20 (0.9)
missing	3 (0.1)
Ethnicity	
White	1778 (83.9%)
Asian	131 (6.2%)
Black	44 (2.1%)
Mixed/Other	78 (3.7%)
Missing	89 (4.2%)
Deprivation Score Pentile	
Most deprived	494 (23.3%)
2	271 (12.8%)

Characteristic	N (%)
3	336 (15.8%)
4	270 (12.7%)
Least deprived	272 (12.8%)
Missing	477 (22.5%)
Total	2120

The demographics are consist with a hypothesis that the patients using this service are working people and parents with children. People in the worst deprivation pentile were twice as likely to use the Satellite Unit as other deprivation pentiles.

When asked to identify what alternative to the satellite unit they would had, 30% of respondents indicated that they would have gone to A&E (Adult (22.2%) or Children's (7.7%)) in the absence of the Satellite Units and only one fifth would have waited to see their own doctor (Figure 7).

Figure 5 Responses to the question "If you had not had this appointment what alternative would you have sought?"



* other includes (n): 111 (58), pharmacy (37), not sure (56), and the response option 'other' (175)

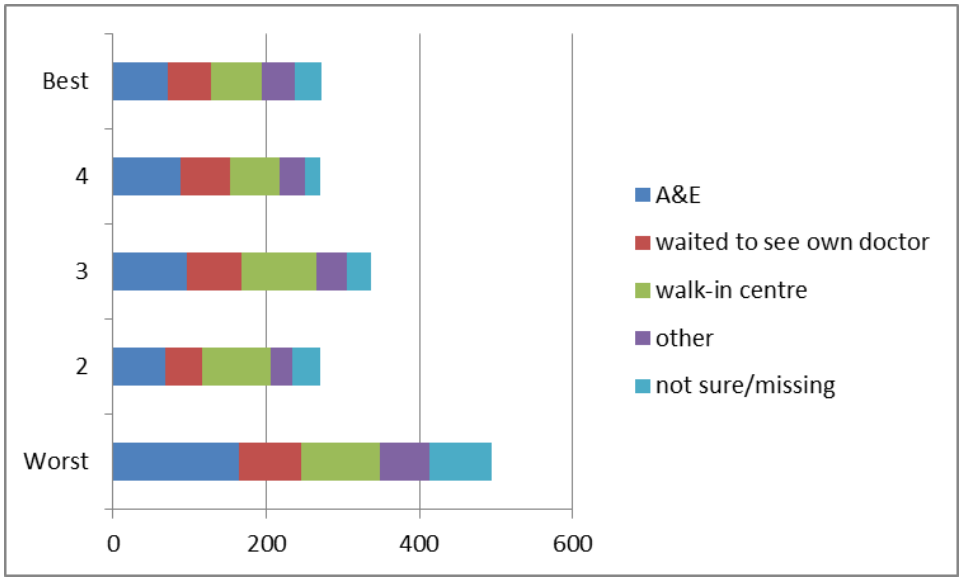
Given the small numbers in some response options we reduced the number of 'alternative to satellite unit' categories and grouped the age bands into fewer categories to look for differences in preference by age group (Figure 8). The 16-34 age group are much more likely to see A&E as an alternative although they also are more likely to use the Walk-in Centre. The number of patients selecting the non-white ethnic categories was too small for reliable reporting at the level of ethnic category.

Figure 6 Preference by age group

* other includes 111, pharmacy, and the questionnaire option 'other'

For other demographic characteristics, there were no major differences in perceived alternatives to A&E by gender but people in the worst deprivation pentile were twice as likely to use the Satellite Unit as other deprivation pentiles and the most likely to consider A&E as an alternative (see Figure 9).

Figure 7 Alternatives to Satellite Unit appointment by Deprivation pentile.



Multivariate model

To look at the combined effect of the demographic variables we conducted a multivariate analysis. The analysis compared those who indicated that they would have gone to A&E (Adult or Children's) if they had not had the Satellite appointment with all other alternatives (i.e., A&E vs other - called

the 'outcome'). Potential explanatory variables were sex, age group, ethnicity, deprivation pentile and the response to the question about recommending the satellite units to others.

Table 14 presents the results of the multivariate analysis. Taking into account all of the demographic variables at the same time, those who were more likely to see A&E as an alternative to the Satellite Units

- If the 'respondent' was in the 0-15 age group they were 1.7 times more likely than those in the 16-34 age group.
- Asian respondents were 2.4 times more likely than white respondents
- those in the most deprived 5th of the population were 1.6 times more likely that those in the middle fifth.

This result emphasised the need for an equality impact assessment.

Table 13 Multivariate analysis comparing those whose alterative to the Satellite Unit was A&E compared with those who had other alternatives.

Explanatory variable *	Odds Radio %	p	95% CI
Age Group			
0-15	1.68	0.001	1.22, 2.31
16-34	1.00	ref	ref
35-54	0.87	0.282	1.12
55+	1.09	0.552	1.45
Ethnicity			
White	1.00	ref	ref
Asian	2.43	<.001	1.60, 3.68
Black	1.87	0.098	0.90, 3.91
Mixed	0.76	0.433	0.37, 1.55
Other	1.36	0.420	0.64, 2.87
No response	0.66	0.363	0.27, 1.62
IMD Pentile			
Most deprived	1.57	0.002	1.18, 2.10
2	1.04	0.521	0.74, 1.45
3	1.00	ref	ref
4	1.12	0.499	0.80, 1.57
Least deprived	1.08	0.652	0.77, 1.51
Constant	0.55		0.42, 0.72
N	1643		

* Gender wasn't included in the final model as it was not statistically significant

% The OR represents the odds that a Satellite Unit patient will go to A&E compared with a non-A&E choice such as wait for the next day or Broad Lane Walk-in Centre.

Content Analysis of Open comments from the Family & Friends Survey

There were 471 comments which were analysed for themes. There were many more good/positive than bad/negative remarks. That said, some were cryptic and all very subjective/situation specific. Typical remarks were along the lines of -

"Everything was fine"

"Good service, I found it good"

"Really appreciate this service being available"

These general remarks, apart from other comments, tended to cluster around the following areas, with some overlap in and between categories -

Theme 1: Timing/hours offered

Very few comments were specifically or solely on the benefit of having extended hours. The following remarks are positive but without context we can't be sure of the reasons for weekend/evening appointments being so useful for these individuals:

"This was a very quick and impressive service (for a weekend especially)"

"Useful to have access to evening appointments."

But when we consider the number of people who remarked on their own work/shift patterns it seems that the extended hours are implicit within their approval of the service.

Theme 2: Work patterns and shifts

"Really useful to have availability of appointments in evening for working patients"

"Really good, I was able to come after work."

"Late nights are a big help as work full time."

In addition the hours when the service was available also impacts on those patients who might have had to make other arrangements for their healthcare needs. In these instances the extended hours act to offer an alternative to either A&E or a walk-in facility. In any case the approval was clear:

Theme 3: Alternative to …

"If I didn't get this appointment and things persisted I would have gone to A&E"

"I was very impressed at the speed I got my appointment today and that it was at the Sloan and we didn't have to go all the way to the Northern General"

"Really good to get an appointment at such short notice and not having to go A&E / walk in centre and waiting hours to be seen"

Theme 4: Sick children

Children were often mentioned. But from the data it's not always clear if the child or the adult was the patient. Some remarks suggest that the adult was ill but couldn't bring the child with them to a daytime appointment but in the evening could leave them at home with someone else.

> *I couldn't do this with 2 children*

Some were clearly talking about the benefits for the sick child:

> *"Very helpful service especially for children to avoid long waits at walk in"*

Any future data collection needs to differentiate between the two.

Theme 5: Catchment area

There was very high approval of the service from those who lived in the locality. This was often expressed alongside remarks about alternative arrangements (see above).

> *"Really quick, efficient and a really convenient local appointment"*

> *"It's really handy to be able to come to see a GP nearby rather than travel up to the Children's hospital etc."*

Theme 6: Information giving and communications

The service attracted more neutral/negative comments on the subjects of information and communications. These were typically that the service was good but not widely advertised or that accessing the service had caused difficulties for potential patients.

> *"It would be good to have a bit more flexibility about changing the time of appointment (i.e. telephone number to call)"*

> *"In conversation with others, no one knows about service"*

> *"I was unaware this service was available. Better advertising would improve use of the service"*

> *"Better referral from normal GP. Staff were unsure where I was allowed Satellite Unit appointment"*

In summary the patient liked the provision and many recognised it as an alternative to OOH and reduced attendance at A&E. There is evidence in the F&F test of the Satellite Units meeting otherwise unmet need although this needs further evaluation. If linkages are permitted in future the question remains: are these patients' regular or rare users of GP services? It also highlights that some patients may not have perceived Satellite Units were intended to be an 'urgent' service. Although, their definition of 'urgent' needs to be determined.

4.2.4 Economic Evaluation

The economic analysis is based on the **12 months** of the project. There are four economic evaluations (EE) for the Satellite Units:
1) A standard EE that covers the term of the scheme
2) An EE which assumes the take up rate for the 3 months October-December 2016 and projects this over 12 months.
3) an EE which models the costs if 90% of appointments are taken up.

Satellite Hub Economic Evaluation 1

A standard EE that covers the term of the scheme

Assumptions and Parameters

Overall costs

The overall cost of the scheme was £2,163,095. This includes £2 out of the £5/patient-on-list paid to the GPs for staffing the Hubs.

Number of Appointments

41,796 appointments were offered over the 12 months of the scheme. This equates to 10,449 hours. 23,904 appointments were taken up equating to 5,976 hours.

Who staffed the appointment

65% of appointments offered were for GPs and the remainder for Advanced Nurse Practitioners (24 per cent) and Practice Nurse's (11 per cent)

- The GP cost is £128/hour
- The Advanced Nurse Practitioner cost is £56/hour
- The Practice Nurse cost is £40/hour.

Dividing the costs of the satellite units against the number of appointments offered and attended reveals:

- The unit cost per appointment offered was £51.75
- The unit cost per appointment attended was £90.49

Which alternate service would the patient have used?

- The Family & Friends survey indicated that 28% of patients would have used the walk-in clinic for a total of 6,736 walk-in attendances avoided.
- The cost of Broad Lane Walk-in Centre is £34.51/contact based on 70,000 contacts per year.
- The Family & Friends survey indicated that 21% would have waited to see their 'GP' the next day (in reality the appointment would have been made with either a GP, ANP or PN) so the Hub visit freed up 5,103 GP appointments equating to 942 hours. We have assumed the expected value of an appointment freed up was
- £17.14 per hour, based on expert advice that 66 per cent of appointments with GP, 10 per cent with ANP and 24 per cent with Practice Nurse.
- The Family and Friends survey indicated that 33% of patients would have gone to an A&E appointment in the absence of a Hub appointment. The Hub data showed that 3-5% were actually sent to A&E. Thus 28% of appointments would potentially have gone to A&E resulting in 6773 fewer A&E visits. An A&E attendance is costed at £116.64 if investigations

are carried out and £68.49 if the patient is seen but no investigations are deemed necessary and no significant treatment is provided.

Cost of avoided appointments

Comparing the costs of the satellite units against the outcomes achieved reveals:

- The cost per A&E attendance avoided was £319.38
- The cost per walk-in clinic attendance avoided was £321.11
- The cost per GP appointments freed-up was £423.93

What is the value of outcomes

The table below shows the monetised value of net additional outcomes. These are then compared to input costs to provide the Return on Investment.

Overall for 12 month term of project

	all A&E scenarios	A&E - no investigation
Value of avoided A&E attendance	£790.006.69	£463,857.14
Value of avoided Walk-in Centre attendances	£232,471.55	£232,471.55
Value of GP appointments freed-up	£87,479.57	£87,479.57
TOTAL VALUE OF AVOIDED OTHER SERVICES	£1,109,957.82	£783,808.27
OVERALL COST OF THIS SCHEME	£2,163,095.00	£2,163,095.00
Rate of return (value of avoided other services divided by overall cost of this scheme)	0.51	0.36

In other words, in the "all A&E scenarios" assumption there is a £51 return for every £100 paid out; in the "A&E visit without investigations" assumption there is a £36 return for every £100 paid out.

Satellite Hub Economic Evaluation 2

An EE which assumes the take up rate for the 3 months October-December 2016 and projects this over 12 months

This calculation was done by applying the appointment take up rate over the 3 months July-September 2016 as if it had been in place for the entire 12 months.

All costs are the same but there are 27,350 appointments taken up

Overall for the last 3 months of the project

	all A&E scenarios	A&E - no investigation
Value of avoided A&E attendance	£903,895.36	£530,727.55
Value of avoided Walk-in Centre attendances	£265,985.04	£265,985.04

Value of GP appointments freed-up	£100,090.77	£100,090.77
TOTAL VALUE OF AVOIDED OTHER SERVICES	£1,269,971.17	£896,803.36
OVERALL COST OF THIS SCHEME	£2,163,095.00	£2,163,095.00
Rate of return (value of avoided other services divided by overall cost of this scheme)	0.59	0.41

In other words, in the "all A&E scenarios" assumption there is a £46 return for every £100 paid out; in the "A&E visit without investigations" assumption there is a £33 return for every £100 paid out.

Satellite Hub Economic Evaluation 3

An EE which models the costs if 90% of appointments are taken up. This is the current level of utilisation for GP appointments and represents what the ROI can be going forward. This calculation was done by applying a target appointment take up rate of 90 per cent for the entire 12 months.

All costs are the same but there are 37,616 appointments taken up

Overall with 90% uptake of appointments

	all A&E scenarios	A&E - no investigation
Value of avoided A&E attendance	£1,243,189.74	£729,946.27
Value of avoided Walk-in Centre attendances	£365,827.60	£365,827.60
Value of GP appointments freed-up	£137,661.76	£137,661.76
TOTAL VALUE OF AVOIDED OTHER SERVICES	£1,746,679.10	£1,233,435.63
OVERALL COST OF THIS SCHEME	£2,163,095.00	£2,163,095.00
Rate of return (value of avoided other services divided by overall cost of this scheme)	0.81	0.57

In other words, in the "all A&E scenarios" assumption there is a £81 return for every £100 paid out; in the "A&E visit without investigations" assumption there is a £57 return for every £100 paid out.

4.2.5 Conclusions and Recommendations

There have been 29,629 additional Satellite Unit appointments between Oct 2015 and November 2016. The Satellite Units were extremely popular with 93% of patients indicating that they were 'extremely likely' or 'likely' to recommend the service to friends and family if they needed similar care or treatment.

GPs recognised that non-urgent appointments were being allocated in the Satellite Units and the quantitative data showed that two thirds required care but not admission to secondary care services. Sheffield PMCF did not provide a definition of urgent care from the CCG and while Sheffield GPs recognised the benefits of Satellite Units for patients with urgent problems this restriction was not shared nationally where Phase 1 of the PMCF was used to increase capacity in the system..[12] GP's expressed a range of opinions about the operation of the new service including some frustration that the costs of service were being allocated to non-urgent cases.

In contrast the Family and Friends data suggests that the patients regarded the Satellite Units as extended access that provided a solution to the constraints of working/everyday life and, therefore, access to a GP. This is supported by the non-attendance rate which was low (1.8%) suggesting that the take-up was timely and valued by the patient population.

While some GPs did recognise that not all patients can attend a usual-working-hours appointment, this was not a universal view. The Family and Friends survey (N= 2120) demonstrated that the most deprived groups were more likely to use the satellites and that the majority of patients were 16-34 (young parents?). The Satellite Units therefore represent a service for the working population who are unable to use daytime GP services. There is widespread reporting of recent employment trends of an increase in zero-hours working contracts which provide no paid sick leave or time-off for healthcare visits. The poorest people, those most likely to have poor working conditions, were much more likely to consider A&E as an alternative to the Satellite Unit than better off segments of Sheffield society. Presumed lack of access also raises the question of preventative practices. For example, hypertension is often described as a 'silent' disease as there are no symptoms in the early stages and considerable research supports the benefits for both patient, and healthcare system costs, of early diagnosis.

Potential lack of access is further supported by data from the Family and Friends survey of Satellite Unit users open comments added to the survey. The patients commented about being in full-time employment and we suggest they may be in low-level jobs without paid sick leave and/or pressure to not take time off from work.

But the overall issue of additional capacity (i.e. the Satellite Units have quickly filled up) means there is a residual question related to how much more capacity is needed and is available, given the current usage and a finite level of investment. The Satellite Units have quickly established as part of

[12] Whittaker, W., Anselmi, L., Kristensen, S. R., Lau, Y. S., Bailey, S., Bower, P., ... & Hodgson, D. (2016). Associations between extending access to primary care and emergency department visits: a difference-in-differences analysis. PLoS Med, 13(9), e1002113.

Dolton, P., & Pathania, V. (2016). Can increased primary care access reduce demand for emergency care? Evidence from England's 7-day GP opening. Journal of Health Economics, 49, 193-208.

the GP additional workload and this constitutes 'more of the same' - traditional one-to-one GP appointment slots. The evidence suggests that the outcome of visits was 50% prescribing of medication and a further third was clinician advice. Is this manageable only by GPs? Or, as we highlight in the Supplementary Report are new ways of working needed.

One third of respondents to the Family and Friends Survey report that they would have gone to A&E if the Satellite Unit appointment had not been available. This is similar to the one-quarter estimated in the other evaluations conducted on PMCF Phase 1 programmes.

The removal of Advanced Nurse Practitioner shifts from weekends also supports the view that the extra hours are not for older patients with complex needs as the ANPs manage chronic conditions. Some surgeries have prioritised access and have managed demand without use of the Satellite Units. Further information about how these practices work, including the use of telephone triage and 'drop-in sessions' for those with complex social, as well as health, needs to be evaluated and shared if effective. The patients report high levels of satisfaction with locality based provision but patients who don't get appointments won't be reporting.

Patient representatives had limited knowledge of the new provision as it not widely communicated to patient and carer communities on the basis that the use of new provision is only at the discretion of GPs for use in critical and urgent cases. Patient representatives supported the new provision as an opportunity to offer a further appointment to children and those with acute infections at risk of very quick deterioration. In particular, in analysing the Family & Friends data, when taking all factors into account at the same time it is patients in the 0-15 age group who were most likely to say they would have gone to A&E. This is presumably their parents completing the survey and they do not want to take any chances with their child's health.

Overall the lack of data-linkage-based evidence to support reduced A&E attendance, and our reliance on patients self-reports of A&E as an alternative, means that we had to consider other avenues of evidence. As the Supplementary Report makes clear, GPs preference was to provide additional appointments in the practice rather than Satellite Units (see Supplementary Report) although some practices used the Satellite Units a lot. The GPs also raise the perfectly reasonable issue of sustainability and being involved in the decision making around the Satellite Units. The analysis presented here also raises questions about the nature of the patients using the Satellite Units and further investigation is needed to determine if there is indeed unmet patient need.

4.3 Primary Care Pharmacy

£730,000 - 01 October 2015 to 30 September 2016. Levels 1 and 2 engagement

4.3.1 Introduction

One session of pharmacist time (3.5 hrs) per week was provided to each practice signed up to the EPC. The work programme of the pharmacists was intended to free up GP time and provide quality enhancement by including the following menu of tasks: repeat prescription management; discharge medicines processing and liaison with primary care; structured medication reviews; shared care monitoring requirements; liaising with community pharmacies; supporting patients with long term conditions and complex medication issues; supporting patients in residential care. The patient mix in each practice should be related to the uptake and use of this scheme and it could be assumed that those with a greater proportion of older patients with complex care would appreciate the benefit more.

The PCP scheme was tested in a small number of sites between Jan and June 2015 after which it was deemed suitable for city-wide expansion. All surgeries that wished to engage were matched with a pharmacist and joint working arrangements put in place. Some practices already had a working relationship and this was retained. The menu of activities was based on core competencies of pharmacists as determined by the scheme manager:

- Release GP time by a medicines expert performing tasks currently carried out by GPs
- Support general practice prescribing with the provision of expertise from a pharmacist
- Improve patient outcomes such as: Increased patient safety, continuity of care and management of long term conditions
- Redefine and improve the potential of the patient-pharmacist relationship
- Support the best management and use of NHS resources such as reduction of waste.

4.3.2 Qualitative Findings

Reducing administrative demand on GPs is recognised as a core purpose of Pharmacy provision. GP's mainly used Pharmacists to manage medicines (e.g.., medication review, discharge reviews, dosette box preparation) and widely welcomed the additional resource. The community pharmacy scheme has been widely welcomed as a way to manage GP workload and to incorporate a core expertise into the surgery-based team.

> "*we have utilised that in that she comes and looks at all our discharge summaries, basically: the people who have just come out of hospital, making sure we've already gone through all the notifications that they liaise with patients, making sure that all the medicines are up-to-date and patients are aware of what they're supposed to be taking and everything else. That's actually been quite useful for us*" GP interview

> "*we're under a huge amount of pressure with paperwork and discharge summaries, and I think anything that helps that is a good thing. So generally the pharmacist that we've employed, which isn't with the Prime Minister's Challenge money, has helped because any medication changes on discharge summaries we hand them straight to her, which saves us time.*" GP interview

Receptivity to new pharmacy role was mixed and related to the perceived competency level of pharmacy support. GP's expressed a range of opinions about the access they had to pharmacy support and the use of that scheme in their practice. Those who are very supportive saw it as working well because the individual could take on independent tasks and work autonomously. Others suggest that it's not viable due to limited pharmacist time or they reported a lack of confidence in skills of pharmacists or the individual's skill. GP's receptivity to managing new staff and different disciplines also made a difference to the way the scheme worked.

> *"we already had a pharmacist within the practice who was working for us. She was able to extend her scope and range further, and she's been excellent, but that was partly because we had a very good pharmacist.*" GP interview

> "I *think the main thing he's done is try to take all our patients off 56 tablets for two months and put them onto 28, which is a bit frustrating when we've decided we want 56. And look at people being prescribed paracetamol. So he's not been a great asset, unfortunately. It felt quite limited in what we could do with him."* GP interview

> *"Because they need a lot of input, they needed help with using SystmOne and finding patients. They didn't really know what they were expected, you know, get an idea of what they could do. They needed a lot of input on a day-to-day basis when they were in."* GP interview

> "*I think it's really variable depending on, the same as anything it's really variable depending on what pharmacist you get, so some Pharmacists within other people's practices seem to be doing loads of stuff, you know, adding drugs that have been discharge summaries from hospital, doing medication reviews, that type of thing. And I think we've got quite a junior Pharmacist so I'm not sure at the moment that it massively reduces our workload but I could see how it could"* GP interview

There was an appreciation about the need to work as a team although this capability existed in some practices more than others.

Team development and pharmacy scope of role has been generated in the scheme, has produced some shared understanding of how community pharmacy and GP's working together, has characterised where the scheme has worked best. The opportunity for learning from this improvement pilot now remains, with an additional need to systematically profile the successful collaborations and build on the activity.

> "*quite useful because he's given us a bit of a perspective on what the community pharmacist want from GPs, you know. I think the pharmacist quite like because they get monthly prescriptions rather than two monthly prescriptions. We've had quite a lot of conversations with him about various other things that he could do in the practice.*" GP interview

Having a specialist input for medicines management was overall deemed to be helpful and was perceived as a quality, as well as a time-releasing, innovation. A number of GPs found the experience new and complained that the time to supervise and support outweighed the benefits but in the main the limitation was associated with the lack of familiarity and the need to

establish good team practices and management and governance methods to support individual practitioners

> *"we've used our community pharmacist for a wide variety of different tasks, including various audits and quiz work, that's on the prevention of asthma, and also polypharmacy. She's been used for expensive drug, to feed identification and she's been going into the nursing homes to do some education for the staff there on - so yeah, it's a wide range of different…".*

4.3.3 Quantitative Findings

We requested the original data (without patient identifiers) and conducted further analysis, beyond that done by the scheme itself, that examined the nature of the uptake by GP Practices. The following fields were provided in an Excel spreadsheet: SysID; Provision Date; Provider; ODSCode; Identifier; PatientLinkID; Surgery; Surgery AssocData; Role; Referred by; Setting; Menu Activity; Referred to; GP time saved; Alternative support; Record / Claim Status

The pharmacists listed 18,044 individual activities between 02 Oct 2015 and 01 Jul 2016. They also estimated the amount of GP time saved and the final calculation of this from the complete dataset is a saving of 3,171.25 hours of GP time.

The service provided to the practice could be by employee (community) pharmacist, locum or practice pharmacist, or by a pharmacy technician. 69% of activities were completed by an employee (community) pharmacist, 30.6% by locum or practice pharmacist, and 0.4% by a technician. The majority of referrals were from the GP, Practice Staff and Practice Manager (see Table 15) with only a small number of patients self-referring.

Table 14 Patients referral findings

Referred by	**N (%)**
GP	7336 (40.7%)
Practice Manager	1952 (10.8%)
Practice Nurse	290 (1.6%)
Practice Staff	7795 (43.2%)
Patient self-referral	340 (1.9%)
Pharmacist request	331 (1.8%)

The pharmacist could also refer-on a patient although 90.5 % of activities were managed with no referral. As Table 16 shows the majority of the remaining 9.5% were referred to the GP (5.4%) or to other staff within the practice (2.9%).

Table 15 Patients refered by pharmacist

Referral to:	N (%)
Managed, no referral	16,334 (90.5)
Discussed with GP or multi-disciplinary team	22 (0.1%)
Asked patient to come in	9 (0%)
Referred to GP	977 (5.4%)
Referred to other Practice staff	522 (2.9%)
Referred to outside clinicians	15 (1%)
Referred to other pharmacist	43 (0.2%)
Unfinished activity	12 (0.1%)
Missing data	110 (0.6%)

Pharmacists recorded the amount of time they spent on each activity and more than 2/3rds of the activities were completed within 10 minutes (see Table 17). There were some complex activities that took a great deal of time: two reviews were recorded as taking 3 hours and 6 were recorded as taking 2 hours. All of the activities that took a great amount of time included some combination of medication reviews, adherence review and/or reconciling discharge medications. 86% of the activities that took more than 1 hour of the pharmacist's time were managed completely by the pharmacist and required no referral or consultation with others.

Table 16 Pharmacists recorded time spent on each activity

Amount of time	N(%)
5 minutes or less	6703 (37.1%)
6-10 min	6390 (35.4%)
11-15	2572 (14.3%)
16-20 min	1296 (7.2%)
21-25 min	296 (1/6%)
26-30 min	536 (3%)
Half to 1 hour	223 (1.2%)
More than 1 hour	28 (0.2%)

As the qualitative interviews make clear, there was considerable variation in uptake by the Practices: median number of activities was 141 (range, 1-1059) and in median rate of PCP reviews per 1000 patients on list was 8.2 (range, 0.1, 286.4). There were temporal patterns in how the Practices engaged with the PCP that could be seen when we examined the monthly rates of use (per 1000 patients). We identified four patterns of engagement (see Table 18). One-fifth of Practices either didn't use the service at all or used it very infrequently. One-third of Practices started with the service and quit or used the service sporadically. For one-quarter of the practices usage built steadily and slowly and a final one-fifth were consistent high users.

Table 17 Pattern of uptake of Pharmacy Scheme

Pattern	N(%)
Consistently non or low user	17 (19.5%)
Tried and quit or erratic user	31 (35.6%)
Usage built slowly	21 (24.1)
Consistently high user	17 (19.5)

Amongst the 'consistently high users' group of practices the referral pathways tended to be from many different staff within the practice: GP, practice nurse, practice manager, other practice staff, or even the patient themselves.

It is also possible that the uptake is related to the characteristics of the patients in the practice or other reason associated after practice capacity or capability (see supplementary report).

4.3.4 Economic Evaluation

Assumptions and Parameters

Overall costs

The overall cost of the scheme was £336,364.00 .

Number of consultations

18,044 individual services were offered over the 12 months of the scheme. This equates to £18.64 per service

Hours of GP time saved

The scheme estimated that it save 3171.25 hours of GP time at a cost of £106.07/hour for a total of £336,374.49.

Overall for 12 month term of project

	GP time saved
Value of GP time freed-up (assuming 100% take up)	£395,707.93
OVERALL COST OF THIS SCHEME to 30Jun2016	£336,364.00
Rate of return (cost of avoided other services divided by overall cost of this scheme)	1.18

In other words, in the all GP-time assumption there is a £118 return for every £100 paid out.

4.3.5 Conclusions and Recommendations

The Scheme Manager estimated that PCP saved 3,171.25 hours of GP Time and we calculated that the return on investment was 1.18..

This scheme represents a significant achievement in relation to the primary goal of releasing GP time. The pharmacy professional community have welcomed the opportunity to extend practice and, in the best examples of uptake, integrate their professional work within a GP-led team. Indeed,

the pharmacy provision is an extension of the team practices reported in some surgeries and groups where multi-professional practice is well established.

The Primary Care Pharmacy Scheme was established on top of considerable existing variation in how pharmacists were used within the Sheffield Practices. Where the working relationship was already well established the scheme quickly became fully utilised. The pharmacist was, in some cases, used to reduce medication, polypharmacy management and more general assessment, medicine review and these were welcomed by some GP's. Other Practices were slower to go to full capacity and some just never bought-in to the scheme. This is likely due to a variety of factors including GP preferences for working style. Because the pharmacists were primarily community pharmacists the Scheme managers reported that it improved working relationships that spilled over into the rest of the working week.

The nature of the patients on the list (e.g., two practices are predominantly university students), is also likely to influence the use of pharmacist within the Practice. Staff understanding, and use, of inter-professional management and governance is also not well developed in some practices. Success also depended on individual skills and knowledge of the pharmacist (see supplementary report). Where the capability of the pharmacist was met with receptivity, and a knowledge and willingness from the GPs to work together, then the provision was very successful. Overall, 20% of practices were consistently high users from the start and another 24% steadily increased their usage. In contrast there was a 20% who were consistently low or non-user, and 36% were erratic users. This is entirely consistent with the usual pattern of adoption of new ways of working.

We would expect the pharmacist to be utilised more in practices that have a greater proportion of patients with complex care needs and this could be investigated further If data linkage was permitted. But there are a number of other unknown variable including : the level of existing medicine management in the surgeries which may be denoted by the level and complexity of prescribing practice.

4.4 Acute Same Day

£637,500 - 01 October 2015 to 31 August 2016. Levels 1 and 2 engagement.

4.4.1 Introduction

This scheme builds on the current city wide ‘same day appointment service’ that has been funded for 2 years through winter monies. Extra same day appointment slots were made available on a daily basis and patients requesting urgent medical help for acute conditions were booked into the extra slots at the nearest available practice to avoid patients having to be ‘slotted in’ to already full clinical sessions or having to be seen the next day. The level of funding was projected to provide approximately 31,875 additional GP appointments.

The Aim was to implement a city wide acute, same day service across Sheffield to reduce the number of patient contacts who have an acute condition.

4.4.2 Qualitative Findings

No data

4.4.3 Quantitative Findings

The scheme manager provided the following output data which has been reformatted for this report.

There is good uptake of the additional appointments and very low non-attendance rates (Table 19).

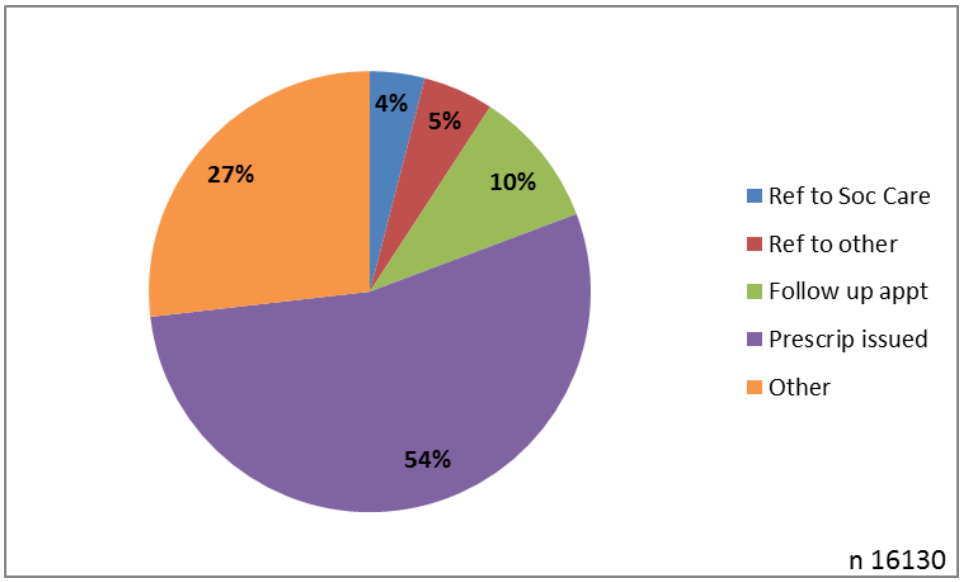
Table 18 Acute same day

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May*
Offered	3856	4979	4284	3832	4294	4728	4095	1168
Booked	3159	4045	3398	3183	3573	4017	3208	1363
% Booked of Offered	81.9	81.2	79.3	83.1	83.2	85.0	78.3	116.7
Attended	3068	3956	3313	3051	3333	3910	3101	1329
% Attended of Booked	97.1	97.8	97.5	95.9	93.3	97.3	96.7	97.5
Cancelled	8	21	39	13	8	37	11	4
DNA	79	77	75	59	61	51	52	22

* partial month

Over the length of the scheme the services provided are somewhat different from the Satellite Units (see Figure 10) with a greater proportion of of appointments issuing a prescription (54% v. the 12.6% in a Satellite Hub appointment).

Figure 8 Outcome of visit

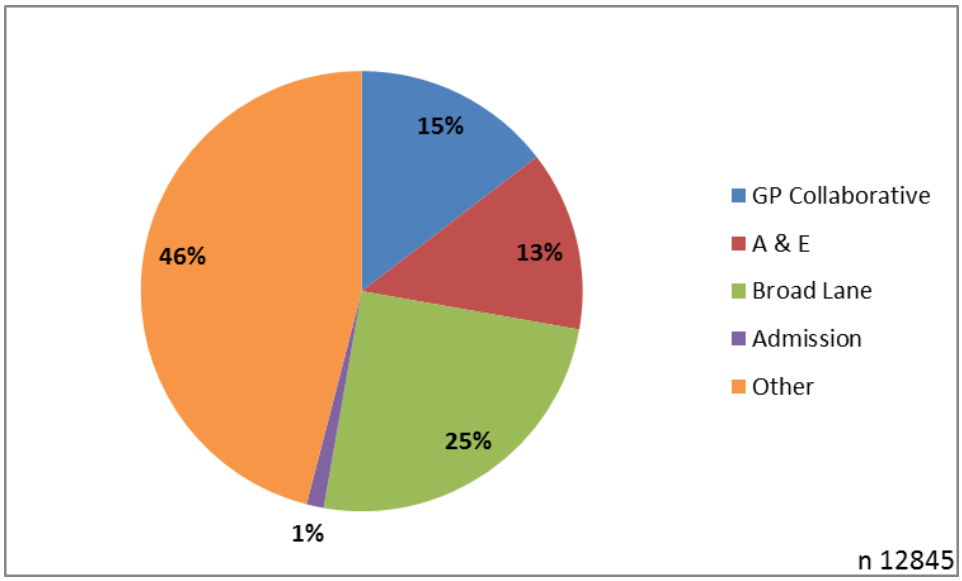


This may be due to differences in patient demographics but we cannot confirm this as these appointments cannot be separated out from regular appointments in the data systems.

Practice staff were asked to record what alternative service the patients would have used. One would expect to see differences between in-hours (this service) and out-of-hours choices for patients (se Satellite Units) and there are some (see Figure 11 and Table 11b). The proportion going

to the Broad Lane Walk-in Centre is similar to Satellite Units (see Family & Friends data in Figure 8) but only half as many patients say they would have gone to A&E. Again, without being able to examine the demographics of these patients it is difficult to determine whether this is because the patients are different or that time of day is relevant.

Figure 9 Where would the patient have gone if this scheme was not in place?



4.4.4 Economic Evaluation

Assumptions and Parameters

Overall costs

The overall cost of the scheme was £601,360.00 .

Number of Appointments

- 30,068 appointments were offered Oct 2015 to April 2016. This equates to 5011 hours. 24,583 appointments were bookede and 23,732 attended.

Cost Efficiency - the overall cost of the scheme divided by the number of appointments offered, book or attended.

- cost per appointment offered £20.00
- cost per appointment booked £24.46
- cost her appointment attended £35.34

Which alternate service would the patient have used?

- Data collected between Oct 2015-April 2016 in the scheme reported on a subset of patients that 13.3% would have gone to A&E, 25.1% to the Broad Lane Walk-in Centre and14.9% would have used the GP Collaborative. Applying these proportions to the total numbers of appointments there were
- 3170 A&E visits avoided

- 5948 Broad Lane Walk-in clinic appointments avoided
- 3532 GP Collaborative appointments freed-up

Scheme cost per avoided appointments - the total cost of the scheme divided by the number of prevented A&E, walk-in or GP collaborative visits

- cost per A&E attendance avoided £189.73
- cost per walk-in clinic attendance avoided £101.10
- cost per GP collaborative appointment freed-up - £170.26

Value of reduced demand on alternative services

- The value of GP collaborative appointments freed up is £119,625.83. This has been calculated by applying the GP collaborative cost per appointment (£33.87) to the estimated 3532 appointments which were freed-up
- The value of avoided Broad Lane Walk-in Centre attendances is £205,274.72. This has been calculated by applying the average cost of a Walk-in Centre appointment (£34.51) to the estimated 5948 appointments avoided
- the average cost of an A&E attendance is £116.64 if investigations are carried out and £68.49 if the patient is seen but no investigations are deemed necessary and no significant treatment is provided. For 3170 avoided A&E attendances this equates t0 £369,710.19 and £217,077.54,respectively.

Overall for 12 month term of project

	all A&E scenarios	A&E - no investigation
Value of avoiding an A&E attendance	£369,710.19	£217,077.54
Value of Walk-in Centre attendances avoided	£205,274.72	£205,274.72
Value of GP collaborative appointments freed-up	£119,625.83	£119,625.83
TOTAL COST OF AVOIDED OTHER SERVICES	£694,610.74	£541,978.09
OVERALL COST OF THIS SCHEME	£601,360.00	£601,360.00
Rate of return (cost of avoided other services divided by overall cost of this scheme)	1.16	0.90

In other words, in the "all A&E scenarios" assumption there is a £115 return for every £100 paid out; in the "A&E visit without investigations" assumption there is a £90 return for every £100 paid out.

4.4.5 Conclusions and Recommendations

It was difficult to determine in the interviews which additional appointments are being referred to (acute same day or satellite units) and to distinguish between the different schemes which provided additional capacity. When GPs complain about the Satellite Units, they may, or may not be thinking about this scheme which extended a previous scheme funded by winter monies. The data was poorly recorded in this scheme and it took quite a few reminders to get Practice staff to record the monitoring information.

And precisely because these appointments are just embedded into the daily appointment schedule we would not be able, if further analysis is permitted by NHS Digital in future, to determine if these appointments reduced A&E visits.

However, based of the data provided, this scheme is cost effective (ROI = 1.15). But, the outcomes suggest that different patients use the Acute Same Day Service and the Satellite Units. This needs further investigation

4.5 Social Work Out of Hours Assessment and Crisis Prevention Home Support Service

£377,750 (Out of Hours Assessors) + £177,216 (Crisis response support)- 01 October 2015 to 30 June 2016. Level 2 engagement

4.5.1 Introduction

The original remit was to establish a service capable of responding rapidly to emergency care referrals and which provides home care to people who are either new and/or existing users and who have been deemed by SPA, as requiring short term support to prevent an un-necessary hospital admission or unnecessary long-term-care admission. Additional social work staff were put in SPA to improve triage of primary care referrals (see also4.6.4) to dispatch social workers to provide timely community assessment and resolution.

The primary focus of this pilot was to provide response to emergency care referrals from primary care, through SPA, for people requiring short term support to prevent unnecessary admission to hospital or long term residential care and keep people safe and well in their own homes.

Specifically, the aims of the scheme were to:

- Demonstrate a reduction in hospital admissions for non-acute reasons
- Establish an effective single point of access for GPs to secure short term home support
- Support a person to stay at home for non-acute treatment
- Support carers in an emergency situation
- Determine if there is a demand for this type of service
- Determine if the market is able to respond to, and provide, a model of rapid home support delivery which is of good quality and value for money

The following were requirements in the draft contract

- Increase capacity in the Adult Social Care services to allow a rapid response to emergency care referrals between the hours of 7:00am and 11:00pm 7 days a week providing care and support in the home for existing users
- Increase capacity in the Adult Social Care services to allow a rapid response to emergency care referrals between the hours of 7:00am and 11:00pm 7 days a week providing care and support in the home for new users
- Provide the above support for a period of up to 8 days per service user at which point the service user will be transferred to alternative provision or discharged from the service.
- Reduce and avoid hospital admissions.
- Improve understanding, collaboration and shared learning between services in particular the community and voluntary sector.
- Patient and carer satisfaction with the service
- Staff satisfaction with the service
- Provide all data reasonably requested by PCS to enable evaluation of the project [scheme].

4.5.2 Qualitative Findings

The social work scheme was based on an identified need that GPs had "nowhere to go" with frail, vulnerable patients out of hours resulting in unnecessary admissions and sometimes

multiple admissions where admission of the person's carer-for is required. 18 social work (SW) staff were allocated to a 6 week shift pattern to provide support to adults over 18 with an out of hours social care assessment. Referral was from GP and Emergency care Practitioners (ECPs) via SPA.

The Social Worker met the care provider at a person's property and undertook a social care needs assessment. Care providers provided hands on service /ADL support for up to 8 days. The SW made a long-term needs plan in the same period and might also provide small aids (from a joint funded community store) and signpost or refer for therapy or further rehabilitation. They were also able to assess and fit a City wide Alarm (telecare).

Of the few GPs who mentioned the schemes the responses related to access and there seemed to be less than expected use of the scheme.

> *"Social work out-of-hours crisis response doesn't appear to be working or running- In the last two weeks I have had patients who have needed increased social care but it has been very difficult to access and I have been given the run around by social care."*
>
> *"I think the sound of the same day social worker and things like that sounded very good. I didn't have to use it but that sounded like it would be a really good idea."*
>
> *" Yes we have signed up but I haven't used"*

4.5.3 Quantitative Findings

The data was provided in a spreadsheet and variables provided were: Date (Referral); Time of Referral; Age; Ethnicity; Gender; Referrer (GP name and surgery); Service Requested (GP); Reason for Request; Service user type; Repeat Referral to CRS?; Referral outcome; Reason for refusal; Service Type; If a known client, Current Service in place; Date of Assessment Visit; Time of Assessment Visit; Within Two Hours? ; Reason (if not within two hours); Agency Providing the Service; Referral required for ongoing homecare?; Unpaid Carer?; Service requested by SPA (hours per day HH:MM); Service requested by SPA (no of days); Double Handed Calls? ; Assessment; Assistive technology; Service commencement from request for service (existing clients only); Start date of package; Date SAF and Grid completed; Proposed start date on SAF after 8 free days; Planned end date of service and call to be provided by INSPIRE; Actual end date of service by PROVIDER; Number of days PROVIDER have been in ; Exceeding 8 days? ; End date of six weeks; Proposed provider; Package requested for six weeks; Exit Route; Change to existing package; Satisfaction monitoring complete?; Carer: Satisfied overall?; Carer: Would they use CR again?; GP: Satisfied with availability of CR; GP: Would they refer again in the future?; GP: CR has prevented; Referral Completed by; Time taken from GP referral to Assessment; Indicative hours with PROVIDER in month; Total indicative hours with INSPIRE in month; Easting (of accepted referrals); Northing (of accepted referrals); Frequency; Neighbourhood; Ward; Contract Area; Month

The data supplied recorded 131 assessments (see Table 20) of which 65% (n=85) were female and 97% white British. Clients ranged in age from 47 to 104 (mean (SD) age 82.2 (9.7) years. There was a surprisingly wide representation from most to least deprived areas. The client had an unpaid carer in two-thirds of cases but service user type was missing in 50% of referrals and so cannot be commented on in this evaluation.

Table 19 Demographics of the Clients (n(%))

Gender	
Male	45 (34.4)
Female	86 (65.6)
Age Group	
<70	16 (12.2)
71-19	20 (15.3)
80-89	65 (49.6)
90+	27 (20.6)
Missing	3 (2.3)
Ethnicity	
White British	127 (96.9)
Other	4 (3.1)
Deprivation Quintile	
Least deprived	20 (15.3)
Pentile 2	16 (12.2)
Pentile 3	27 (20.6)
Pentile 4	25 (19.1)
Most deprived	35 (26.7)
Unpaid Carer	
No	38 (29.0)
Yes	87 (66.4)
Missing	6 (4.6)
Service User Type	
Older	62 (47.3)
Physical disability	2 (1.5)
Missing	67 (51.1)

The original remit had assumed that there would be increased referrals through SPA but as can be seen GPs have gone directly to the scheme. There were referrals from 53 different GPs based in 42 different surgeries (see Table 21). The most common type of service requested was a care package.

Table 20 Referral Information (n(%))

Who Requested Referral	
GP	65 (49.6)
Care Active Recovery Service	14 (10.7)
SPA/GP Collaborative	14 (10.7)
Family	8 (6.1)
Hospital	8 (6.1)
Ambulance/Emergency Care Practitioner	3 (2.3)
	9 (6.9)
Community Care	1 (0.8)
Care Home	9 (6.9)
Missing	
Service Requested	
Care package	112 (85.5)
Increase in care	13 (9.9)
Practical support	1 (0.8)
Support	4 (3.1)

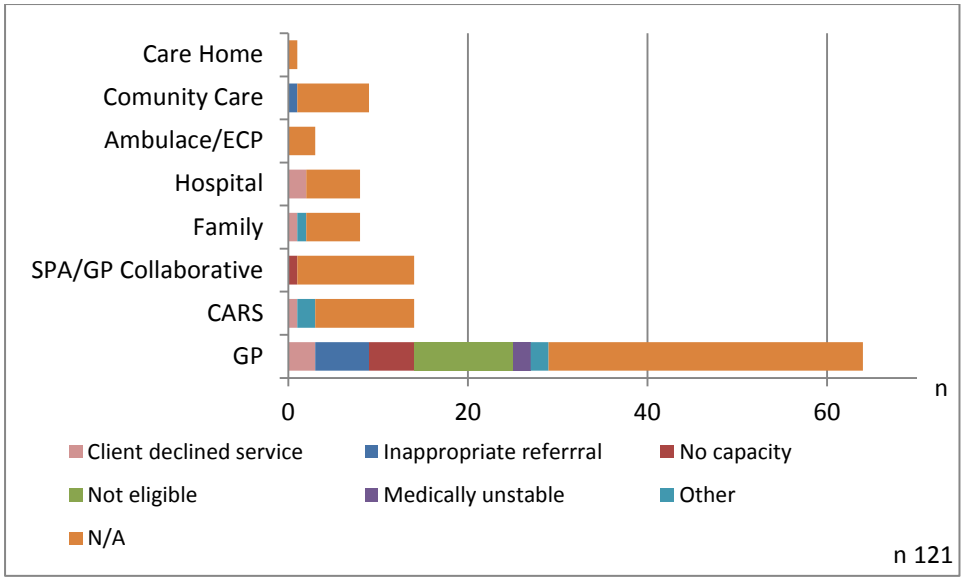
Missing	1 (0.8)
Reason for Request	
Carer Support	32 (24.4)
Deterioration	34 (26.0)
Social Care Support	65 (49.6)
Repeat Referral to CRS	
Yes	5 (3.8)
No	126 (96.2)
Referral Outcome	
Accepted	90 (68.7)
Rejected (see next table)	41 (31.3)
Referral required for ongoing homecare?	
No	40 (30.5)
Yes	83 (63.4)
Missing	8 (6.1)

This was a revamped service and the change in remit did cause some confusion as can been seen in the reason for refusal (Table 22 and Figure 12) and noted in the interviews. The referral pathway had changed but the GPs were unaware of this change and that SPA could have directed their referral to the correct pathway.

Table 21 Reason for refusal

	Frequency	Valid Percent
Client declined services	7	5.4
Inappropriate referral	7	5.4
No capacity	6	4.6
Not eligible	12	9.2
Medically unstable	2	1.5
Other	6	4.6
N/A	90	69.2
Total	130	100.0

Figure 10 Source of referral by outcome



4.5.4 Economic Evaluation

The data provided was not sufficient to do an economic evaluation for this scheme.

4.5.5 Conclusions and Recommendations

This scheme focused on crisis intervention with a narrow referral criterion. However, other schemes such as social prescribing were available and enabled this scheme to hold to a very specific remit. But, this evaluation must acknowledge that a critical problem arose that led to the closure of the scheme; the withdrawal (or end) of one of the private sector partners in the provision of social support following SW assessment. This makes any conclusion about effectiveness and viability difficult to evidence.

On the positive side, GP's could directly refer, and did so, in half of cases (65 out of 131)) although qualitative and quantitative data suggests that there was a variation in understanding of referral criteria and methods, as one third of GP referrals were rejected, (see Figure 12). This level of rejection was not seen in any other referral pathway.

Additionally, GPs expressed frustration expressed about the eligibility criteria and it this may be because many GPs are unaware of the range of social care options for their patients. SPA (see section 4.5.2) has expanded from its original remit and is now intended to be a 'one stop shop' for referrals to support GPs to facilitate the signposting and access to constantly changing range of health and social care provision. As with many other schemes in this evaluation, communication with GPs is difficult and a better understanding of the role of SPA in supporting their care provision is clearly needed.

Overall the reporting of referral for social care provision was uneven across schemes making it difficult to comment on "joined-up services".

4.6 Projects that Self-evaluated or Were Evaluated by Others

4.6.1 Roma

£107,250 - April 2015 to March 2016. Level 2 engagement.

Introduction

This scheme builds on, and learned from, current and previous projects from the Darnell Well Being Roma Community Workers and the Health Exchange Project in Sheffield. This scheme was initiated in Page Hall Surgery. The services was developed using a community development approach, with four health workers trained to work across 6 surgeries offering an afternoon clinic with support on 1st appointments including;

- GP registration
- Working with families to book and cancel appointments
- Signposting into services
- Work across wider health training schemes to promote health (e.g. smoke-free pledge)
- Hep B screening and health literacy training in sexual health (other sessions delivered by Sheffield Public Health)
- Making links with health trainers and across the wider system (e.g. *Introduction to Community Development and Health* community courses).

Key deliverables of the project were:

- Regular clinics and presence within primary care
- Health information sessions within local community settings
- recruitment and training of members of the Slovak Roma community
- Engagement of GP practices, Sheffield Children's Hospital and A&E

Qualitative Findings

No GP completing an interview had experience of the Roma scheme although we purposely sampled for those practices.

The scheme self-evaluated and reported:

> Feedback captured for almost 80% of patients: they are happy with the service and thankful of help at such an early stage in their move to the UK. Patients feel more listened to and able to express themselves as they can engage with someone from their own community who doesn't patronise or downplay their concerns (as reportedly happens on occasion with Slovak interpreters).

Quantitative Findings

No data was provided to the evaluation team but the scheme self-evaluation reported:

Sessions established at 4 sites: Darnall Primary Care Centre (monthly), Tinsley-Highgate Surgery, Firth Park Surgery, Page Hall Medical Centre (all weekly)

Total 584 recorded points of contact across 41 clinics: 18.5% of the total Roma patient population (3,158) – NB this does not capture where patients chose not to share contact details

25 Health Trainer referrals received via Health Trainers / SOAR's Social Prescribing scheme, York Road and Firth Park Surgery as well as from the Physio Team and self-referrals.

12 Training courses and 7 team meetings

Increased appropriate use of services and access to primary care: Supporting patients: explaining how system works (booking, cancelling, attending appointments), form-filling, signposting to advice, registrations at dentist/schools etc., managing minor ailments, screening uptake messages re. vaccinations / immunisations etc., supporting GP triage, diabetes management.

Economic Evaluation

No data was provided to the evaluation team but the scheme self-evaluation reported:

It is too early to establish genuine cost savings. However, there will be savings from: freed up GP and staff time, expensive interpreter costs, better use of services and drugs, fewer Roma health problems, less staff stress, fewer missed appointments etc.

Conclusions and Recommendations

The scheme self-evaluated - see Appendix 3

The Roma advocacy and health scheme has now come to an end under the auspices of the PMCF Programme (end March 2016) and has now been commissioned by the Local Authority and the CCG. The project has now run for longer outside of the Programme than it did within the Programme which is a sign of its success.

Locally, we have been told that this scheme has generated many other health improvement opportunities with community services, particularly relating to children's health.

4.6.2 Roving GP

£314,850 - October 2015 to March 2016 (West &HASC Localities); November 2016 to April 2016 (North and Central Localities). Levels 1 and 2 engagement.

Introduction

The Aim of the scheme is to reduce the number of non-elective admissions/hospital readmissions especially through medication review.

The scheme developers have based the scheme on is based on evidence that seeing a patient within 60 minutes of the visit-request reduces the likelihood of non-elective admission or hospital readmission by 50% (no citation provided). The Roving GP scheme began in Dover Court Surgery and was offered across the city. It uses additional hours of GP time to enable home visits and guarantees home visits within 1 hour of the request.

The teams focus on patients that have been discharged from hospital who receive a home visit or a telephone call to ascertain their post discharge health. Also, when patients contact their GP for an urgent visit, the visit request was triaged and, if appropriate, passed to the team for an urgent home visit.

Four rapid access teams working across Sheffield, providing urgent primary care home visits Teams consist of either a GP or an Advance Nurse Practitioner. Calls are triaged by the registered GP and if appropriate passed to the team.

Qualitative Findings

It has been accepted in most practices as an opportunity to share work and potentially reduce secondary care admissions by signposting to other care services (Social Work and District Nursing services). There is a variation in perceived need

> *"Really helpful- urgent care when the GP has to visit creates a real backlog for the surgery patients in clinic."*
>
> "*We don't get a lot of visits within our practice and the vast majority we'd sort out ourselves. So we haven't seen it as a huge advantage"*

Some practical challenges existed to do with the timing and criteria for referral and capacity

> *"We have had problems contacting the Roving GP*
>
> *"So roving GP when available I found, personally found that quite useful. Others doctors have said where they've rung the GP has not been at the right time of the day, or that roving GP has not been useful."*
>
> *"the hours of availability are not necessarily the hours that we need people and so again the duty doctor has gone to look for help and found it not there sometimes."*
>
> *"So the criteria was that it had to potentially prevent an admission, and the timings that they were here[i.e. available] were quite restricted".*

"The GP hadn't got the capacity to come over and visit my patient, and then get back and do his afternoon work, which is very disappointing really"

"It's probably two or three months we've not been able to contact them. We've tried to use them, so I don't know what happened there".

Some GPs recognise that the most vulnerable, house-bound patients are the ones that they want to prioritise; " they won't know my patient".

"haven't used the service we manage our own home visits mainly in the afternoons- these are the sickest patients and so we prioritise their care with 4 partners and 3 trainees this is possible"

Some practices have declined to use this service due to concerns about the lack of recurrent funding. Roving GP is planning an audit to substantiate a perceived positive response from patients.

Quantitative Findings

The data was supplied by the scheme and reformatted for this report. The large fluctuations in numbers may be from recording issues. Table 23 gives usage data for the scheme.

Table 22 Referrals seen & admissions avoided by area by month

			Month *						
	Area	**TOTAL**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Total no of refs seen	West	231	39	35	39	31	41	33	13
Total seen within 1 hour		203	33	27	31	31	37	31	13
No of potential avoided admissions		101				26	32	30	13
Total no of refs seen	Central	115		34	19	25	25	12	
Total seen within 1 hour		102		31	13	25	21	12	
No of potential avoided admissions		49				16	23	10	
Total no of refs seen	North	76		14	13	18	7	18	6
Total seen within 1 hour		55			12	18	3	17	5
No of potential avoided admissions		11				6	5		
Total no of refs seen	HASC	485		63	61	107	84	88	82
Total seen within 1 hour		420		37	30	105	78	88	82
No of potential avoided admissions		169				82	27	42	18
Total no of refs seen	All Areas	907	39	146	132	181	157	151	101
Total seen within 1 hour		780	33	95	86	179	139	148	100
No of potential avoided admissions		330	0	0	0	130	87	82	31

* It took some time to get reporting systems in place and in use

Economic Evaluation

Assumptions and Parameters

Overall costs

The overall cost of the scheme was £228,337.00 .

Number of consultations

907 over the 7 months of the scheme. This equates to £251.75 per visit

Hospital Admission avoided

The scheme estimated that it prevented 330 hospital admissions which means the scheme cost per avoided admission is £450.10. The scheme developers report on evidence that seeing a patient within 60 minutes of the visit-request reduces the likelihood of non-elective admission or hospital readmission by 50%.

The commissioner cost of an admission is £1,836.16 (range £75 to £52,932) so the total value of reduced admissions is £931,493.30 (From John Soady)

Overall for the term of the scheme (Oct 2015 to April 2016)

Value of avoided hospital admissions	£931,493.30
OVERALL COST OF THIS SCHEME	£228,337.00
Rate of return (cost of avoided other services divided by overall cost of this scheme)	4.08

In other words, in the all GP-time assumption there is a £408 return for every £100 paid out

Conclusions and Recommendations

GPs appear to highly value and prioritise schemes that deliver personalised care to their sickest patients. In the Surgeries that did not use or value Roving GP, they had this same priority and managed the demand for home visits themselves rather than use the new offered capacity.

Of those who used service there was a perception of value in 'external review' of care and additional 'second opinion ' about what was required.

The original remit explicitly mentions post-hospital discharge and shared synergies, and possibly savings, might be made by aligning this scheme with the Primary Care Pharmacy Scheme (Section 4.3)

There was a modest and steady number of referrals to this scheme but data provided make it difficult to draw any conclusions. We recommend that a mechanism be found to link usage of this service with hospital data to properly evaluate the impact on the secondary care system.

4.6.3 WebGP

£146,750 - start and end dates vary for each practice. Level 2 engagement.

Introduction

WebGP/EMIS is an e-consult (i.e., web based service) which sits on a practice website. Patients use the web-based system to access self-management information and check their symptoms. The system then signposts them to local services or a self-referral option. There is also an option for the patient to complete an e-consultation. The e-consultation takes the form of a health questionnaire which is then emailed through to the practice for action. The aim of the service is to reduce the need for face to face appointments with primary care.

Qualitative Findings

WebGP was not mentioned in any interviews.

Quantitative Findings

In total, 9 practices signed up to WebGP and sign-up was not related to level of participation in Program

The scheme provided an activity report There were 3634 sessions by 3183 users. The scheme estimated that it saved between a half and 3.5 appointments per week (see Table 24)

Table 23 Key Activity Report –Cumulative Activity Data up to 22nd May 2016

Hostname	Sessions	Users	Self-help	Pharmacy self-help	111 Page	e-consults submitted	Est appt saved*	Mean est appt saved /week*
Abbey Lane	63	57	5	1	0	16	9.6	1.2
Birley Health Centre	1280	1120	87	31	22	154	25.2	3.15
Carterknowle & Dore	841	746	86	29	21	175	33	4.1
East Bank	139	114	10	8	5	29	4.2	0.5
Gleadless	789	681	54	27	22	199	27.6	3.45
Tramways (Milner)	522	465	37	25	9	89	16.8	2.1
Total	3634	3183	279	121	79	662	116.4	

*Please note the data relating to potential appointments saved is only from the start of April 2016. Estimated appointments saved is based on approx. 60% of patients not being called in following their eConsult request which is based on data collected during the eConsult pilot.

The scheme also reported on 610 of the e-consults with the outcomes seen in in Table 25. One quarter of e-consultants resulted in advice, and one-third were "kept at home". A further 15% resulted in the issue of a prescription.

Table 24 Key Outcome of Internet Session –Cumulative Activity Data up to 22nd May 2016

	Area				
Outcome	West	Central	North	HASC	All Areas N (%)
Advice	83	0	1	71	155 (25.4%)
Follow Up with own GP	11	25	2	20	58 (9.5%)
Presc issued	11	12	7	61	91 (14.9%)
Ref to Sec Care	2	2	2	0	6 (1.0%)
Ref to other	14	0	0	20	34 (5.6%)
Admitted	5	2	1	25	33 (5.4%)
Kept at home	1	23	2	174	200 (32.8%)
Other	8	0	10	15	33 (5.4%)

Economic Evaluation

Assumptions and Parameters

Overall costs

The overall cost of the scheme was £49,000.00 .

Number of consultations

3634 internet sessions over the term of the scheme. These sessions resulted in 662 submitted e-consults. This equates to £13.48 per consultation or £74.02 per submitted e-consult.

GP appointments saved

The scheme estimated that it prevented 397.2 GP consultations. This means the scheme cost £123.36 per GP-appointment saved. The estimation of the number of appointments saved is based on approx. 60% of patients not being called in following their eConsult request which is based on data collected during the pilot for this project

Based on the national average GP cost per appointment (£20.80) the estimated value of GP consultations avoided is £8,260.42

Overall for the term of the scheme

Value of GP appointments saved	£8,260.42
OVERALL COST OF THIS SCHEME	£49,000.00
Rate of return (cost of avoided other services divided by overall cost of this scheme)	0.17

In other words, in the all GP-time assumption there is a £17 return for every £100 paid out

Conclusions and Recommendations

We have insufficient information upon which to draw any conclusions or recommendations.

4.6.4 Additions to Single Point of Access (SPA)

Introduction

Includes (all Level 2 engagement):

> **SPA Primary Care Access to Psychiatric Liaison** - also sometimes referred to as SPA Mental Health Workers - £283,587 - 23 November 2015 to 22 August 2016
>
> **SPA - Increased Clinical Triage and Signposting** - also sometimes referred to as Liaison Out of Hours Team - £390,785 (approximate) 01 October 2015 to 30 June 2016.
>
> **SPA Weekend Specialist Mental Health Support** - £278,054 - 09 November 2015 to 08 August 2016.

SPA has been in place since 2006 and grown incrementally. There are 26 work-streams including urgent and unscheduled care. Three main areas of activity: Nurses, admin staff, social care staff deal with GP referrals and recommend referrals to multiple services. They also facilitate calls to a geriatrician to either prevent or speed up admission. In October 2014 social care staff joined the team, and in November 2015 mental health workers out of hours were added to allow GPs refer into the service, offer alternative care packages to prevent hospital admissions, and/or facilitate the admission process. Funding from three schemes extended the provision of the older adult community mental health team, the home treatment team and the dementia rapid response teams.

For the SPA Primary Care Access to Psychiatric Liaison, funding provided additional capacity to the existing mental health liaison service being developed with the support of the CCG and resilience funds. This scheme extends the offer in primary care for older adults and increase the assessment capacity in the community. The intention was to avoid sending frail/vulnerable adults to A&E for a mental health assessment. The scheme provided:

- A direct referral route to mental health liaison assessment services through SPA
- Outreach to community and primary care to support holistic assessments
- An increase in specialist mental health nursing staff to cover min of 18:00-21:30pm Monday to Friday and 10:00-18:00 on Saturday and Sunday.
- Additional speciality psychiatrist time
- Increased mental health support worker - hospital avoidance and supported discharges to maintain a person at home.
- Increase perinatal mental health support

The SPA - Increased Clinical Triage and Signposting was funded to provide an increased number of call handlers, triage nurses, evening and night service nurses and health care assistants in SPA. This

increased capacity was put in place, particularly for the times that the new Satellite Units were operating and provides a service not previously available in SPA.

The funding for SPA Weekend Specialist Mental Health Support was for additional nurse capacity extending the weekend provision of the older adult community mental health team and the home treatment teams, including: the Functional Intensive Community Service (FICS) and; 2) Dementia Response Team (DRRT). This enabled the home treatment teams to accept new referrals at weekends to support primary care admissions avoidance and weekend discharges

The Social Workers Out of Hours Assessment and Crisis Prevention Home Support scheme also partially is SPA, was in partnership with Sheffield City Council and is covered in section 4.5 of this report as the data is different.

Overall, aims of the SPA-based schemes were to:

- Improve access to specialist mental health expertise for primary care out of hours.
- Provide weekend access to avoid admission and supported discharge
- Increase the number of patients receiving a same day response
- Increase the number of patient contacts delivered at weekends
- Reduced admissions to older-peoples functional mental health wards at weekends
- Improve coordination at all ages for home treatment, inpatient and liaison services at the weekend.

Qualitative Findings

SPA was relatively well understood as an access point for other services although the new services were not well differentiated from usual provision. It was anticipated that when Satellite Units were open, there would be additional demand for community services. Access to community services is through SPA so it was seen as logical to expand the existing SPA provision.

> *" We make a lot of referrals through that, bed bureau, district nurses"*
>
> *"They have a very holistic approach and an easily accessible provision of care has been good. It's been timely. Yeah, a single phone call can gain you access to the carers, nurses, pharmacists, physio, OT. It's been brilliant actually. I can't speak highly enough of that. The admin team are really helpful, and it's helped to keep a lot of patients that I've seen as part of the roving GP at home in their own homes, so also saving resources at the hospital"*
>
> *"The SPA works quite well - but I am unaware of any improvements in the service.".*
>
> *"I use single point of access. I mean it's mainly to admit patients. So I've used it twice tonight, but it's basically not to help me decide what to do with a patient, it's basically the route through which I have to admit patients. So I generally use them for admission to hospital. I use it to admit patients to hospital. That's the only way GPs can now admit patients to hospital is through SPA. If there's any extension to what SPA do over and above what they were two years ago I've not heard of anything The numbers of referrals are increasing and so far feedback is good. Monitoring data is strong for point of access*

and referral but less so for outcomes because there are a huge number of people involved once the patient is referred out of SPA. "

Quantitative Findings and Economic Evaluation

The nature of this service provision is such that separate records for each scheme do not exist, nor does the overall broader service collect any data. The data supplied by the Social Work Out-of-Hours Crisis Support Service is reported in Section 4.5.

In the monthly reports to the management board of the overall activity level in the scheme was lower than expected in terms of number of service requests. We were not able to confirm or refute this.

Conclusions and Recommendations

In the monthly reports to the management board of the overall activity level in the scheme was lower than expected in terms of number of service requests. The nuance of these three individual activities as separate schemes was not understood well and activity data was difficult to untangle from the larger service.

The unexpectedly low uptake may also be because the Satellite Unit patients are not the same patients filling up waiting rooms in-hours as there were many fewer older patients in the Satellite Unit Out of Hours service. The planning for the SPA expansion assumed frail, elderly and complex patients would take up the new Satellite Unit appointments.

The qualitative data suggests that GPs may not be using the service as effectively as they could and/or are unaware of what referrals pathways are available. The Social Work Out of Hours scheme (section 4.3) was able to provide both quantitative and qualitative data to support the assertion that the GPs do not distinguish between the various types of mental health, social and community care provision. A single point of referral is a good idea as it saves the GPs having to keep track of constantly changing social care providers and the range of options available.

We recommend a the development of a communication strategy **with** GPs to help them appreciate the value-added and to use SPA more effectively.

SPA do not hold any data in relation to final destination or outcomes of advice and so unable to evaluate the success of activity

4.6.5 Florence

£30,000 (approximately) - February/March 2016 - ongoing

Introduction

Florence is a text based tele-health system designed to increase patient involvement in the management of their conditions. This project expands Florence to primary care to monitor patients with hypertension with the aim of reducing the need for hypertensive patients to visit their GP for monitoring of their blood pressure.

Patients sign up to the scheme and are provided with a home blood pressure monitor. They are texted twice a day to measure their blood pressure and text the readings back to Florence. The values are flagged and supporting messages and blood pressure reduction activities (like reducing salt intake) are sent back to the patient.

The scheme was piloted in 4 practices in the North Locality from February 2016. The funding provided additional administrative support for the roll out to practices. To date 150 patients have been identified to be part of the scheme and 40 are currently being monitored. Additional Clinics are planned to enable remaining patients to be added to the scheme. Elm Lane Practice no longer taking part in the scheme.

Qualitative Findings

This scheme was not mentioned in any of the interviews.

Quantitative Findings

Patients are still being recruited and the scheme will self evaluate.

Economic Evaluation

No economic evaluation could be completed

Conclusions and Recommendations

There is no information upon which to draw conclusions. A mid-project note records that the scheme is self-evaluating

4.6.6 Improving Access to Psychological Therapies (IAPT)

£52,000 - This is an extension to a 'test of change' project that commenced in October 2014 with funding up to end March 2015. This funding was for 01 April 2015 to not stated. Level 2 engagement.

Introduction

IAPT is at national NHS scheme titled *Improving Access to Psychological Therapies* (IAPT). Regular IAPT schemes don't see people at home. This *Central Parks Integrated Community Nursing Project (Depression and Anxiety)* enabled dual trained Community Nurses to provide integrated mental and physical health interventions for the housebound, who were often older adults. The scheme ran in 10 practices: Sothall M/C, Park H/C, Mosborough H/C, The Medical Centre Crystal Peaks, Westfield H/C, Norfolk Park M/C, White House Surgery, Duke M/C, Manor Park, Owlthorpe M/C

Qualitative Findings

The scheme was not mentioned in the interviews

Quantitative Findings

In total, 10 practices were involved in the project. An interim report is available in Appendix 3. A further evaluation of the project is being undertaken within the NIHR CLAHRC (Collaboration and Leadership for Applies Health Research and Care) Yorkshire and Humber Mental Health and Co morbidities Theme.

Economic Evaluation

See Appendix 3

Conclusions and Recommendations

The evaluation being undertaken within the CLAHRC will help to inform conclusions and recommendations.

4.6.7 Community Volunteer Scheme

£80,625 - was not established as originally envisaged

Introduction

In January 2016 expressions of interest were sought by the end of January to develop options for community volunteers to support carers or cared for people to avoid hospital admissions and/or support discharges and to look at the role of primary care and care planning in meeting carers needs

The remit after revision was to use desk-based research and co-production with carers and cared-for, and voluntary providers to develop options and, where possible, small scale testing of these.

Qualitative Findings

This scheme was not discussed in the interviews

Quantitative Findings

no data was provided

Economic Evaluation

Not within the scope of this evaluation.

Conclusions and Recommendations

We have insufficient information upon which to draw any conclusions or recommendations.

4.6.8 Interoperability and Use of the Interoperability Gateway

£100,000 - 01 Oct 2015 to 30 September 2016. Levels 1 and 2 engagement.

Introduction

This funding was used to support the procurement and one-year licence fees for the systems to manage remote booking of appointments and sharing of the full clinical record

The procurement of *rota geek* and the *systm1* OOH[13] module has enabled the 4 satellite units to read and write records for patients from Systm1 practices. For patients from Practices which use the EMIS patient record system, the MIG is the interoperability solution which allowed the Satellite Units to have read only access to patient's records from EMIS.

The providers of the MIG state that it "also has the potential to enable records to be shared across secondary care, mental health and social care."

Primary Care Sheffield are working closely with the CCG and other stakeholders to roll this out although will likely take longer than the 12 months of the PMCF programme.

Qualitative Findings

No data was provided

Quantitative Findings

No data was provided

Economic Evaluation

Not within the scope of this evaluation.

[13] Systm1 is one of the providers of GP Practice record systems. OOH was a special module created to collect data from the Satellite Units.

Conclusions and Recommendations

We have insufficient information upon which to draw any conclusions or recommendations but lack of interoperability was a frequently reported issue and hampers many of the changes desired within the NHS.

4.6.9 Integrated Care Management Teams

£440,000 - February 2016 to 31 July 2016

Introduction

This scheme does not form part of the evaluation. The scheme is described in the extract below from Appendix 1.

> 4 service coordinators (1 for each locality) were employed to support practices to develop their integrated working (both between practices and with wider community services). In addition the 4 localities developed specific pieces of work focused on integrated working in their area. West, central and North practices are looking at how to better support housebound patients. HASC are to sign out the model of Shared Medical appointments.

Qualitative Findings

The scheme had not started when the interviews were carried out.

Quantitative Findings

No data was provided

Economic Evaluation

Not within the scope of this evaluation.

Conclusions and Recommendations

We have insufficient information upon which to draw any conclusions or recommendations.

5.0 Overarching Findings

The ECPC was set up and provided PCS with funding to pilot some new initiatives and extend some local existing innovations across all of Sheffield. In this respect, the programme represented a process of spread and adoption of innovations designed in primary care to enable the six key goals set for the programme:

1. "Care closer to home - Social Work Out of Hours; SPA Psychiatric and Weekend Mental Health; Florence; Roving GP; Community IAPT; WebGP
2. Increased availability of GP appointments for adults and children in practices and satellite units across the city (particularly targeted at areas of high A&E utilisation) - (EPCC; Satellite Units; City Wide Acute Same Day Service)
3. Further integration of health and social care services (Roma, SPA Weekend Mental Health, IAPT)
4. Improved transitions between services with better communication across the traditional providers of care, in and out of hours (Social Work Out of Hours; SPA triage and Weekend Mental Health; ICM)
5. Better utilisation of technology in care processes; to improve communication and information sharing across providers (Florence; WebGP; MIG)
6. Locally based innovations to address the needs of some marginal local communities and support people to manage their own care" (Social Work Out of Hours; Roma, WebGP; Community Volunteer)

Of the 16 schemes, anonymised patient-level quantitative data was available for 3 schemes (Satellite Units, PCP, Social Workers Out of Hours), aggregate usage statistics for another 3 schemes (Acute Same Day, Roving GP, Web GP), and so economic evaluations could be completed for those 6 schemes. Five schemes were discussed during the qualitative interviews (Satellite Units, PCP, Social Worker Out of Hours, Roving GP and SPA). Five schemes self-evaluated (Acute Same Day, Roving GP, WebGP, Roma and IAPT).

As a result of changes within NHS data agreements with the transfer of responsibility from HSCIC to NHS Digital there is a serious problem attributing any of the activity (e.g. appointments) to patient outcomes (e.g. hospital admissions or A&E visits) because of the lack of access to population and HES data. However, the activity data provided does allow us to draw conclusions and recommendations about how Satellite Units, PCP and Social Work Out of Hours are perceived by GPs and patients. This represents all sectors but does not provide conclusive evidence of the effectiveness of reducing the burden on A&E.

An economic evaluation found

- a financial benefit for the Primary Care Pharmacy, Acute Same Day and Roving GP schemes although we caution that none of the reported decreases in A&E attendance could be verified for the two schemes using that reported this an outcome.
- Once the uptake on Satellite Unit appointments reached 90% the return on investment was good (£81 saved for every £100 spent). As the scheme appears to be filling some unmet need for evening and weekend appointments for the working poor this could be regarded as a good investment.

- WebGP, with the data provided, does not appear to provide a financial benefit. However, this does not take into account the long-term benefits of alcohol, obesity and smoking awareness programmes.

5.1 Successes

The following schemes have been accepted and adopted by GPs and are recognised as contributing to programme goals (and have data associated with the investment)

- Satellite Units (Section 4.1) - between October 2015 and November 2016 (the scheme has been extended beyond the PMCF) the scheme has provided as additional 24,448 appointments with very high approval ratings from the patients. Although, GPs reported that many appointments were not urgent less than 1% were considered inappropriate. 3.3% of appointments led to direct hospital admission. Responses from the Family & Friends questionnaires collected from Satellite Unit users suggest that 30% of patients would have gone to A&E without the Satellite Units. The patient data also highlights that patients viewed the Satellite Units as an extended-hours service rather than an urgent service. The very high proportion of patients who are living in the most deprived areas suggest that this extended access provided a solution to the constraints of working/ everyday life and therefore access to a GP. The Satellite Units were officially extended with Government funding in Autumn 2016.
- The Primary Care Pharmacy scheme recorded 18,044 individual activities and calculated that this released 3,171.25 hours of GP time released which is a benefit. There was the additional benefit of specialist expertise in medicines-management. The pharmacy provision is an extension of the team practices reported in some surgeries and groups where multi-professional practice is well established and forms a good model for new ways of working.
- The Acute Same Day Service extended an existing programme and provided an additional 30,068 appointments of which 23,732 were utilised. The vast majority of these 'acute' appointments resulted in prescriptions and 1 in 6 of these patients reported that they would have gone to A&E, fewer than with the Satellite Units.

A separate data system was set up to support the Satellite Units and so the data was available for explorations. This contrasts with the Acute Same Day appointments which were incorporated into the usual appointment system and could not be extracted for analysis. Both Satellite and Acute Same Day appointments demonstrate the widely recognised evidence that increased capacity will quickly fill and, this increase in capacity doesn't necessarily discriminate for those with urgent healthcare needs and/or model any transformational change in the way GP's provide service.

Besides PCP, there are other schemes which were intended to change ways of working into a more collaborative model with multi-disciplinary teams. Like PCP some of these schemes had a pre-existing remit and GPs recognised and used these services. But, for some, there were confusions about the additional offer and this is reflected in uptake of the schemes. Perhaps more time and effort would have been needed to familiarise GPS with the new schemes. And their lack of knowledge about schemes is reported in this and the Supplementary Reports.

- Extensions to the Single Point of Access included: 1) Increased clinical triage; 2) access to psychiatric liaison and; 3) specialist mental health support. The difference between these three individual pathways as separate schemes was not understood well and activity data was difficult to untangle from the pre-existing service. In the monthly activity reports had lower than expected numbers of requests and the qualitative data suggests that GPs may not be using the service as effectively as they could and/or are unaware of what referrals pathways are available. Further communication of the offer from SPA to GPs is critically needed to facilitate the signposting and access to constantly changing range of health and social care provision.
- The Social Work Out of Hours Scheme (in partnership with Sheffield City Council) was designed to reduce hospital admission for healthcare for the patients or respite-relief for their carers. GPs who used this scheme spoke well of it but the scheme was ended by the withdrawal of one of the 3rd sector partners. The scheme supplied 131 assessments with GPs making 50% of the referrals and other primary care services providing the other half. The eligibility criteria for this service was restricted to social and respite need and 50% of GP-referrals were refused. The high rejection rate was not seen in other referral routes.
- IAPT is a well-regarded nationally as a mental health treatment pathway but this is a new approach that provides the service inside 10 GP Practices. It used dual-trained Community District Nurses to offer the intervention for mostly elderly patients. This scheme self evaluated.
- Roving GP (City Wide Rapid Access Team) was developed from earlier testing of the approach. It was expanded as part of the scheme to help GPs manage home visits for vulnerable patients. The data provided by the scheme estimates that 330 hospital admissions were avoided. This is a self-reported measure by GPs provided by the service and there is no objective means of confirming this data. The GPs that participated, value it highly although many GPs who weren't in the scheme expressed a preference to manage their own demand for home visits.

In addition there was the piloting of a community health and literacy programme in 6 Practices for a marginalised Roma-Slovak population that was successful in improving communication and health literacy in this demographic group.

Learning has arisen from the inclusion of knowledge-management solutions and interoperability contracts in the original remit. The findings on this highlight the opportunities and weaknesses in the current IT systems but change is constrained by the changing national picture.

5.2 Challenges and Limitations

There are some important challenges and limitations and these are to be expected in a project of this scale and complexity and should constitute further learning opportunities.

- The Programme was too complex with 87 GP Practices and 16 schemes.
- There was insufficient organisational development of pathways . to engage all GPs effectively with all new .schemes. Some were confused about the complex offer and this limited the number of patients who could benefit in some schemes.

- There were insufficient communication pathways to, between, and from GPs to the PCS prior to and during the Project. Future schemes would benefit from more extensive programme-level communication and formative organisation learning (i.e., tell people what is happening).
- There was a problem with data completeness and the nature of what data was recorded in all schemes. And, the evaluation team were unable to collect and collate data on outcomes and impact across the target populations.
- This evaluation was severely hampered by the national turbulence around NHS data but there is a chronic inability at CCG level to understand the restrictions and lack of skills at the scheme level around data. This includes sharing, extraction, analysis, and linkage. Even before the switch from HSCIC to NHS Digital existing NHS data rules would have required that these schemes have data sharing agreements which were not always in place.
- Interoperability of the IT systems resulted in read and write functionality on SystmOne but read only for EMIS. This problem was seen in the national evaluation as well.
- An economic evaluation requires good data of both the schemes activity and for the entire population of the region served. This was not available at this time.
- Future schemes would benefit and should be underpinned by an integrated care model to reduce problems associated with service fragmentation and allow GP's and others to recognise and use the range of providers across the primary and community services.
- Many GPs reported in interviews that they would prefer to manage the care of local patients within their own surgeries and using their own staff. Some practitioners saw the opportunity to collaborate across practices as a beneficial outcome of the SEPCP. See the Supplementary Report for the full analysis.
- Programme delivery, typically short term, made effective Process Evaluation and data clarification very challenging which limited the level of shared critical thinking.

6.0 Recommendations

There are a number of key recommendations to both the Sheffield CCG and to PCS that are made on the basis of the evaluation activity and outcomes. These were shared with the SEPCP Board and those that received their endorsement have been retained as a means to continue learning about systems change and transformation and to learn lessons to support further programmes. Further findings and analysis about the specific perceptions and key factors about retaining GP involvement is contained in the Supplementary Report. This highlights the need for reliable referral and feedback processes for new schemes that are co-designed **with** GPs. This would ensure that innovations are piloted before rolling out as a standardised offer across community and primary care.

6.1 Across primary care there is a limited capability around data. Specific expert advice is needed to identify relevant, valid, reliable and possible data related to outputs and outcomes. This would result in a convincing evidence-base to facilitate transformational change across community and acute care. 'Experts' should include patient representation to identify the desired outcomes relative to quality of life and well-being.

6.3 Further investment in leadership capacity was recognised as a continuing need across the services and specific reference to systems leadership and improvement capability is likely to facilitate learning and organisational change.

6.4 A central referral service (here offered by SPA) for health and social care removes the burden from GPS to to keep up with the changes in how community and social care are provided and who is providing the service (e.g. 3rd sector contracts). As the NHS outsources and integrates services, the systems and process offered by central referral services are going to be increasingly needed.

6.5 Locality managers have been influential in sharing understanding and supporting the evaluation , providing a the broader perspective on the culture and current ways of working in primary care. Their knowledge could be shared further to support systems- learning and developing the interface with community and secondary care and their influence at CCG level could be further enhanced

6.6 The majority of GPs recognise their own ways of working and have less knowledge and skill (and some would say power) to influence integrated care planning. Workforce development in primary care with general practitioners may include a range of organisational learning initiatives including:

- sharing of successful local innovation
- the establishment of evidence of successful innovations
- mobilisation of knowledge based on research evidence

Future roll-outs should be staged such that the most innovative practices are recruited first, followed by those who buy-in once some evidence of benefit is provided. Data from this evaluation could be used to design an approach strategy to more effectively engage GPs in future change.

6.7 Demand management strategies for complex case management are working well for a number of innovative primary care groups and resulting in better access for patients. These initiatives are local and need evidencing - particularly in relation to the impact on demand for out-of hours care and then dissemination regionally and nationally

7.0 Evaluation Team

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Appendices

Appendix 1- PMCF Business Case Summary Descriptions February 2016 (prepared by PCS staff)

Appendix 2 - Slovak Roma Health Project: Report Date February 2016

Appendix 3 - PMCF Central Park CN Project - Paper for Board Jan 2016

Appendix 4 - Evaluation of the Sheffield Enhanced Primary Care Programme, Interim Report - March 2016

Appendix 1 PMCF Business Case Summary Descriptions and Interim Recommendations February 2016

(prepared by PCS staff)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
1	Enhancing Primary Care Contract	This is a scheme for practices in Sheffield. It is a non-recurrent contract and whilst parts of it may continue beyond 15/16 (depending on evaluation), some of it will be for initial engagement with "new ways of working". By signing the contract practices have committed to standardising delivery of primary care in core contracted hours (08:00-18:30) and to engaging with the enhanced services being developed through the PMCF in Sheffield. It also includes practices commitment to providing clinical shifts for the satellite units.	2,935,000 **START DATE 01.10.15** **END DATE 30.09.16**	Board conversation – will be essential for longer term engagement of practices	• Strategic practice engagement at scale • Providing time, facilitation and practical support for Practice Development and federated working (SI)
2	Satellite Units (4 sites)	4 new satellite units have been opened (based in existing GP practice premises and the GP collaborative at NGH) providing urgent primary care appointments out of hours (evening and weekends). These work alongside the existing walk in centre and GP Collaborative Service. Each unit will (as	831,677 **START DATE 01.10.15** **END DATE 30.06.16**	Activity: • GP appointments – 6448 appts offered, 3046 booked, overall utilisation to date 47.2% • ANP appointments – 4761 appts offered, 1079 booked, overall utilisation to date 22.7% • Key activity shows 48% of activity within the Satellite Units relates to	• Improved Access for patients (SI) • Reduction in A&E attendances (adults and children) and reduction in Walk in Centre Attendances (IS) • Redistributing urgent (in hours) demand for GPs (SI)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		a minimum) be staffed by a receptionist, a nurse practitioners and a GP. It is estimated that this will provide approximately 16,500 additional OOH GP appointments (15 min slots) and 33,500 Advanced Nurse practitioner apt (15 mins) in 9 months. Changes to date: • Due to low utilisation of ANP slots changes were made on 30 November, to remove the Saturday afternoon and Sunday shifts from Woodhouse and Crookes. • 23 January the ANP weekend shifts Sat and Sun 10-6) will be removed from all Satellite Units		prescribing medicine and 43% clinical advice (Nov – Dec) • The under 12s account for 34% of the activity (Nov- Dec) • 78% of total activity or 2154 patient contacts (Nov-Dec) resulted in 'no further action for practices' with only 10% (370 patients) needing to contact their own GP • Friends and Family results extremely positive. 95% of respondents stated they were either extremely likely or likely to recommend the service • 32% (192) of respondents would have attended adult A&E if they had not had this appointment, 24% (143) would have waited to see their own GP and 27% (163) would have attended the WIC • A&E attendance figures yet to be analysed **RECOMMENDATION:** **Continue testing** Options for further testing • Expansion (post PMCF) to in hours	

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
				provision • Needs to be provided 7/7 but not the same capacity every day • Broaden skill mix e.g. clinical pharmacists etc.	
3	Social Workers Out of Hours Assessment and crisis response home support	Additional social work staff have been put in place to improved triage of primary care referrals into SPA (with a potential to despatch social workers to provide timely community assessment and resolution). Also included within this scheme is funding to enable the installation of assistive technology at the point of need. The crisis response home support provides response to emergency referrals form primary care through SPA for people requiring short term support to prevent unnecessary admission to hospital or long term residential care, thereby keeping people safe and well in their own homes.	£378,750 (OOH Assessors) £177,216 (Crisis response support) **START DATE 01.10.15** **END DATE 30.06.16**	Of the 56 referrals received, 37 have been accepted into the crisis response home support service (Nov / Dec). Providing 225 hours of care (202 hours care for new users, 23 additional hours for existing users) It is estimated that this has avoided 31 hospital admissions. No emergency respite avoidances have yet been reported. To date at least 31 practices have used the service – this does not include referrals through the GP collaborative out of hours. The capacity for new service users is well utilised with 80-100% used every week.	• Improved Access and timeliness of response to social care packages (SI) • Reducing avoidable adult emergency admissions to hospital for social care reasons (IS) • Reducing risk and cost of social care support in the longer term(IS) • Reduce risk of deterioration of patients (IS)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		Referrals accepted into the rapid response service are picked up within 2 hours of the referrals being received and can receive care for up to 8 days. The service is available 7:00am – 11:00pm 7 days a week and provided by independent sector providers		Utilisation by existing service users is poor – only about 10% per week is used. **RECOMMENDATION: Continue both elements of the scheme (assessors and crisis response).** **Need to consider how to improve utilisation in existing service users and/or potential to change of contract to shift resource to focus more on new service users.**	
4a	Single Point of Access – Increased Clinical Triage, Signposting	The funding has provided an increased number of call handlers, triage nurses, evening and night service nurses and health care assistants. This additional capacity has increased the capacity for call handling and triage in SPA, particularly around the times that the new satellite units are operating and includes provision for mental health workers to be involved in the triage process (8am-10pm) which is something not previously available in SPA.	420,785 (approx. 30K of this is Florence costs shown below) **START DATE 01.10.15** **END DATE 30.06.16**	Although workload has increased in both SPA and in the evening and nights service we are unable to date to show evidence that the capacity is directly supporting Satellites, therefore, subject to review in contract period. **RECOMMENDATION: Continue - with action to review referral and utilisation data provided by STH to ensure contract agreement is met and services can be evaluated**.	• Improve the joining up of services and improved access to them (SI) • Improving access to Mental Health and Social Care specialist advice (SI)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
4b	Expansion of the Florence system to primary care	The use of Florence (a text based tele health system designed to increase patient involvement in the management of their conditions) across primary care in the city is also being introduced piloting in 4 practices in the North of the city from February. The funding requested will provide additional administrative support for the roll out to practices.	Approx. £30,00k (dependent upon BP monitor costs) **START DATE FEB/MAR 16** **END DATE JUL/AUG 16**	4 practices have been identified and a band 6 nurse to support them has been recruited. Expect to start recruiting patients in Feb 2016. End date dependent on recruitment schedule. **RECOMMENDATION: Continue in life of programme.**	• Increase self-management (SI) • Reducing practice demand for patient cohort(SI)
5	Community Volunteer Scheme	Expressions of interest are to be sought by the end of January to develop options for community volunteers to support carers or cared for people to avoid hospital admissions and/or support discharges and to look at the role of primary care and care planning in meeting carers needs Developing the options will include desk based research and co-production with carers and cared for and voluntary providers and where possible small	£80,625 **START DATE FEB 2016** **END DATE AUG 2016**	This is now time limited work (6 months) to assess carers support needs **RECOMMENDATION: Continue as per plan and feed findings into relevant strategic links**	Research / Audit

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		scale testing of the options.			
7	City Wide Rapid Access Team (Roving GP)	Four rapid access teams working across Sheffield, providing urgent primary care home visits When patients contact their GP for an urgent visit, the visit request will be triaged and if appropriate passed to the team for an urgent home visit. As well as urgent appointments the teams will also focus on patients that have been discharged from hospital to ascertain their health state in an effort to reduce readmissions.	314,850 **START DATE OCT 15 (West & HASC)/ NOV 16 (North and Central)** **END DATE MAR (West & HASC)/ APR 2016 (North and Central)**	Activity: • 317 referrals made to the rapid access teams of which 214 were seen within one hour (67.5%) • On a crude approximation of referrals seen within a 12 week average period utilisation is around 50% • Number of admissions avoided as a result of the visits to be analysed (at evaluation) **RECOMMENDATION:** • **Continue testing (in isolation not beyond PMCF)** • **Make links to 'in hours' Satellite Units beyond PMCF**	• Reduction in A&E attendances (adults and children) and reduction in Walk in Centre Attendances (IS) • Reduced demand on practices (SI)
8	City Wide Acute, Same Day Service.	The service is delivered through all 87 practices in Sheffield, extra same day appointments slots are being made available on a daily basis and patient requesting urgent medical help for an acute condition will be booked into these slots at the nearest available practice to avoid patients having to be 'slotted in' to already full clinical	637,500 **START DATE 01.10.15** **END DATE 31 AUG 2016**	Activity: • Oct and Nov activity data shows 8835 appointments offered 7204 appointments booked 7024 appointments attended (80%) • Incomplete outcome data submitted by practices during October and November • Appropriateness of referrals to be audited	• Improved access (in hours) to primary care (SI) • Redistribution of workload (SI) • Practices Working together (SI)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		sessions or having to be seen the next day. The scheme builds on the current city wide 'same day appointment service' that has been funded for 2 years through winter monies. This funding will provide approximately 31,875 additional GP appointments.		**RECOMMENDATION:** • **Continue testing** • **Don't see continuing on its own post PMCF**	
9	Primary care access to psychiatric liaison	Providing additional capacity to the existing mental health liaison service being developed with the support of the CCG and resilience funds. This extends the offer in primary care for older adults and increase the assessment capacity in the community, rather than sending frail/vulnerable adults to A&E for a mental health assessment. The funding would provide: • A direct referral route to mental health liaison assessment services (through staff based in SPA) • Outreach to community and primary care to support holistic assessments	**283,587** **START DATE 23 NOV 2015we** **END DATE: 22 AUG 2016**	**Activity to date:** The workstreams started in November and data remains incomplete. **SPA MH workers**: 29 referrals have been made through the MH workers in SPA since November start – all but one through GPs. No outcome data available at time of report. **Perinatal Service**: In November received 2 referrals (one from A&E, one from a GP). **Liaison**	• Improved access to MH liaison in and out of hours for primary care (SI) • Reduction in A&E attendances (IS) • Possibly reduction in admissions to STH and/or SHSC (IS)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		• An increase in specialist mental health nursing staff providing input to the whole age range by 2.0 WTE. Staff to cover min of 6:00pm-9:30pm Mon-Fri and 10am-6pm Sat/Sun. • Additional speciality psychiatrist time • Increased mental health support worker led hospital avoidance / supported discharges to maintain a person at home. • Increase perinatal mental health support		No referral data available at time of report **RECOMMENDATION: Continuation of workstream with action to review referral and utilisation data provided by SHSC to ensure contract agreement is met and services can be evaluated**.	
10	Weekend Specialist mental health support (general and older adults)	Additional nurse capacity extending the provision of the older adult community mental health team and the home treatment teams (Functional Intensive Community Service – FICS and Dementia. Response Team – DRRT) over the weekend. This enables the home treatment teams to accept new referrals at weekends thereby supporting primary care admissions avoidance and weekend discharges	278,054 **START DATE 09.11.15** **END DATE 08.08.16**	**<u>Activity to date:</u>** The workstream started in November and data remains incomplete. To date the referrals recorded have come from the community mental health teams (2) , the OOH team (1) and Older Adult liaison psychiatry (2) **RECOMMENDATION: Continuation of work stream with action to review referral and utilisation data provided by**	• Improved access for weekend out of hours specialist mental health support (SI) • Reduced admissions and A&E attendances (IS)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
				SHSC to ensure contract agreement is met and services can be evaluated.	
11	Training Community Nurses to provide IAPT interventions for housebound patients	Integrated community nursing (ICN) scheme to be delivered by community district nurses who have been trained and qualified as IAPT Psychological Wellbeing Workers. The nurses will provide physical and IAPT mental health interventions to people who are housebound and therefore unable to currently access IAPT services in GP Practices. This would be an extension to a test of change project that commenced in October 2014 with funding up to end March 2015.	52,000 **START DATE 01.04.15** **END DATE 31.03.16**	**Activity to date:** 62 referrals have been received by the nurses, 44 of which were appropriate and taken onto caseloads, leading to 155 direct patient contacts. A report is due at the end of January to show outcomes. **RECOMMENDATION – Due to small scale of the programme, results are too small to extrapolate for a city wide model and therefore should stop at end of March.**	• Improving access for housebound patients with a mix of physical and mental health needs (SI) • Workforce development (WD)
12	Primary Care Pharmacy Programme (PCPP)	The scheme will be delivered by pharmacists and pharmacy technicians providing support to GP practices across the city. The model places the pharmacist initially within a practice for their sessions with the potential for remote working where criteria around	730,000 **START DATE 01.10.15** **END DATE 30.09.16**	Activity: • Very positive data received to date • 4022 patient interventions carried out • Estimated 700 hours of GP time released to date • Only 5% of patient contacts resulted in referring the patient to the GP	• Improved patient outcomes on long term medication (SI) • Reduce prescribing spend (IS) • Reducing medication related admissions / readmissions (IS) • Release of GP time (IS)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		IT and information governance are met. The support will be made up of a menu of tasks, including: • Repeat prescription management • Discharge medicine processing (and liaison with secondary care) • Structured medication reviews • Shared care monitoring requirements • Liaising with community pharmacies • Supporting patients with long term conditions and complex medication issues • Supporting patients in residential care		• 33% relate to Repeat Meds • 15% relate to Medication Reviews • 31% relate to TTO (reconciled discharge meds) Options for further testing: • Expanding menu to include: - domiciliary support - data sharing practice and pharmacist **RECOMMENDATION:** **Continue testing**	• Testing benefits of working with clinical pharmacists (WD)
13	Interoperability and use of the Medical Interoperability Gateway (MIG)	The procurement of rota geek and the systm1 OOH module has enabled the 4 satellite units to manage remote booking of appointments and sharing of the full clinical record (for patients from Systm1 practices) read and write. The funding through the PMCF will pay for licences for 12 months.	£100,000 **START DATE (for S1 and Rota Geek) 01.10.15**	1. Rota Geek and Systm1 procured and in place. 2. Procurement of MIG for use in the Satellite Units (to improve access to EMIS records) to be completed by end of February 2016 3. Partnership with CCG to develop Sheffield digital roadmap and information sharing agreements	• Patient Safety (SI) • Reduced duplication and save clinician time (IS) • Improved Communication and collaboration (SI)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		The MIG is a managed secure gateway for exchanging real time data between systems, providing a secure mechanism, residing in the N3 network. The MIG is the interoperability solution which will enable the Satellite Units to have improved (read only) access to patient's records from EMIS practices. The MIG also has the potential to enable records to be shared across secondary care, mental health and social care. PCS are working closely with the CCG and other stakeholders to roll this out (though will likely take longer than the 12 months of the PMCF programme)	**END DATE (for S1 and Rota Geek) 30th SEP 2016**	across all practices – on-going. **RECOMMENDATION: Licences purchased for 12 months- therefore continue to end of programme. Continue relationship with CCG and development of city –wide digital roadmap and information sharing**	
14	WebGP	WebGP is a web based service (which sits on a practice website). It enables patients to access self-management information, symptom checker and signposting to local services and self-referral option. There is also an option	146,750 **START / END DATES – variable dependent on**	**Activity To date:** 2990 individual users have completed 3339 sessions on Web GP. Of those, 323 completed online questionnaires requesting a response from their GP.	• Improved supported self-care (SI) • Reduced demand for GP /practice nurse appointments (IS)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		for the patient to complete an e-consultation. The e-consultation takes the form of a health questionnaire which is then emailed through to the practice for action (to provide a prescription, follow up phone consultation or bring patient in for an appointment).	**start date of each practice)**	Outcome data not yet available for these completed questionnaires **RECOMMENDATION: Continuation as planned and potentially expand to other practices for 6 months if EMIS can provide short contracts.**	
15	Integrated Care Management Teams	4 service coordinators (1 for each locality) have been employed to support practices to develop their integrated working (both between practices and with wider community services). In addition the 4 localities are developing specific pieces of work focused on integrated working in their area. West, central and North practices are looking at how to better support housebound patients. HASC are to sign out the model of Shared Medical appointments.	£440,000 **START DATE FEB 2016** **END DATE 31st July 2016**	Outline Service Level Agreements are being drafted prior to go live in Feb 2016. The 4 Service coordinators start in post on 1st February 2016. **RECOMMENDATION: Continuation as planned**	• System and Workforce development (SI) • Mapping of Services (SI)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
16	Roma Advocacy and Health Project	The business case requests funding for Roma Health and Advocacy Workers and Link workers building on and learning from current and previous projects in Sheffield (Darnell Well Being Roma Community Workers and the Health Exchange Project). The scheme will support the health educational needs of the Slovak Roma Community in Sheffield, working with primary care and other agencies to address wider determinants of health and build capacity and resilience within the community. Key deliverables of the scheme will include: • Regular clinics and presence within primary care • Health information sessions within local community settings • recruitment and training of members of the Slovak Roma community • Engagement of GP practices, Sheffield Children's Hospital	107,250 **START DATE APRIL 2015** **END DATE March 2016**	Activity: • **Sessions established at 4 sites**: Darnall Primary Care Centre (monthly), Tinsley-Highgate Surgery, Firth Park Surgery, Page Hall Medical Centre (all weekly) • **Total 584 <u>recorded</u> points of contact across 41 clinics**: 18.5% of the total Roma patient population (3,158) – NB *this does not capture where patients chose not to share contact details* • **25 Health Trainer referrals** received via Health Trainers / SOAR's Social Prescribing scheme, York Road and Firth Park Surgery as well as from the Physio Team and self-referrals. • **12 Training courses and 7 team meetings** • **Increased appropriate use of services and access to primary care<u>:</u>** Supporting patients: explaining how system works (booking, cancelling, attending appointments), form-filling, signposting to advice, registrations at	• Improved appropriate access for a specific population (SI) • Save GP time (IS) • Reduction in A&E attendances (adult & children) (IS) • Improved linkage of Primary Care to 3rd sector (WD)

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		and A&E		dentist/schools etc., managing minor ailments, screening uptake messages re. vaccinations / immunisations etc., supporting GP triage, diabetes management. It is too early to establish genuine cost savings. However, there will be savings from: freed up GP and staff time, expensive interpreter costs, better use of services and drugs, fewer Roma health problems, less staff stress, fewer missed appointments etc. **<u>Improved patient experience</u>** Feedback captured for almost 80% of patients: they are happy with the service and thankful of help at such an early stage in their move to the UK. Patients feel more listened to and able to express themselves as they can engage with someone from their own community who doesn't patronise or downplay their concerns (as reportedly happens on	

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
				occasion with Slovak interpreters). **RECOMMENDATION:** • Continue testing until the end March • Commissioner led discussion and decision required to ascertain future of scheme	
17	Programme Development and Delivery Costs	The funding requested is to cover: • Administrative and programme management capacity to coordinate and deliver the PMCF programme of work. • Programme monitoring and evaluation • Communications, primary care and patient engagement support to the programme • Contribution to the setting up the new company Primary Care Sheffield (PCS) • Operational delivery and management oversight of Satellite Units (line 2), rapid access primary care (line 7) and urgent same day appointments (line 8) • Clinical Leadership	1,397,214		

No.	Scheme Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		• Contract Management			
TOTALS			**9,311,258**		

Appendix 2 Slovak Roma Health Project: Report Date February 2016

PMCF OMG 11.06.15 (PAPER 3)

Project Highlight Report			
This highlight report updates the Project Sponsor and Board about the project's progress to date. It also provides an opportunity to raise concerns and issues with the Board, and alert them to any changes that may affect the project.			
Project Name:	Slovak Roma Health Project	**Sponsoring Organisation:**	Sheffield Health & Social Care Trust and Darnall Well Being
Project Lead:	Lucy Melleney	**Report Date:**	February 2016 **(Feb-Mar activity)**
Project Objective/s:	• To test and embed a targeted, holistic community development approach to improving health and wellbeing outcomes for Slovak Roma o build health literacy through reinforced messages o increase knowledge, resilience and confidence • Develop a dedicated core team to work in primary care and community settings that is sensitive to the needs of the Slovak Roma community • Build on learning from previous pilots to help facilitate a 2-way communication between the Slovak Roma community and primary care, share learning and improve service provision in a way that helps to reduce pressures on both primary and secondary care		

1. Status			
Current status:	Green = on track	**Status trend:**	⇧ but funding at risk
Reason for current status:	• Maintaining core provision across 4 sites and expanded in to 5th site • Staff retention maintained – core team of 9 workers • New opportunities and previously unidentified unmet need emerging • Linked to citywide strategy: o Learning Champions – SCC Raising English Levels Project o Local Government Transformation Fund – new arrivals o Health Trainer Service – Public Health o Best Start – reaching communities		

2. Progress since last Highlight Report *(output-focussed)*:

Key Achievements during February 2016

- Upwell Street Surgery – sessional staff have started to put a presence into Upwell Street with a drop in information session on Monday afternoons. This is linked to "new" arrival clinics and is going well.
- PhysioWorks PLI (17th Feb)
- Roma Young Helper Ambassador – The project welcomes Igor Tomko to the role of young Ambassador and link to youth activity promoting and engaging peers to the venues and session.
- Youth Session – 6 boxercise sessions started on Monday 29th February.
- Partnership-work: Safe Sleeping Week Event co-production with PACA (17th Mar) responding to high prevalence of cot deaths. Public health messages board produced for ongoing work. Jointly delivering an event and promotion throughout the clinics and drop in sessions to promote. Event date 17th March.
- Link to ESOL – Roma Project Learning Champions: co-production with DWB, LLSS and Upwell Street HCA re. weight management course
- Family Fun and Fitness Course – continues inc. sugary drinks and oral health learning
- Hep B targeted work with families at Firth Park Surgery and Page Hall Medical Centre (development plan).
    - Home Visits by Link Workers and support workers to engage patients and pass on appointment and health messages – outcomes – improving DNA appointments and understanding
    - Supported visit to link patient to appointments with specific clinics away from GP practice – outcomes: improving DNA appointments and one to one support accessing appointments – understanding and communication.
- Presented at Citizen's Reference Group – Evaluation Panel (18th Feb)
- Mental Health Training currently been planned with SHSCT/NHS

Added Value / Outcomes

Stats - February

Health Trainer
Referrals received **17** in February.

Clients have been referred for a number of reasons: healthy eating, stop smoking, increase exercise, reducing snacks, reducing alcohol, managing diabetes, high blood pressure, pain management.

Clinics:
During February we delivered **20** sessions at Firth Park, Page Hall, Highgate, Upwell Street and Darnall and supported a total of **132** adults. The length of time supporting each adult who came through the session was on average **28 minutes.**

Slippage (give reasons)**:**

None

3. **Key milestones and deliverables** (as per your project plan; noting any slippage - anything significant that has an impact on key actions/outputs)**:**		
Milestone	**Planned Completion Date**	**Progress/Slippage**

4. **Communication:** Please detail below any communications activity you have undertaken or are planning (with dates where known) to promote the project. Please include conferences, media, social media, public speaking engagements, awards.
• **February SRHP newsletter**

5. Actions and outputs for the next period:

Sustainability & Evaluation

6. Most significant current risk/s and mitigation plans/actions:

Risk Description	**Risk Score**			**Mitigating Actions**	**Planned completion date**	**Status (complete / in progress)**
A statement describing the cause, risk event and impact	**Likelihood**	**Impact**	**RAG Status**	*Systems and processes that are in place and operating that mitigate this risk, including assurances*		
There is a risk of quick disengagement from workers, patients and practices if at least short-term funding not secured asap.	H	H	R	• Good communication with staff – regular supervision and DWB Board review of any usage of reserves as emergency measure to maintain consistency and worker retention • Regular dialogue with GPs		Ongoing
There is a risk of the project stopping completely and valuable learning lost	H	H	R	• Approach to commissioners, Public Health and elsewhere to raise profile of work • Testimonials sought from beneficiaries, workers, stakeholders and partners		Ongoing

7. Most significant current issue/s:

Issue Description	**Risk Score**			**Mitigating Actions**	**Planned completion date**	**Status (complete / in progress)**
A statement describing the cause, risk event and impact	**Likelihood**	**Impact**	**RAG Status**	*Systems and processes that are in place and operating that mitigate this risk, including assurances*		
Staff retention, sickness and absenteeism due to	L	M	G	• Daily supervision, Staff Handbook and protocols, peer support from senior members		

family commitments impact on service delivery				• of staff, quick and early management response to emerging or potential issues • Staff training and support network – workers feel valuable and able to input their ideas at group supervisions • 2 – 3 workers assigned to sessions to ensure minimum cover and flexible work patterns		Ongoing

8. Variances:

Give details of any variances to your project finances (where applicable e.g. expenditure, funding, planned savings)**:**

- None – phased increase to expenditure due to phased recruitment end Q2 and early Q3 but on track and inline with natural development and gradual scaling up of programme

Give **details of any other changes to your project** (where applicable e.g. to the benefits, assumptions, timescales, quality or scope)**:**

- Scope is clearly much wider than previously anticipated with new opportunities and previously unidentified unmet need emerging e.g. increase of referrals for chronic pain management from Physios, potential links to Children's Hospital, Children's Centre, Pharmacies and new practices not in original business case i.e. York Road Surgery

9. Decisions required from Operational Management Group:

Include any exceptions that require escalating.

10. Key lessons:

Please describe below any key lessons you have learned over the last month.

Category* E.g. Service improvement, Engagement; IT; Workforce etc	**Description of challenge or situation** Description of the challenge or issue that resulted in the lesson. (It could be a negative situation that could have been managed better)	**Lessons Learnt** Description of suggested method of handling potential problems. What could have been done differently? What advice would you give to other areas who want to develop a project or service like this?
See previous highlight reports		

Best Practice – community engagement	Engaging the community – in order to encourage take up of services and be part of the project	Time – time needed to build trust both from a worker perspective but also from patients....good support structure in place and consistent, reliable service....

Appendix 3 PMCF Central Park CN Project (IAPT) - Paper for Board Jan 2016

Prime Ministers Challenge Fund

Central Parks Integrated Community Nursing Project (Depression and Anxiety)

Sustainability paper to PMCF Board

Introduction

Although small (1.2 wte staff, £52,000 budget), this project is of national and local importance. The project is testing a new model for increasing access to talking therapies, and delivering integrated physical and mental health care. It is contributing to meeting PMCF objectives, and to the Five Year Forward View (2014) drive for an equal response to mental and physical health and the "two being treated together".

The project is funded until March 2016. The purpose of this paper is to (a) summarise progress to date (b) seek an extension of funding for the project in order that we can explore options with commissioners, including potential contributions to the Active Support and Recovery Integrated Commissioning Programme, and research opportunities.

Project overview

The project is being delivered by three dual trained community district nurses (DTCNs), each working 0.4 wte. The nurses are all qualified IAPT Psychological Wellbeing Practitioners (PWPs), having trained as part of the YH Health Education Sheffield Physical Health and Psychological Wellbeing (IAPT) Project. Clinical supervision and mental health governance is provided by a senior IAPT manager.

PMCF funding is providing the DTCNs with essential protected time to deliver integrated interventions, and is facilitating partnership working across primary care, SHSCFT and STHFT. The project steering group is chaired by Dr Brian Hopkins, Whitehouse Surgery

Referral criteria: the project is focused on people who are housebound AND required a district nurse intervention/help with managing physical health problems AND where low mood/anxiety/negative thinking is thought to be impacting on long term condition management.

Referrals are taken from: Whitehouse Surgery, Duke Medical Centre, Manor Park Medical Centre, Park Health Centre, Community Development Support Workers and Central Parks Community Nursing Team. From October 2014, referrals have also been taken from GP practices covered by Owlthorpe Community Nurse (CN) Team (Owlthorpe Medical Centre, Crystal Peaks Medical Centre, Sothall, Medical Centre, Westfield Health Centre, and Mosborough Health Centre), via the Owlthorpe CN Team

Progress in relation to delivery requirements

The project is required to:

1. Provide integrated physical health interventions and evidence based IAPT mental health interventions to referred patients
2. Improve access to evidence based psychological therapies for housebound patients, though direct clinical work and upskilling and consultation to community nurses
3. Work to provide reliable improvement and/or clinical recovery in the mental health of housebound patients
4. Where appropriate work collaboratively with patients to reduce the degree to which the patient is housebound
5. Reduce demand on GPs and other NHS services through timely interventions
6. Improve understanding, collaborative and shared learning within and between services
7. Work with Sheffield PMCF and CLAHRC YH Mental Health and Comorbidities Theme to evaluate the project
8. Provide data on patient/carer satisfaction with service
9. Provide data on staff satisfaction with the service (those referring and those working in the service)

Increasing access to mental health assessment and talking therapies

Between April and December 2015, the DTCNs assessed the mental health of 68 people, referred by GPs, CNs, Community Development Support Workers or identified via case finding or screening of people listed for a chronic disease management review. Of the 48 people who then went on to receive an intervention, the vast majority received an integrated MH and PH intervention. (see Appendix 1 for more detail). Without this project, it is likely the mental health needs of these patients would remain under-recognised and undertreated.

Delivering reliable improvement/clinical recovery in mental health within an integrated intervention.
The project is able to demonstrate reliable improvement and/or clinical recovery in the mental health of patients seen by DTCNs.

We have pre and post therapy data sets for 25 patients. Our results, using the same validated measures and analysis that NHS England require from IAPT services, show of 25 people treated, 17 showed an improvement in depression, of whom 12 show reliable improvement, and 6 can be classified as moving to recovery. In addition, of these 25 people, 17 patients had an improvement in their anxiety scores, post therapy, including 12 showing reliable improvement, of whom 8 can be classified as having moved to recovery.

Depression can impact on the ability and motivation of people to seek help from their GP and can remain undetected. One man, with multiple health problems, disclosed that he was actively suicidal at time of assessment. When asked one of the standard project feedback questions ‘what has changed for you as a result of [this intervention]? he replied “I wouldn’t still be here [if I hadn’t seen you]”.

Working with patients to improve their self-management of physical and mental health conditions
Improving self-management of physical and mental health is at the heart of the work undertaken by the DTCNs, and often an explicit goal patients have set themselves (“I want to be more independent, to start looking after myself again’; ‘I would like to regain control and re-establish a routine’).

Providing strategies to help patients and carers to manage low mood, anxiety and anger, combined with psychoeducation on the interplay between mental health and physical health has been a critical factor in helping patients to better self-manage, for example, COPD, diabetes, fatigue, heart disease and mental health. This is evidenced in tangible ways, for example, in better blood sugar regulation, and through patient self-report: "… I have more control, and I have not been readmitted to hospital [for COPD], I have done more walking and exercise'; " "[You've] helped me sort out the self-harm in my head because it just makes things worse. Talking to you. Getting sorted out; my life [is] back to where I want to be in my head".

Managing complexity and multiple comorbidities: helping to close the gap

People are being referred to the project with marked levels of complexity and multiple co-morbidities. Brief integrated interventions with someone with multiple longstanding problems have led to major improvements. However, at times, case management, liaising with and bringing other practitioners together has been an important focus of the DTCN response to referrals. The DTCN are trained to deliver Step 2 mental health interventions and there is no facility to Step 3 for housebound patients. The implications of this are under review.

Reducing degrees of 'houseboundness'

Being housebound increases social isolation and loneliness, decreases independence and impacts of families and carers.

The project has been successful in reducing 'houseboundness'. Patient goals at the outset of therapy, such as "I want to get myself up and mobile, and able to go to my appointments again', or "I want to be able to walk round to the local shops and doctor" have not been uncommon.

The DTCNs have used PWP skills (such as five areas assessment, behavioural activation and exposure therapy) combined with nursing knowledge and skill to address physical and mental barriers to going outside. For some, this intervention has led to dramatic change, and they have been able to leave the house completely, been taken off the DN case load and are now able to attend the GP practice. For others it is a smaller but significant step towards greater independence: "I can go to my garden gates more often, can put blue bin out and collect it in the morning…".

Upskilling and consultation to community nurses

A core principle of this project has been to share mental health skills, to increase awareness and build the confidence of community nurse colleagues to enable mental health to become part and parcel of district nursing. The DTCNs are based with the Central Parks CN Team, Norfolk Park Surgery, and one also with Owlthorpe CN Team. Co-location is enabling both upskilling via formal teaching, and importantly, through opportunistic discussions and case consultation. A three phased approach to training to the Central Parks and Owlthorpe Team has been taken, including a 'Brief supportive guide to screening for depression and anxiety', which nurses keep with their diaries.

Session One: Screening for anxiety and depression (delivered)

Session Two: Assessing suicidal risk (planned for February)

Session Three: SHARP training (www.primarycare-selfhelp.co.uk) (planned for March 2016)

Reducing costs

Our learning suggests costs savings associated with the following areas:

Reduction in GP home visits due to

- Enabling people to become less housebound and access the GP surgery
- DTCNs being able to undertake mental health assessments, as required by NICE Guidance CG91, and suicidal risk screening, rather than CNs or CDSWs having to refer to the GP for a home visit

Reduction in CN workload and costs due to

- Enabling people to become less housebound and access the GP surgery
- Improving self-management, leading to a discharge, or a marked reduction in the number of visits required (for example recently facilitating a patient to press a rocker switch to turn on the nebulizer for herself will reduce DN visits from three times a day to a monitoring arrangement)
- Enhanced compliance with treatment, for example, acceptance rather than interference with compression bandages to treat ulcerated legs, will speed recovery and reduce bandage costs and nurse time.

Feedback from Central Parks DN Team Manager "Our workload has been reduced as frequent callers are calling less as their anxiety has been reduced. Complex patients are being more holistically assessed and their needs addressed." "[you provide] security for the team as it fulfils an active need that is not currently filled."

Reduction in preventable hospital admissions through improved self-management and earlier interventions.

Improved understanding, collaborative and shared learning within and between services

The DTCNs continue to collaborate with Sheffield IAPT. The Community Development Support Worker joined the DTCNs at a project 'SHARP Training the Trainers' day. One DTCN presented to Health Education Yorkshire and Humber Board, and the Project Lead presented to the HE YH South Yorkshire Partnership Council.

Data on patient, referrer and staff satisfaction is being collected.

Conclusion

Whilst there is a large unmet need in relation to mental health, the initial learning from this project suggests that addressing mental health needs, integrated with physical health interventions, has the potential to improve both mental and physical health outcomes and improve self-management, leading to improved patient, carer and practitioner experience, and cost savings in the longer term.

This project is at an early stage. Dual trained practitioners, supervised by experienced mental health colleagues, are able to increase access for housebound, older people with multiple comorbidities, and work with greater effectiveness and efficiency by combining mental and physical health interventions. We would welcome support to enable us to continue to develop the project and to seek research grants and look at how to take forward to the next stage.

Moira Leahy, January 2016

Appendix 1: Referral and intervention data

Referrals (April to December 2015)

Number of referrals, including case finding: **68**

Number of referrals where assessment was followed by an intervention: 49 Number of referrals where assessment only/or not appropriate: 19

Referral source (April to December 2015)

District Nurses	31
GP	8
Community Matron	6
Community Development Support Worker	9
Case found or via screening within chronic disease management review	14
Total referrals	68

Age range and Frequency

18-60	12
61-70	8
71-80	13
81-90	1
91+	4
Not recorded	11
Total 68	68

Intervention type by contact

Interventions:	**4/2015 – 12/2015**
Assessment	45
Telephone assessment	22
Combined PWP and PH Intervention	83
PWP Intervention	18
Physical Health Intervention	0
Carer Intervention	1
Telephone intervention	12
Indirect – consultation on named pts	7
Set up and MDT case conference	1
No access/DNA	15
Other	1
Total contacts (not including DNAs)	**189**
Total direct patient contact	**181**

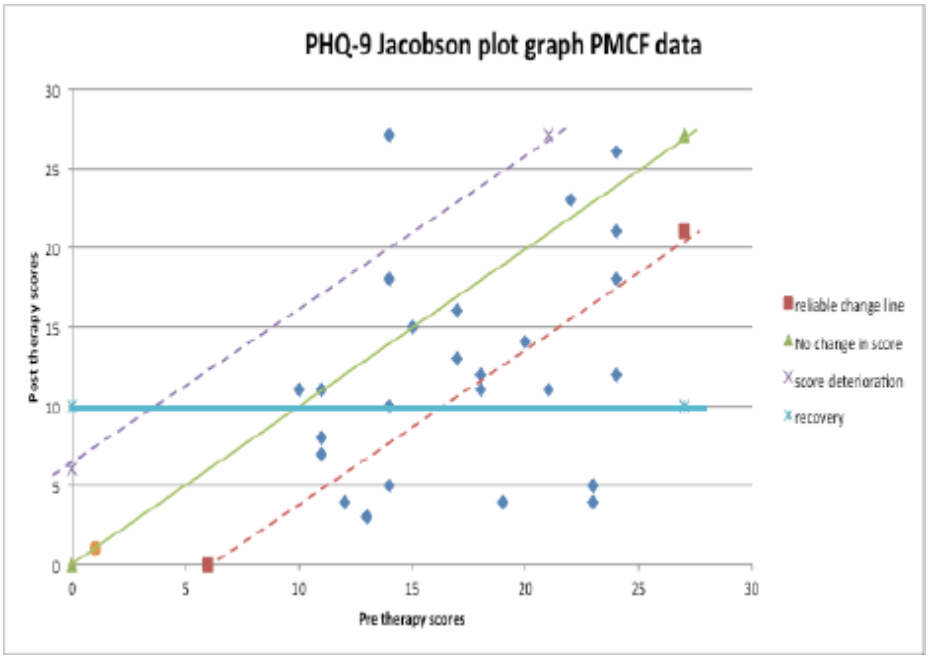
Onward referral: 3 people referred back to GP, 4 to IAPT, one to each of the following services: diabetes service, memory service, drug and alcohol service, falls service, primary care psychology (PCHaMPS), pulmonary rehabilitation, housing, and three to other services,

Appendix 2: Demonstration of reliable improvement/recovery following interventions

Depression - PHQ-9

The Patient Health Questionnaire (PHQ-9) is designed to facilitate the recognition and diagnosis of depression in primary care patients. It can be used to monitor change in symptoms over time and provides a depression severity index score as follows:
0 – 4 None; 5 – 9 Mild; 10 – 14 Moderate; 15 – 19 Moderately Severe; 20 – 27 Severe
The recommended cut-off for the PHQ-9 severity index is a score of 9. Anyone who scores 10 or above can be considered to be suffering from clinically significant symptoms of depression. This is referred to as meeting "caseness".

Graph 1: Pre and post PHQ9 scores (n=25)

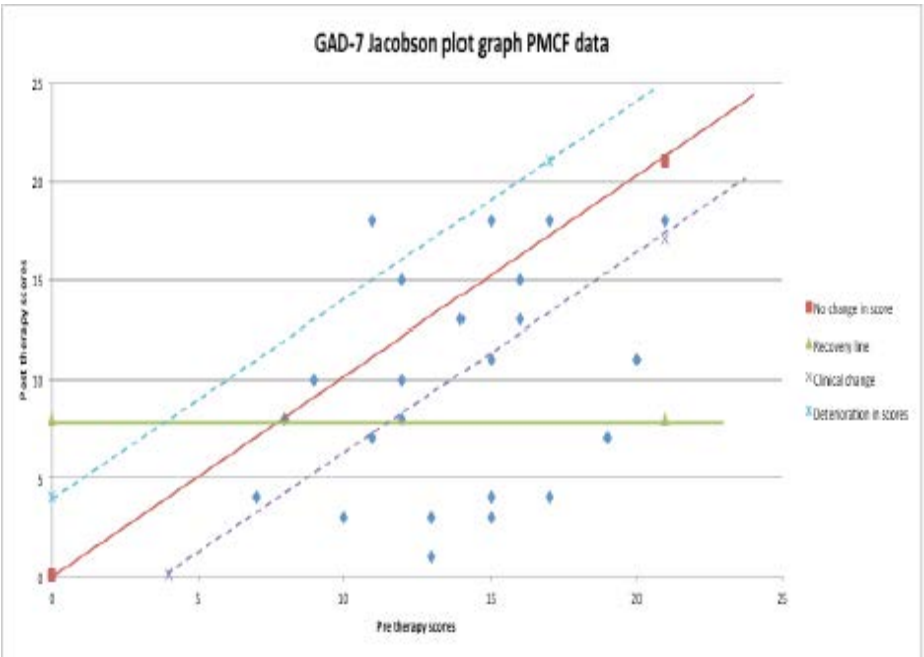


Graph 1 maps patients pre and post PHQ-9 scores. Each blue diamond is one patient. Pre-therapy scores on the bottom axis and their final score along the vertical axis. The Green diagonal line is the line of no change (patients who scored the same at the beginning and end of therapy). Any diamond below the GREEN diagonal line show their scores have improved. 17 patients are showing improvement in their scores post therapy. Any diamond below the DARK BLUE DASHED line show reliable improvement. 12 patient's scores indicate reliable improvement. The LIGHT BLUE line represents 'recovery' rate. 6 patient's scores have dropped so much that they can be classified as in recovery.

Any diamond above green line shows a deterioration in score. Anything on or above the PURPLE DASHED line would show reliable deterioration.

Generalised Anxiety Disorder - GAD7
The GAD7 is designed primarily as a screening and severity measure for generalised anxiety Disorder. The index scores are as follows:
0 – 4 None; 5 - 10 Mild Anxiety; 11 – 15 Moderate Anxiety; 15 - 21 Severe anxiety
The recommended cut off for the GAD7 severity index is a score of 7. Anyone who scores 8 or above can be considered to be suffering from clinically significant anxiety symptoms.

Graph 2: Pre and post GAD7 scores (n=25)



Graph 2 looks at 25 patients with pre and post GAD-7 scores. Each diamond is one patient. Pre therapy scores are on the bottom axis and their final score along the vertical axis. The RED diagonal line is the line of no change (patients who scored the same at the beginning and end of therapy). The light blue line shows reliable deterioration; 1 person scores have deteriorated significantly.

Any diamond below the RED diagonal line show scores have improved. 17 patients are showing improvement in their scores post therapy. The dashed lines show reliable change. Any square on or below the PURPLE DASHED line shows reliable improvement. 12 patient's scores show reliable improvement. The GREEN line represents 'recovery rates. So any that fall below 8 on their final scores and below the PURPLE DASHED line are demonstrate clinically significant change (recovery). 9 patient's scores dropped so much that they can be classified as in recovery.

Data analysis acknowledgement: Sally Ohlsen, Research Assistant, CLAHRC YH, Sheffield University

Sheffield Hallam University

Evaluation of the Sheffield Enhanced Primary Care Programme

Interim Report

March 2016

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Contents

Executive Summary

A mixed methods approach is being used in this evaluation of the Sheffield Enhanced Primary Care Programme (SEPCP) which contains 16 individual projects (see Appendix 1 for more details). The analysis combines data from interviews with analysis of health records data. This report lays out the progress achieved after 9/10 weeks of evaluation in three sections:

Project mapping
Qualitative component
Quantitative component

PATIENT REPRESENTATION- A specialist Patient and Public Involvement Panel has been recruited to support the evaluation and participants on this group have meet once to establish the terms of reference. The group represents a range of populations and users of primary care services including minority ethnic groups and people with long term disability. We have yet to include young people/ service users and people with mental health service needs and are continuing to seek this representation. The existing group have had presentation of the initial outcomes of the interviews and we have incorporated their comments into the overview of schemes and the themes generated. In addition, the evaluation team has presented to the Citizen's reference panel (Right First Time programme)

This report is written in the spirit of co-production and will be presented at the Programme Board with follow-up meetings with the Programme Management as needed. Further detail, if it is required, can be found in the appendices which are referred to in each section.

Project Mapping

The Prime Minister's Challenge Fund emphasises improving access to GPs - specifically out-of-hours options with the, apparent, underlying belief that restricted access to GP services increases hospital use, particularly after 5pm and at weekends. Extending this idea further the SEPCP was established to enhance access to local community-based and primary care services, and to manage more care in out-of-hospital settings. Six areas were described in the SEPCP remit:

A. "Care closer to home
B. Increased availability of GP appointments for adults and children in practices and satellite units across the city (particularly targeted at areas of high A&E utilisation)
C. Further integration of health and social care services
D. Improved transitions between services with better communication across the traditional providers of care, in and out of hours
E. Better utilisation of technology in care processes; to improve communication and information sharing across providers
F. Locally based innovations to address the needs of some marginal local communities and support people to manage their own care"

Appendix 2 - lists the 16 projects and maps them onto the 6 SEPCP areas. The benefits from each project have been described by the SEPCP (see Appendix 1). These benefits were content analysed and produced 4 themes which have been mapped back to the projects (see Appendix 3).

A. release of GP time

B. Increasing patient self-management

C. Reducing the Use of Secondary Care

D. Service Redesign and Workforce Development

It is interesting to note that the emphasis on improving access by specifically offering out-of-hours options for patients. It is quite clear from the 'benefits' analysis that the underlying belief is that restricted access to GP services for urgent care, increases secondary care visits. The follow on logic is that that 7-day working and a longer work day, etc., should decrease hospital admissions and A&E visits. This is certainly consistent with the view that is being presented nationally and furthermore that the cost efficiencies from reduced attendance at A&E may be realised and the costs re-distributed into primary care or community services.

The programme aims to invest in and pilot a range of mainstream general practice initiatives, building capacity to meet current demand for the management of complex needs and urgent care. The initial findings from the first of the qualitative interviews have highlighted a number of different perspectives that contrast with the underlying logic; that new demand and a variation of needs are being presented as urgent care and that additional capacity will be used for some new patient, carer and community demands. These may or may-not result in any reduction in A&E visits.

Further quantitative data tracking the patterns of service utilisation may allow us to test the initial assumption.

Qualitative Component

(More detail on the qualitative component is available in Appendix 4)

METHOD-We have telephone interviewed and validated our understanding of the information provided by the operational leads for each of the commissioned schemes (using contacts received from Programme team). In addition, we have interviewed four locality managers for their views about the schemes and to understand the perceptions of primary care practitioners. The reported perceptions of operational leads and locality managers has been used to identify some key themes and also generate conclusions and recommendations that will be used for planning further evaluation. The scheme leads represent a range of services across the health systems including mental health social care and public health as well as community services commissioned through Sheffield Teaching Hospitals Trust. Their views reflect their service role and their individual understanding of the purpose and intended outcomes of the programme. We have received full participation from those contacted and appreciate their participation in the evaluation process to date.

THE SCHEME OPERATIONAL LEADS shared a common understanding that the core strategic purpose of the investment was to increase capacity for urgent care. including- out of hours and offer new primary care access between 8am and 10pm. In addition scheme leads commented on an additional purpose, to reduce the workload of GPs and to also reduce unnecessary admissions to A&E.

URGENT CARE needs will reflect a wide range of patient values, views and opinions and will be subject to a wide variation in the capacity to 'self-manage' and there does not appear to be a shared understanding of what constitutes urgent care. The variation in demand was not raised by scheme leaders although some indication of the complexity of demand was raised by locality managers and clinical leadership. The understanding of demand in relation to patient care in general practice needs further exploration in particular given the policy focus and wider population health agenda, particularly for inclusion of marginalised communities. The demand on primary care is recognised to have grown but little is currently shared about the specific range of urgent care needs and how these are managed for different populations. We will focus on capacity and demand issues in a further round of interviews with general practitioners in the next phase of the qualitative evaluation aiming to understand how primary care seeks to diversify the workforce and skill mix to meet their patient and community need.

INCREASING SELF MANAGEMENT IS being addressed to build health literacy and self-management in the Roma Slovak project and within 'Florence' and Web GP schemes. The adoption of a community development approach (Slovak Roma) to a marginalised population may offer a range of learning to the programme as a whole and raise wider issues about defining demand at a population level. The programmes are based on new capacity but are focused on a good evidence base to meet previously unmet need and the methods mesh well with the existing local and community based understanding used within primary care.

REDUCING THE NEED FOR SECONDARY CARE is reported as a core function of several schemes including Roving GP (focusing on complex demand for housebound older patients and those at risk of rapid deterioration). A population of parents with young children, using satellite units are being recognised as taking up urgent care appointments and further evaluation will be needed to investigate whether the use of new capacity has resulted in the desired health outcome and whether the input has diverted the rational decision to attend A&E departments.

RELEASE OF GP TIME-The core provision of 'same day appointments', Roving GP and community pharmacy were existing schemes that have been adopted into the programme and trialled across localities. These schemes are reported as popular additions to existing primary care and the utilisation is on the whole very active across surgeries. The Satellite units are increasingly regarded as a core provision and there are aspirations to embed these schemes supported by and connected to SPA, social care and mental health provision within the programme. The opportunity to access services out of hours is a key output for the programme. This, in addition to the increased access via satellite units and other capacity in SPA was reported as an opportunity for better, joined up service provision. A number of schemes managed to use investment to re-design services and Community Pharmacy is an example of

additional capability to enable surgeries to manage medicines and staff to work more flexibly in primary care teams. The take up of pharmacy knowledge has been supported by professional associations.

CAPABILITY AND DEVELOPMENT - We recognised that workforce diversification has been to specifically address the frustrations of both the different communities of service users and the primary care team but this work is on-going and needs on-going investment. There are clearly leaders in the systems who are engaged with developing a multi-professional team approach to care but there is wide variation in this and schemes are not required or supported to engage in organisational development to enable this to happen. The programme consists of a wide range of activity and there is a further need to share knowledge and data across the programme to develop a shared understanding of this as a sustainable change in the system. There were no reported incidences of collecting and sharing outcome data or wider knowledge sharing across schemes of work.

Whilst capacity building initiatives are evident and all schemes are currently using investment to 'do more', the related development of new capability to support and sustain schemes was highlighted by several interviewees and supported by the PPI group. These include cultural awareness familiarisation for GP receptionists, understanding of nurse practitioner practice role for general practitioners and outcomes and data management capability across services. Learning about population need and adopting new services / service models to meet this need would appear to be a key issue across the GP workforce.

DATA MANAGEMENT - Data management is recognised as part of the contractual requirement. Data are being collected in different ways with different identifiers for utility and uptake of the schemes: NHS number, Council Care Number and Hospital number are collected on SystmOne, EMIS, and a discrete spreadsheet (in SPA). Services are pre-dominantly collecting outputs data (of service activity) and schemes are not routinely collecting outcomes data (for patients and populations) based on service activity. Outcomes are regarded in terms of services achieving one or more of the programme goals (. release of GP time Increasing patient self-management. Reducing the Use of Secondary Care. Service Redesign and Workforce Development)

The analytics at service level are being managed by separate services and at programme level by programme managers

SUMMARY The interview data has summarised the purpose of schemes based on reports from the programme managers, operational leads, clinical leadership and locality managers. (Appendix 4 provides a summary of interview data- scheme by scheme)

The mapping of schemes provides an indication of the desired outcomes across schemes (release of GP time
Increasing patient self-management.
Reducing the Use of Secondary Care.
Service Redesign and Workforce Development) as a set of mechanisms to achieve the programme goals.

Schemes can report on their utilisation although the uptake and outcomes are unclear because of the inability to accurately track patient's health access across the system and services.

Urgent care is not well described within the programme although there may be a complex range of needs at patient and population level that constitute urgent care

Further organisational and workforce development need has been identified by scheme leads and patient representatives to assist in the continuing roll out of schemes and to enhance the shared understanding of access issues in primary care

The programme operation is apparently focused on developing the new capacity for primary care to meet urgent care need. Increased outputs and utilisation are regarded as an achievement and indicators of scheme success

Therefore the success to-date needs to be qualified as an opportunity and a risk because of the clear risk of exponential growth and therefore cost increase without the proven release of resources or the resultant benefits to patients.

Quantitative Component

The projects have been mapped into 4 groups related to the data collection processes.

1. Projects for which we have sufficient information to make statements about analytics
2. SPA-related projects:
3. Projects for which I have incomplete information so can't discuss analysis
4. No evaluation required by SHU beyond the qualitative component

The projects have been mapped into the 4 groups and the tables in Appendix 5 reorder them into these groupings. It is important to note that we **can't receive NHS number data directly**. It has to be sent under safe haven procedures to the DSCRO team for de-identification, and only once the DPA documentation is in place.

1. Projects for which we have sufficient information to make statements about analytics: satellite Units, Roma, the 2 City Wide (Roving GP) projects
2. SPA-related projects: Social Workers Out of Hours Assessment; SPA-increased clinical triage; primary care access to psychiatric liaison; weekend mental health support
3. Projects for which we have incomplete information so can't discuss analysis: Florence; community volunteer; Integrated Care management teams.
4. No evaluation required by SHU beyond the qualitative component: the overall national data collection on the scheme; IAPT training by community nurses; primary care pharmacy programme; interoperability (no qualitative either); WebGP.

To summarise the data issues for groups 1 and 2 briefly:

- as evaluators SHU can only ask for psuedonymised data or data that does not contain any identifiers.
- We need confirmation that any data collected on the projects below includes an NHS number as this is the item that links the project data with secondary care data. John Soady provided the following information in a 07Mar16 email:
    - Satellite Units [data would have to be extracted from each of the 3 practices and from the GP collaborative individually]
    - City Wide Rapid Access Team [the scheme would have to provide the data – can't do by data extraction procedure]
    - City Wide Acute, Same Day Service [ditto]
    - Social Workers Out of Hours Assessment and crisis response home support [SPA extract?]
    - Single Point of Access – Increased Clinical Triage, Signposting [SPA extract?]
    - Primary care access to psychiatric liaison [SPA extract?]
    - Weekend Specialist mental health support (general and older adults) [SPA extract?]

- data agreements currently exist with many of these projects. John Soady will determine if they cover the PMCF Programme data needs and who the data steward is.

- if there are no existing data agreements then they these will have to be prepared. John has already confirmed that the Satellite data is not covered by an existing agreement.

- In an email on 16Mar16 John Soady confirmed that we cannot get GP appointment data (date and time) as there are "no validated data extraction and data processing algorithm. When this was attempted in the past it resulted in unusable data." In a nutshell - we can't look at changes how patients access GP appointments. This is unfortunately as it would have been helpful to look at how the 'young families' were using GP services before and after the extended hours, and confirm that the care in community programmes are reducing the number of visits to GPs.

A two hour discussion between Ian Wilson, John Soady and Shona Kelly reluctantly came to the conclusion that it may not be possible to identify a comparison group for analysis as was originally requested. This arises primarily because the city-wide remit of the programme means all GPs are participating and there is no comparison within the boundaries of this CCG. As a result the analysis will be restricted to a before and after comparison. This is less robust from an evidence perspective but even the national review is likely to have similar limitations. Shona is working with some staff in SHU Computing on a similar set of data to try and identify a 'natural' cluster of GPs which might be able to provide comparisons but this work is still underway.

Appendix 5 provides detail on each project, including: title and contact names, outcomes listed by PCS, contract specification of what data was to be provided, what is missing from contract specification of data to be provided, what analysis is possible without NHS number, what analysis is possible with NHS number and a data sharing agreement, and what we can't do

Next Stages of the Evaluation

Based on the findings of the evaluation and in the light of discussions with the PPI reps and process evaluation even on 14 Mar, we are proposing the following evaluation plan:

1. A focussed assessment of the perceived value of the programme/schemes by GP partners will investigate their perception of patient demand in the light of re-structuring and skill mix. A sampling strategy has been developed and the process on-going until reporting in mid may. And we are aiming to speak to around 30 GPs and report on findings in mid-May.

2. We will sustain the PPI support and collect their comments and contributions and share these with the programme team

3. The focus for acquiring pseudonymised data is currently on 2.Satellite, 7.Roving GP, 8.City Wide Acute, and the projects running through SPA. The slow process of identifying who is the data steward for each pot of data is proceeding. Existing data sharing agreements will be reviewed to confirm that pseudonymised data can be shared with the evaluation. John is key in this process and is responsible for preparing the data sharing agreements.

4. We will do some preliminary analysis of de-identified data from the projects but this must be kept to a minimum to conserve enough resource for the analysis of pseudonymised and linked data provided at a later date after data agreements are signed.

7. Testing for the possibility of identifying 'natural' comparison General Practices is underway but at this time we are assuming that the analytic method will be a comparison of secondary-care-utilisation before and after the project intervention

Recommendations for the Programme; for Discussion

We invite the programme managers to consider the following:

- develop a shared definition of 'urgent care' to be used across the schemes, as the evaluation event identified different meanings and maybe creating some inconsistency in the use of schemes.
- consider the learning needs across the schemes, of the entire workforce, and work with other NHS bodies as needed.
- Continuing effort needs to be made to release data for analysis across the schemes

Appendix 1 - PMCF Business Case Summary Descriptions February 2016 (prepared by PCS staff)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
1	Enhancing Primary Care Contract	This is a scheme for practices in Sheffield. It is a non-recurrent contract and whilst parts of it may continue beyond 15/16 (depending on evaluation), some of it will be for initial engagement with "new ways of working". By signing the contract practices have committed to standardising delivery of primary care in core contracted hours (08:00-18:30) and to engaging with the enhanced services being developed through the PMCF in Sheffield. It also includes practices commitment to providing clinical shifts for the satellite units.	2,935,000 **START DATE 01.10.15** **END DATE 30.09.16**	Board conversation – will be essential for longer term engagement of practices	• Strategic practice engagement at scale • Providing time, facilitation and practical support for Practice Development and federated working (SI)
2	Satellite Units (4 sites)	4 new satellite units have been opened (based in existing GP practice premises and the GP collaborative at NGH) providing urgent primary care appointments out of hours (evening and weekends). These work alongside the existing walk in centre and GP Collaborative Service. Each unit will (as a minimum) be staffed by a receptionist, a nurse practitioners and a GP. It is estimated that this will provide approximately 16,500 additional OOH GP	831,677 **START DATE 01.10.15** **END DATE 30.06.16**	Activity: • GP appointments – 6448 appts offered, 3046 booked, overall utilisation to date 47.2% • ANP appointments – 4761 appts offered, 1079 booked, overall utilisation to date 22.7% • Key activity shows 48% of activity within the Satellite Units relates to prescribing medicine and 43% clinical advice (Nov – Dec) • The under 12s account for 34% of the activity (Nov- Dec) • 78% of total activity or 2154 patient	• Improved Access for patients (SI) • Reduction in A&E attendances (adults and children) and reduction in Walk in Centre Attendances (IS) • Redistributing urgent (in hours) demand for GPs (SI)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		appointments (15 min slots) and 33,500 Advanced Nurse practitioner apt (15 mins) in 9 months. Changes to date: • Due to low utilisation of ANP slots changes were made on 30 November, to remove the Saturday afternoon and Sunday shifts from Woodhouse and Crookes. • Wef 23 January the ANP weekend shifts Sat and Sun 10-6) will be removed from all Satellite Units		contacts (Nov-Dec) resulted in 'no further action for practices' with only 10% (370 patients) needing to contact their own GP • Friends and Family results extremely positive. 95% of respondents stated they were either extremely likely or likely to recommend the service • 32% (192) of respondents would have attended adult A&E if they had not had this appointment, 24% (143) would have waited to see their own GP and 27% (163) would have attended the WIC • A&E attendance figures yet to be analysed **RECOMMENDATION:** **Continue testing** Options for further testing • Expansion (post PMCF) to in hours provision • Needs to be provided 7/7 but not the same capacity every day • Broaden skill mix e.g. clinical pharmacists etc.	
3	Social Workers Out of Hours Assessment	Additional social work staff have been put in place to improved triage of primary care referrals into SPA (with a potential to despatch social workers to provide timely	£378,750 (OOH Assessors)	Of the 56 referrals received, 37 have been accepted into the crisis response home support service (Nov / Dec). Providing 225 hours of care (202 hours care for new users,	• Improved Access and timeliness of response to social care packages (SI)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
	and crisis response home support	community assessment and resolution). Also included within this scheme is funding to enable the installation of assistive technology at the point of need. The crisis response home support provides response to emergency referrals form primary care through SPA for people requiring short term support to prevent unnecessary admission to hospital or long term residential care, thereby keeping people safe and well in their own homes. Referrals accepted into the rapid response service are picked up within 2 hours of the referrals being received and can receive care for up to 8 days. The service is available 7:00am – 11:00pm 7 days a week and provided by independent sector providers	£177,216 (Crisis response support) **START DATE 01.10.15** **END DATE 30.06.16**	23 additional hours for existing users) It is estimated that this has avoided 31 hospital admissions. No emergency respite avoidances have yet been reported. To date at least 31 practices have used the service – this does not include referrals through the GP collaborative out of hours. The capacity for new service users is well utilised with 80-100% used every week. Utilisation by existing service users is poor – only about 10% per week is used. **RECOMMENDATION: Continue both elements of the scheme (assessors and crisis response).** **Need to consider how to improve utilisation in existing service users and/or potential to change of contract to shift resource to focus more on new service users.**	• Reducing avoidable adult emergency admissions to hospital for social care reasons (IS) • Reducing risk and cost of social care support in the longer term(IS) • Reduce risk of deterioration of patients (IS)
4a	Single Point of Access – Increased Clinical Triage,	The funding has provided an increased number of call handlers, triage nurses, evening and night service nurses and health care assistants. This additional capacity has	420,785 (approx. 30K of this is Florence costs shown below)	Although workload has increased in both SPA and in the evening and nights service we are unable to date to show evidence that the capacity is directly supporting Satellites,	• Improve the joining up of services and improved access to them (SI) • Improving access to Mental Health and Social Care specialist advice (SI)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
	Signposting	increased the capacity for call handling and triage in SPA, particularly around the times that the new satellite units are operating and includes provision for mental health workers to be involved in the triage process (8am-10pm) which is something not previously available in SPA.	**START DATE 01.10.16** **END DATE 30.06.16**	therefore, subject to review in contract period. **RECOMMENDATION: Continue - with action to review referral and utilisation data provided by STH to ensure contract agreement is met and services can be evaluated**.	
4b	Expansion of the Florence system to primary care	The use of Florence (a text based tele health system designed to increase patient involvement in the management of their conditions) across primary care in the city is also being introduced piloting in 4 practices in the North of the city from February. The funding requested will provide additional administrative support for the roll out to practices.	Approx. £30,00k (dependent upon BP monitor costs) **START DATE FEB/MAR 16** **END DATE JUL/AUG 16**	4 practices have been identified and a band 6 nurse to support them has been recruited. Expect to start recruiting patients in Feb 2016. End date dependent on recruitment schedule. **RECOMMENDATION: Continue in life of programme.**	• Increase self-management (SI) • Reducing practice demand for patient cohort(SI)
5	Community Volunteer Scheme	Expressions of interest are to be sought by the end of January to develop options for community volunteers to support carers or cared for people to avoid hospital admissions and/or support discharges and to look at the role of primary care and care planning in meeting carers needs Developing the options will include desk based research and co-production with	£80,625 **START DATE FEB 2016** **END DATE AUG 2016**	This is now time limited work (6 months) to assess carers support needs **RECOMMENDATION: Continue as per plan and feed findings into relevant strategic links**	Research / Audit

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		carers and cared for and voluntary providers and where possible small scale testing of the options.			
7	City Wide Rapid Access Team (Roving GP)	Four rapid access teams working across Sheffield, providing urgent primary care home visits When patients contact their GP for an urgent visit, the visit request will be triaged and if appropriate passed to the team for an urgent home visit. As well as urgent appointments the teams will also focus on patients that have been discharged from hospital to ascertain their health state in an effort to reduce readmissions.	314,850 **START DATE OCT 16 (West & HASC)/ NOV 16 (North and Central)** **END DATE MAR (West & HASC)/ APR 2016 (North and Central)**	Activity: • 317 referrals made to the rapid access teams of which 214 were seen within one hour (67.5%) • On a crude approximation of referrals seen within a 12 week average period utilisation is around 50% • Number of admissions avoided as a result of the visits to be analysed (at evaluation) **RECOMMENDATION:** • **Continue testing (in isolation not beyond PMCF)** • **Make links to 'in hours' Satellite Units beyond PMCF**	• Reduction in A&E attendances (adults and children) and reduction in Walk in Centre Attendances (IS) • Reduced demand on practices (SI)
8	City Wide Acute, Same Day Service.	The service is delivered through all 87 practices in Sheffield, extra same day appointments slots are being made available on a daily basis and patient requesting urgent medical help for an acute condition will be booked into these slots at the nearest available practice to avoid patients having to be 'slotted in' to already full clinical sessions or having to be seen the next day.	637,500 **START DATE 01.10.16** **END DATE 31 AUG 2016**	Activity: • Oct and Nov activity data shows 8835 appointments offered 7204 appointments booked 7024 appointments attended (80%) • Incomplete outcome data submitted by practices during October and November • Appropriateness of referrals to be audited **RECOMMENDATION:**	• Improved access (in hours) to primary care (SI) • Redistribution of workload (SI) • Practices Working together (SI)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		The scheme builds on the current city wide 'same day appointment service' that has been funded for 2 years through winter monies. This funding will provide approximately 31,875 additional GP appointments.		• **Continue testing** • **Don't see continuing on its own post PMCF**	
9	Primary care access to psychiatric liaison	Providing additional capacity to the existing mental health liaison service being developed with the support of the CCG and resilience funds. This extends the offer in primary care for older adults and increase the assessment capacity in the community, rather than sending frail/vulnerable adults to A&E for a mental health assessment. The funding would provide: • A direct referral route to mental health liaison assessment services (through staff based in SPA) • Outreach to community and primary care to support holistic assessments • An increase in specialist mental health nursing staff providing input to the whole age range by 2.0 WTE. Staff to cover min of 6:00pm-9:30pm Mon-Fri and 10am-6pm Sat/Sun. • Additional speciality psychiatrist time • Increased mental health support worker led hospital avoidance /	**283,587** **START DATE 23 NOV 2016** **END DATE: 22 AUG 2016**	**Activity to date:** The workstreams started in November and data remains incomplete. **SPA MH workers**: 29 referrals have been made through the MH workers in SPA since November start – all but one through GPs. No outcome data available at time of report. **Perinatal Service**: In November received 2 referrals (one from A&E, one from a GP). **Liaison** No referral data available at time of report **RECOMMENDATION: Continuation of workstream with action to review referral and utilisation data provided by SHSC to**	• Improved access to MH liaison in and out of hours for primary care (SI) • Reduction in A&E attendances (IS) • Possibly reduction in admissions to STH and/or SHSC (IS)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		supported discharges to maintain a person at home. • Increase perinatal mental health support		**ensure contract agreement is met and services can be evaluated**.	
10	Weekend Specialist mental health support (general and older adults)	Additional nurse capacity extending the provision of the older adult community mental health team and the home treatment teams (Functional Intensive Community Service – FICS and Dementia. Response Team – DRRT) over the weekend. This enables the home treatment teams to accept new referrals at weekends thereby supporting primary care admissions avoidance and weekend discharges	278,054 **START DATE 09.11.15** **END DATE 08.08.16**	**Activity to date:** The workstream started in November and data remains incomplete. To date the referrals recorded have come from the community mental health teams (2) , the OOH team (1) and Older Adult liaison psychiatry (2) **RECOMMENDATION: Continuation of work stream with action to review referral and utilisation data provided by SHSC to ensure contract agreement is met and services can be evaluated**.	• Improved access for weekend out of hours specialist mental health support (SI) • Reduced admissions and A&E attendances (IS)
11	Training Community Nurses to provide IAPT interventions for housebound patients	Integrated community nursing (ICN) project to be delivered by community district nurses who have been trained and qualified as IAPT Psychological Wellbeing Workers. The nurses will provide physical and IAPT mental health interventions to people who are housebound and therefore unable to currently access IAPT services in GP Practices. This would be an extension to a test of change project that commenced in	52,000 **START DATE 01.04.15** **END DATE 31.03.16**	**Activity to date:** 62 referrals have been received by the nurses, 44 of which were appropriate and taken onto caseloads, leading to 155 direct patient contacts. A report is due at the end of January to show outcomes.	• Improving access for housebound patients with a mix of physical and mental health needs (SI) • Workforce development (WD)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		October 2014 with funding up to end March 2015.		**RECOMMENDATION – Due to small scale of the programme, results are too small to extrapolate for a city wide model and therefore should stop at end of March**	
12	Primary Care Pharmacy Programme (PCPP)	The scheme will be delivered by pharmacists and pharmacy technicians providing support to GP practices across the city. The model places the pharmacist initially within a practice for their sessions with the potential for remote working where criteria around IT and information governance are met. The support will be made up of a menu of tasks, including: • Repeat prescription management • Discharge medicine processing (and liaison with secondary care) • Structured medication reviews • Shared care monitoring requirements • Liaising with community pharmacies • Supporting patients with long term conditions and complex medication issues • Supporting patients in residential care	730,000 **START DATE 01.10.15** **END DATE 30.09.16**	Activity: • Very positive data received to date • 4022 patient interventions carried out • Estimated 700 hours of GP time released to date • Only 5% of patient contacts resulted in referring the patient to the GP • 33% relate to Repeat Meds • 15% relate to Medication Reviews • 31% relate to TTO (reconciled discharge meds) Options for further testing: • Expanding menu to include: - domiciliary support - data sharing practice and pharmacist **RECOMMENDATION:** **Continue testing**	• Improved patient outcomes on long term medication (SI) • Reduce prescribing spend (IS) • Reducing medication related admissions / readmissions (IS) • Release of GP time (IS) • Testing benefits of working with clinical pharmacists (WD)
13	Interoperabilit	The procurement of rota geek and the	£100,000	4. Rota Geek and Systm1 procured and in	• Patient Safety (SI)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
	y and use of the Medical Interoperability Gateway (MIG)	systm1 OOH module has enabled the 4 satellite units to manage remote booking of appointments and sharing of the full clinical record (for patients from Systm1 practices) read and write. The funding through the PMCF will pay for licences for 12 months. The MIG is a managed secure gateway for exchanging real time data between systems, providing a secure mechanism, residing in the N3 network. The MIG is the interoperability solution which will enable the Satellite Units to have improved (read only) access to patient's records from EMIS practices. The MIG also has the potential to enable records to be shared across secondary care, mental health and social care. PCS are working closely with the CCG and other stakeholders to roll this out (though will likely take longer than the 12 months of the PMCF programme)	**START DATE (for S1 and Rota Geek) 01.10.15** **END DATE (for S1 and Rota Geek) 30th SEP 2016**	place. 5. Procurement of MIG for use in the Satellite Units (to improve access to EMIS records) to be completed by end of February 2016 6. Partnership with CCG to develop Sheffield digital roadmap and information sharing agreements across all practices – on-going. **RECOMMENDATION: Licences purchased for 12 months- therefore continue to end of programme. Continue relationship with CCG and development of city –wide digital roadmap and information sharing**	• Reduced duplication and save clinician time (IS) • Improved Communication and collaboration (SI)
14	WebGP	WebGP is a web based service (which sits on a practice website). It enables patients to access self-management information, symptom checker and signposting to local	146,750 **START / END DATES – variable**	**Activity To date:** 2990 individual users have completed 3339 sessions on Web GP. Of those, 323 completed online questionnaires requesting a	• Improved supported self-care (SI) • Reduced demand for GP /practice nurse appointments (IS)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		services and self-referral option. There is also an option for the patient to complete an e-consultation. The e-consultation takes the form of a health questionnaire which is then emailed through to the practice for action (to provide a prescription, follow up phone consultation or bring patient in for an appointment).	**dependent on start date of each practice)**	response from their GP. Outcome data not yet available for these completed questionnaires **RECOMMENDATION: Continuation as planned and potentially expand to other practices for 6 months if EMIS can provide short contracts.**	
15	Integrated Care Management Teams	4 service coordinators (1 for each locality) have been employed to support practices to develop their integrated working (both between practices and with wider community services). In addition the 4 localities are developing specific pieces of work focused on integrated working in their area. West, central and North practices are looking at how to better support housebound patients. HASC are to sign out the model of Shared Medical appointments.	£440,000 **START DATE FEB 2016** **END DATE 31st July 2016**	Outline Service Level Agreements are being drafted prior to go live in Feb 2016. The 4 Service coordinators start in post on 1st February 2016. **RECOMMENDATION: Continuation as planned**	• System and Workforce development (SI) • Mapping of Services (SI)
16	Roma Advocacy and Health Project	The business case requests funding for Roma Health and Advocacy Workers and Link workers building on and learning from current and previous projects in Sheffield (Darnell Well Being Roma Community	107,250 **START DATE**	Activity: • **Sessions established at 4 sites**: Darnall Primary Care Centre (monthly), Tinsley-Highgate Surgery, Firth Park Surgery, Page Hall Medical Centre (all weekly)	• Improved appropriate access for a specific population (SI) • Save GP time (IS) • Reduction in A&E attendances (adult &

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		Workers and the Health Exchange Project). The project will support the health educational needs of the Slovak Roma Community in Sheffield, working with primary care and other agencies to address wider determinants of health and build capacity and resilience within the community. Key deliverables of the project will include: • Regular clinics and presence within primary care • Health information sessions within local community settings • recruitment and training of members of the Slovak Roma community • Engagement of GP practices, Sheffield Children's Hospital and A&E	**APRIL 2015** **END DATE March 2016**	• **Total 584 recorded points of contact across 41 clinics**: 18.5% of the total Roma patient population (3,158) – NB *this does not capture where patients chose not to share contact details* • **25 Health Trainer referrals** received via Health Trainers / SOAR's Social Prescribing scheme, York Road and Firth Park Surgery as well as from the Physio Team and self-referrals. • **12 Training courses and 7 team meetings** • **Increased appropriate use of services and access to primary care:** Supporting patients: explaining how system works (booking, cancelling, attending appointments), form-filling, signposting to advice, registrations at dentist/schools etc., managing minor ailments, screening uptake messages re. vaccinations / immunisations etc., supporting GP triage, diabetes management. It is too early to establish genuine cost savings. However, there will be savings from: freed up GP and staff time, expensive interpreter costs, better use of services and drugs, fewer Roma health problems, less staff	children) (IS) • Improved linkage of Primary Care to 3rd sector (WD)

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
				stress, fewer missed appointments etc. **<u>Improved patient experience</u>** Feedback captured for almost 80% of patients: they are happy with the service and thankful of help at such an early stage in their move to the UK. Patients feel more listened to and able to express themselves as they can engage with someone from their own community who doesn't patronise or downplay their concerns (as reportedly happens on occasion with Slovak interpreters). **RECOMMENDATION:** • Continue testing until the end March • Commissioner led discussion and decision required to ascertain future of scheme	
17	Programme Development and Delivery Costs	The funding requested is to cover: • Administrative and programme management capacity to coordinate and deliver the PMCF programme of work. • Programme monitoring and evaluation • Communications, primary care and patient engagement support to the programme	1,397,214		

No.	Project Title	Description	Agreed Funding (£) and end dates	Evidence to continue scheme/stop (to include key data, recommendation and options for further testing if applicable). January data and recommendations to PMCF January Board.	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)
		• Contribution to the setting up the new company Primary Care Sheffield (PCS) • Operational delivery and management oversight of Satellite Units (line 2), rapid access primary care (line 7) and urgent same day appointments (line 8) • Clinical Leadership • Contract Management			
TOTALS			**9,311,258**		

Appendix 2

The PMCF programme was established in April 2015 and rests strongly on the ideas and learning of the Right First Time programme team. A range of activities that occurred between 2013 - 15 was used as a basis for the PMC funding bid and 16 schemes of work established. Table 2.1 list the name of the project and the number and acronym of the project used in this report.

Table 2.1

Project Name	Acronym	Project number
Enhancing Primary Care Contract	EPCC	1
Satellite Units (4 sites)	Satellite	2
Social Workers Out of Hours Assessment and crisis response home support	SPA SW OHH	3
Single Point of Access – Increased Clinical Triage, Signposting	SPA - triage	4a
Expansion of the Florence system to primary care	Florence BP	4b
Community Volunteer Scheme	Community Volunteer	5
City Wide Rapid Access Team	Roving GP	7
City Wide Acute, Same Day Service.	City Wide Acute	8
Primary care access to psychiatric liaison	SPA Primary Psychiatric	9
Weekend Specialist mental health support (general and older adults)	SPA Weekend MH	10
Training Community Nurses to provide IAPT interventions for housebound patients	Community IAPT	11
Primary Care Pharmacy Programme (PCPP)	PCPP	12
Interoperability and use of the Medical Interoperability Gateway (MIG)	MIG	13
WebGP	WebGP	14
Integrated Care Management Teams	ICM Teams	15
Roma Advocacy and Health Project	Roma	16

The Sheffield Enhanced Primary Care Programme was established to enhance access to local community-based and primary care services, and to manage more care in out-of-hospital settings. Six areas were described and have been mapped across the 16 projects:

A. Care closer to home
B. Increased availability of GP appointments for adults and children in practices and satellite units across the city (particularly targeted at areas of high A&E utilisation)
C. Further integration of health and social care services
D. Improved transitions between services with better communication across the traditional providers of in and out of hours
E. Better utilisation of technology to improve communication and information sharing across providers
F. Locally based innovations that will address the needs of local communities and support people to manage their own care

Table 2.2

		care closer to home	increased GP appt's	integrated health and social care	impr transit & better commun	technology to improve comm and info sharing	local innov for locals to manage own care
1	EPCC		y				
2	Satellite		y				
3	SW OHH	y			y		y
4a	SPA triage				y	?	
4b	Florence BP	y				y	y
5	Community Volunteer						?
7	Roving GP	y					
8	City Wide Acute		y				
9	SPA Primary Psychiatric	y					
10	SPA Weekend MH	y		y	y		
11	Community IAPT	y		?			
12	PCPP						
13	MIG				y	y	
14	WebGP	?				y	?

		care closer to home	increased GP appt's	integrated health and social care	impr transit & better commun	technology to improve comm and info sharing	local innov for locals to manage own care
15	ICM Teams			?	y		
16	Roma	?					y

Appendix 3

Information on all 16 projects was provided by PCS staff (see Appendix 1, last column) was also used to identify the expected benefits expected from each programme. These were content analysed to produce 4 themes.

Theme A: - release GP time

Project	Num	benefit
City Wide Acute	8	improved in hours access
Satellite, Roma	2, 16	? improved overall access
City Wide Acute, Satellite	2, 8	Redistributed urgent in-hours demand
Roving GP, WebGP	7, 14	Reduced demand
PCPP, Roma	12, 16	Release GP time
Primary Psychiatric	9	Improved access to MH liaison in and out of hours
possibly related to release of GP time		
Roma	16	improved links between primary care & 3rd sector
SPA-triage	4a	improved access, including mental health and social care
Satellite, Roving GP	2, 7	reduced walk-in centre use

B: - Increasing patient self-management

Project	Num	benefit
Florence BP, WebGP	4b. 14	improved self-care/management
possibly related to increasing patient self-management		
Community IAPT	11	Improving access for housebound patients with a mix of physical and mental health needs

C: - Reducing the use of Secondary Care

SPA SW OHH, PCPP	3, 12	manage chronic conditions better
SPA SW OHH	3	improved social care liaison
SPA Primary Psychiatric, SPA Weekend MH, Community IAPT	9, 10, 11	improved mental health in and out of hours
Satellite, SPA SW OHH, Roving GP, SPA Primary Psychiatric, SPA Weekend MH, Roma	2, 3, 7, 9, 10, 16	reduced A&E visits
Satellite, Roving GP	2, 7	reduction in Walk in Centre Attendances
Roma	16	Improved appropriate access for a specific population

D: - Service Redesign and Workforce Development

Roma	16	Improved linkage of Primary Care to 3rd sector
ICM Teams	15	Mapping of Services
EPCC	1	Providing time, facilitation and practical support for Practice Development and federated working
PCPP	12	Reduce prescribing spend
MIG	13	Reduced duplication and save clinician time
Florence BP	4b	Reducing practice demand for patient cohort
EPCC	1	Strategic practice engagement at scale
ICM Teams	15	System and Workforce development
PCPP	12	Testing benefits of working with clinical pharmacists
Community IAPT	11	Workforce development
MIG	13	Patient Safety

MIG	13	Improved Communication and collaboration
City Wide Acute	8	Practices Working together
SPA-triage	4a	Improve the joining up of services and improved access to them

What is interesting to note here is the emphasis is on improving access from the PMCF – specifically out-of-hours options. And it is quite clear from the 'benefits' analysis that the underlying belief is that restricted access to GP services increases secondary care visits. The follow on logic that that 7-day working and a longer work day, etc., should decrease hospital admissions and A&E visits. This is certainly the view that is being presented nationally and it will be interesting to see how embedded this idea is in the Process Evaluation days.

In contrast the initial findings from the first of the qualitative interviews have highlighted a slightly different perspective.

Appendix 4 - Qualitative evaluation of the Prime minister's Challenge ECPC: - Initial Interviews with Operational Leads and Locality Managers

Dr Sally Fowler Davis
Dr Hilary Piercy
Dr Sarah Pearson

Introduction

An initial interview with operational leads aimed to evaluate the operational leads' understanding of the strategic and operational purpose of the EPCP programme. In addition, we invited each scheme to identify the inception and backdrop to their inclusion in the programme and to identify, with reference to their patient and service data, the ways that their scheme was working and any key successes or challenges to date.

We accepted group or individual telephone contact and prioritised contact with staff in provider roles, however we have included some commissioning managers in social care and project managers in the programme. In addition, we met and briefly discussed the plan with the 4 locality managers and also outlined the initial analysis with the PPI Evaluation Group.

Method

Interviewees were selected from the list of operational leads for schemes under the programme. Telephone interviews were arranged (30 minutes) and a participant information sheet e-mailed. Consent was taken over the phone and included in a verbatim write up of the issues discussed. Interviewees were asked to validate the written document as a true record of the facts and discussion. These reports were collated and discussed between the three interviewers to draw themes from the content of discussions and to report back on the aim and purpose of the interview.

Results of interviews with scheme leads, locality managers and clinical leadership

Project Name	All interviews took place between Jan 11th and 22nd Feb	Project number
Enhancing Primary Care Contract	interviewed clinical leadership/ locality leads	1
Satellite Units (4 sites)	interview with programme manager	2
Social Workers Out of Hours Assessment and crisis response home support	interview SPA leads and social care manager	3

Project Name	All interviews took place between Jan 11th and 22nd Feb	Project number
Single Point of Access – Increased Clinical Triage, Signposting	interview SPA leads	4a
Expansion of the Florence system to primary care	interview scheme lead	4b
Community Volunteer Scheme	interview commissioning Manager (Carers) at Local Authority	5
City Wide Rapid Access Team/ Roving GP	interviewed Clinical leaders and locality leads	7
City Wide Acute, Same Day Service.	no specific interview	8
Primary care access to psychiatric liaison	interviewed Deputy Director Specialist Services and Manager PMCF	9
Weekend Specialist mental health support (general and older adults)	interview SPA leads	10
Training Community Nurses to provide IAPT interventions for housebound patients	interview with IAPT	11
Primary Care Pharmacy Programme (PCPP)	interview with Pharmacy Development Manager and clinical leadership	12
Interoperability and use of the Medical Interoperability Gateway (MIG)	no interview	13
WebGP	interview programme lead	14
Integrated Care Management Teams	no interview	15
Roma Advocacy and Health Project	interview with Roma project manager and support workers	16

2. Satellite Units

GP satellite units provide access to out of hours (evening and weekend) services for patients needing urgent appointments. They are located in four areas of the city: Crookes practice, North (GP collaborative), Sloan medical centre, Woodhouse health centre. The units are staffed by Sheffield GPs and nurse practitioners and also by locum GPs in one locality. Sessions are weekdays 6-10pm and weekends 10am - 6pm. Appointments are booked by GP surgeries using System One or over the telephone, and via 111 and the out of hours service. Referrals can also be made for inappropriate attendances at A&E.

The units provide access to out of hours (evening and weekend) GP services for people needing urgent appointments. Satellite services are being utilised across the city. Uptake is increasing although it appears to be variable across services with some clinics not currently fully booked. Over capacity at the weekends has been reduced in line with early learning. Most practices in the city have signed up - although there is less take up from single handed practices and concerns have also been raised about the pilot nature of the scheme and the mixed understanding and willingness to refer to nurse practitioners. Some complex logistical issues have been overcome to facilitate booking and to enable the collection of appointment data and DNAs. Output data is available but our understanding is that the only outcomes data is via the friend and family test. In addition, utility [14]information does not include information about the urgency of patient need.

1. Same day Appointments (Enhancing Primary Care Contract)

All but 5 surgeries across the City have signed up to extended hours and are rolling out provision in line their understanding of patient demand. The variation in responses from GP's will be the subject of a specific interview based enquiry during the evaluation. The initial interview with GP leaders suggests that they recognise the wide variation in approaches to the additional capacity and out-of-hours activity. The demand based understanding would be characterised by the following quote:

"People come to us with everything, you can't turn people away but we can't solve all their problem but you can signpost- Practices can't close minds to this but should aim to access the additional services on offer"

Variation in approach to change and service access may be based on a range of practice-based thinking and knowledge including familiarity with multi-disciplinary working, fluidity and growth in demand and particular idiosyncratic approaches to general practice. There has also been initial comment about the unwillingness to adopt a short term pilot. Some/ many GPs may struggle to find time to think about how to make change and adopt new practices and other barriers also exist in terms of referring to new services (*' it might just be easier for me and 'my' patient if I continue to do the work myself)*

[14] Utility here refers to the

7. Roving GP

Roving GP began in Dover Court Surgery and has been implemented across the city. It uses additional hours of GPs enabling home visits. Roving GP is working well (preparatory information about patient made available and visits early in the day are perceived as making the difference) with some variation associated with individual practitioner's home visit practice. It has been accepted in most practices as an opportunity to share work and potentially reduce secondary care admissions by signposting to other care services (SW and DN services) although sceptics suggest that the Roving GP simply delays admission and that " they won't know my patient". Additionally, some practices have declined to use this service due to concerns about the lack of recurrent funding. Roving GP is planning an audit to substantiate a perceived positive response from patients. Contrary to this, there is a suggestion that it generated work for GP practice- (may be quality/variation issue associated with usual home visit practices or mistrust of nursing services and preferring to refer to other GP's) based on the additional time the Roving GP has to address and range of health and social care urgent needs.

16. Roma Advocacy and Health Project

Initiated in Page Hall surgery, this scheme aims to help and improve health outcomes of Roma Slovak (RS) community in Sheffield, increasing access to health services and improving health literacy. Additional goals include community integration and knowledge and understanding of RS service users. Based on a community development approach, four health worker are trained to work across 6 surgeries offering an afternoon clinic to support 1st appointments which includes GP registration, working with families to book and cancel appointments, signpost to services, work across wider health training schemes to promote health (e.g. smoke-free pledge), Hep B screening and make use of health literacy training in sexual health (other sessions delivered by Sheffield PH)- making links with health trainer and across the wider system (ICDH community courses).

Roma Slovak people numbering approximately 2500 across the City are typically high users of children's A&E services and less likely to register with primary care. RS families have expressed frustration with the inability to access care due to a range of reasons including language (low levels of spoken /written English) and lack of shared terms and understanding (e.g. primary education). High reported incidences of DNA and high stress in GP community due to failure to communicate at appointments cost of interpreters, confrontations in waiting areas and with reception staff. Roma Slovak people express overall low levels of confidence and trust in systems and processes in primary care leading to wasted appointments and frustration in services.

Currently the project is reporting a take-up of 580 people supported , as 18.5% of the whole population. (over 4 months). The RS Community is pleased to receive advice on form completion, help with accessing health and social care by phone and in person and advice on self-management and self-care. GP clinics are reporting improvement based on practice nurses and GPs are able to use project health workers effectively and see patients more effectively. Project workers recognise increased Health literacy and themselves have become role models in their own communities, highly connected and 'health advocates'.

12. Pharmacy

Project explores benefits of closer working between community pharmacists and GPs. The idea was tested in a small number of sites Jan-June 2015 which suggested potential for city-wide expansion. All surgeries that wish to engage have been matched with a pharmacist and joint working arrangements put in place - there is a set menu of activities based on core competencies of pharmacists. Demand on GP's to manage medicines generates a massive workload- medication review/

discharge reviews/ dosette box preparation and so the community pharmacy scheme has been widely welcomed. However feedback from practices varies. Some are very supportive and feel that it is working well. Others suggest that it's not viable due to limited pharmacist time or lack of confidence in skills of pharmacists - philosophies of individual GPs make a difference to project outcomes. Community pharmacy are very enthusiastic about the opportunity and in some cases practices are looking at offering SystmOne access to support community pharmacy- "frees up GP and work can be done better by someone else." Having a specialist input for medicines management is good as GP also involved very often for other care reasons. Chair of Pharmacy committee is an advocate for the scheme (has professional support).

15. Integrated care teams

Integrated Care Co-ordinators have been recruited and began roles on 1st Feb- one practitioner per locality and based in a GP. Clinicians are from different clinical backgrounds. All aim to offer additional resources to GPs, seeking to save GPs time and additional stress of managing highly complex caseloads. Schemes were promoted via Primary Care Sheffield as an opportunity to manage and sustain primary care as demand increases and better for patients to organise support. The roles are specifically to enhance the integrated care planning - facilitating the cross organisational utility of new and existing resources in a locality - this development appears to offer specific expertise to primary care about the different ways of managing complex care for very vulnerable patients and the roles appear to prospectively identify some of the more intractable population-level issues and help to manage the need in a primary care context. The focus differs in the 4 localities- 3 of 4 groups are working on house bound schemes and one on shared medical appointments and high users of primary care. Integrated care managers are currently being introduced to practices to identify plans and practice priorities

14. Web GP

Web GP scheme is testing a proof of concept in the introduction of an e-consultation/ self- management online tool to practice websites. Web GP was selected following a tendering on specification and adopt process by 9 practices. Licences are based on an up-font payment of licence but GP's have to design processes to monitor and follow up. Interview was with programme manager not with the ICT provider. Web GP collects just output data and other aspects such as patient and staff satisfaction are not included nor are process information associated with outcome for patient.

Increasing access to primary care is the clear goal but since inception the concern for GP workload and workforce is apparent and a subsidiary goal is to reduce the GP workload by increasing capacity in other service. GPs views may differ about the range of patient contact they would like and the project is based on the assumption that this has not been segmented for the purpose of managing caseload- there is no apparent baseline of demand or segmented use of urgent care

3. Out of Hours Social Work

Service identified prior to programme being awarded based on need identified that GPs had "nowhere to go" with frail, vulnerable patients out of hours resulting in unnecessary admissions and sometimes multiple admissions where admission of the person cared-for is required. 18 social work (SW) staff have been allocated to a 6 week shift pattern to provide support to adults over 18 with an out of hours social care assessment. Referral from GP and Emergency care Practitioners (ECPs) via SPA.

7-day staffing is arranged for a 2 hour response to referral. The SW meets the care provider (INSPIRE- private provider) at a person's property and undertakes a social care needs assessment. Care providers provide hands on service / ADL support for up to 8 days. The SW will make long term needs plan in the same period and also may provide small aids (joint funded community store) and signpost- refer for therapy or further rehabilitation. They are also able to assess and fit City wide Alarm (telecare)

Data being collected include demographic / carer info/ referral/ referral response/ plus other data. NHS number not used - Council care first number used. Take up of services based on referral from GP. The SW responds to a referral and therefore is not able to influence population access currently. Equity of access provided is based on 2 hr response time.

4a. Single Point of Access including 3. Social Work Liaison in SPA

SPA has been in place since 2006 and grown incrementally since then and the scheme has been developed to support the extended satellite hub provision, especially in relation to mental health referral. SPA has 26 work-streams including urgent and unscheduled care. Three main areas of activity: Nurses, admin staff, social care staff deal with GP referrals and recommend referrals to multiple services. They also facilitate calls to a geriatrician to either prevent or speed up admission. In October 2014 - social care staff joined the team, and in November 2015 mental health workers out of hours allow GPs refer into the service - offer alternative care packages to prevent hospital admissions or facilitate the admission process.

Project funding is for a 9 month period which has been used for - 2 FTE band 6 nurses and 2 FTE band 3 administrative staff - to provide additional admin in evening and at weekends. It was anticipated that when satellite centres are open, it could create additional demand for community services. Access to community services is through SPA so it was seen as logical that one of the programmes be an expansion of the existing SPA provision.

Difficult to come up with specific outcomes for the new provision - social work team and mental health (MH) team will collect their own data - SPA is a conduit for those services. The project objectives are: meeting demand for urgent out of hours care, building capacity in community services to meet demand and prevent crises, effective triage and referral via SPA. A lot of effort has been put into preparation and training prior to implementation - getting everything ready for roll-out has been a key challenge. The numbers of referrals are increasing and so far feedback is good. Monitoring data is strong for point of access and referral but less so for outcomes because there are a huge number of people involved once the patient is referred out of SPA.

4b. Florence

Florence is an automated SMS system that is set up to allow patients to receive texts to make reminders or health prompts. Four GP practices in North Sheffield are involved. The practices identify the patients and recruit them to the system. The aim is to have 200 patients on the system - approximately 50 per practice but may vary depending on practice populations. Each practice will have an identified health care assistant (HCA) who will serve as key point of contact with the patient. The HCA will liaise with the band 6 nurse. Patients will get twice daily messages to begin and then frequency will be determined by results. The project team have not yet had direct contact with the practices and the HCA in each GP practice has not yet been identified. Protocols will need to be established for the individual practices.

5. Community Volunteers scheme

Commissioning Manager (Carers) at Local Authority and has led the development of the city wide Carers' Strategy to develop the strategic approach for the city regarding unpaid carers and commissioning local authority support services for unpaid carers. The anecdotal evidence from a frail elderly population, is that when a primary carer needs admission they sometimes leave the dependant vulnerable partner and by default decision that person is then also admitted to hospital. A tender is being invited to scope the actual prevalence of this scenario and pattern of admissions and to offer an alternative model for the support of carers through a volunteer 'network'- (recruitment of a group of volunteers) with the goal of preventing unnecessary admissions to hospital. The goal will be to redirect possible secondary care admission to community and primary care support.

11. IAPT (Improving Access to Psychological Therapies)

Project provides step one and two assessment and evidence based IAPT interventions for people who are housebound. Based in Central Parks Community Nursing Team - referring practices are Whitehouse Surgery, Duke Medical Centre, Park Health Centre, Manor Park Medical Centre. Project aims are to increase access to mental health care (talking therapies) for housebound people with physical health problems, help people to self-manage their conditions, upskill community nurses to be able to detect and deal with mental health problems, reduce service costs. Project grew out of Sheffield IAPT - community nurses trained through IAPT were unable to find space within core District Nurse role to integrate physical and mental health care. Project provides time for community nurses to deliver and test the impact of integrated physical and mental health within community nursing role. Project has progressed well but a key limitation has been the small level of resource available. There has been an unanticipated level of complex need which is beyond the competence of community nurse practitioners. Where interventions have been delivered with patients and carers, outcomes have been good - often there have been significant changes resulting from simple interventions. Feedback from practitioners and patients is that holistic interventions are most effective. There is potential for long term cost savings although demand could be increased in the short term as levels of unmet need are uncovered.

Appendix 5 - Quantitative data analysis:

The following tables describe project title and contact names, outcomes listed by PCS, contract specification of what data was to be provided, what is missing from contract specification of data to be provided, what analysis is possible without NHS number, what analysis is possible with NHS number and a data sharing agreement, and what we can't do

Projects for which we have sufficient information to make statements about analytics

No	Project Title and contact names	Outcomes Expected by PCS	contract specification of data to be provided	what is missing from contract specification of data to be provided	What analysis is possible without NHS number	What analysis is possible with NHS number and a data sharing agreement	What we can't do
2	Satellite Units (4 sites) Contacts: Julie Mather julie.mather1@nhs.net 0114 2264323 07980 583917	• Improved Access for patients (SI) • Reduction in A&E attendances (adults and children) and reduction in Walk in Centre Attendances (IS) • Redistributing urgent (in hours) demand for GPs (SI)	There are 5 spreadsheets and the "Family and Friends" questionnaire in the information we have. The 5 spreadsheets are titled: • outcome data • prescribing report • age breakdown and day seen • read	- none of the documents list NHS number Conversation on 29Feb16 with Julie confirmed the appointment data and some other limited data is in a special SystemOne module and that it has NHS number. Lisa suggested meeting on 22Mar16.	- can only do output counts and some more sophisticated analysis than has been done currently.	link at individual level to A&E, OP, Spells, and 111data and test for a change, from before to after, in :1) inappropriate A&& visits, and 2) a change in hospital	Unless we approach each GP Practice we can't link to GP **appointment** data and look at changes in GP appointments

No	Project Title and contact names	Outcomes Expected by PCS	contract specification of data to be provided	what is missing from contract specification of data to be provided	What analysis is possible without NHS number	What analysis is possible with NHS number and a data sharing agreement	What we can't do
	for 1 Unit the contact is Barry Dobson		codes_age_Practice	On 09Mar16 John Soady reported that Barry Dobson was the person most likely to be able to determine what additional data can be abstracted and that he would make contact		admissions	
16	Roma Advocacy and Health Project Lisa Youle lisa.youle@nhs.net 0114 2716194 PCS Lucy Melleny lucy@darnallwellbeing.org.uk	• Improved appropriate access for a specific population (SI) • Save GP time (IS) • Reduction in A&E attendances (adult & children) (IS) Improved linkage of Primary Care to 3rd sector (WD)	The contract we have says nothing at all about data collection	not sure anything quantitative as there is a problem with having a comparison of any kind. because - they probably weren't in the system before and so can't do before and after - it is difficult to identify a comparison group of Roma outside of this programme for comparison	qualitative analysis can be completed		

No	Project Title and contact names	Outcomes Expected by PCS	contract specification of data to be provided	what is missing from contract specification of data to be provided	What analysis is possible without NHS number	What analysis is possible with NHS number and a data sharing agreement	What we can't do
	0114 249 6315 0114 226 0061 07944 143 470						
City Wide Access (Roving GP) John Soady will determine who is data custodian and does existing data sharing agreement cover this project?							
7	City Wide Rapid Access Team (Roving GP) Contacts - see bottom of table	• Reduction in A&E attendances (adults and children) and reduction in Walk in Centre Attendances (IS) • Reduced demand on practices (SI)	Data listed on spreadsheet as being collected: Date; Time of referral; Referring Practice; Time arrived at patient home; Time visit finished; Outcome of visit; Reason for referral; Potential admission avoided; If other please specify	• NHS number John Soady reported on 08Mar16 that a data abstraction procedure can't be used. Lisa suggested meeting on 22Mar16.	- can only do output counts	link at individual level to A&E, OP, Spells, and 111data and test for a change, from before to after, in :1) inappropriate A&& visits, and 2) a change in hospital admissions	Unless we approach each GP Practice we can't link to GP **appointment** data and look at changes in GP appointments
8	City Wide	• Improve	Data listed on	Need an NHS number	- can only do	link at	Unless we

No	Project Title and contact names	Outcomes Expected by PCS	contract specification of data to be provided	what is missing from contract specification of data to be provided	What analysis is possible without NHS number	What analysis is possible with NHS number and a data sharing agreement	What we can't do
	Acute, Same Day Service.	d access (in hours) to primary care (SI) • Redistribution of workload (SI) Practices Working together (SI)	spreadsheet as being collected: Appointments offered; Appointments booked; Appointments attended; Appointments cancelled; DNAs; What was the outcome of the visit (prescription, referral, GP appt etc) (A) 1. Referral to Secondary Care 2. Refer to other services: 3.Follow up appt 4. Prescription issued 5. Advice 6.Other	Need date and time of service provision	output counts	individual level to A&E, OP, Spells, and 111data and test for a change, from before to after, in :1) inappropriate A&& visits, and 2) a change in hospital admissions	approach each GP Practice we can't link to GP **appointment** data and look at changes in GP appointments

No	Project Title and contact names	Outcomes Expected by PCS	contract specification of data to be provided	what is missing from contract specification of data to be provided	What analysis is possible without NHS number	What analysis is possible with NHS number and a data sharing agreement	What we can't do
			What would the patient have done if the service was not there (B) 1. GP Collaborative 2. A&E 3. Broad Lane 4. Admission 5. Other				

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SPA-related projects

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Head of Primary Care and Interface Services, Sheffield Teaching Hospitals (Community) "

Barry Dobson
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0114 271 190

On 09Mar16 John Soady said he would approach Barry Dobson to determine what existing data sharing agreements might cover and what data might be abstracted

No.	Project Title and contact names	Outcomes Expected by PCS	contract specification of data to be provided	what is missing from contract specification of data to be provided	What analysis is possible without NHS number?	What analysis is possible with NHS number and a data sharing agreement	What we can't do
3	Social Workers Out of Hours Assessment and crisis response home support	• Improved Access and timeliness of response to social care packages (SI) • Reducing avoidable adult emergency admissions to hospital for social care reasons (IS) • Reducing risk and cost of social care	We have the following information "provide all data reasonably requested by PCS to enable evaluation of the project."	NHS number or a number that could be linked to NHS number	without NHS number - can only do output counts needs discussion to see what is possible - particularly if data linked to social care.	needs discussion to see what is possible - particularly if data linked to social care.	Unless we approach each GP Practice we can't link to GP **appointment** data and look at changes in GP appointments

No.	Project Title and contact names	Outcomes Expected by PCS	contract specification of data to be provided	what is missing from contract specification of data to be provided	What analysis is possible without NHS number?	What analysis is possible with NHS number and a data sharing agreement	What we can't do
		support in the longer term(IS) Reduce risk of deterioration of patients (IS)					
4a	Single Point of Access – Increased Clinical Triage, Signposting	• Improve the joining up of services and improved access to them (SI) Improving access to Mental Health and Social Care specialist advice (SI)	We have no information	• NHS number or hospital number that can be linked to NHS number • date and time of service provided • what service was provided (preferably from a specific list of services) needs discussion and development	without NHS number - can only do output counts	With NHS number should be able to: - show a reduction in A&E visits and/or hospital admissions	Unless we approach each GP Practice we can't link to GP **appointment** data and look at changes in GP appointments
9	Primary care access to psychiatric liaison	• Improved access to MH liaison in and out of hours for primary care (SI) • Reduc	We have the following information "provide all data reasonably requested by PCS to enable evaluation of the	Need an NHS number Need date and time of service provision plus some indication of the service provided.	without NHS number - can only do output counts	With NHS number should be able to: - show a reduction in A&E visits and/or	

No.	Project Title and contact names	Outcomes Expected by PCS	contract specification of data to be provided	what is missing from contract specification of data to be provided	What analysis is possible without NHS number?	What analysis is possible with NHS number and a data sharing agreement	What we can't do
		tion in A&E attendances (IS) Possibly reduction in admissions to STH and/or SHSC (IS)	project"			hospital admissions	
10	Weekend Specialist mental health support (general and older adults)	• Improved access for weekend out of hours specialist mental health support (SI) Reduced admissions and A&E attendances (IS)	We have no information or contracts on this project.	Needs discussion			

Projects for which we have incomplete information

No.	Project Title	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)	contract specification of data to be provided	What analysis is possible?	contacts and dates data or DAA requested
4b	Expansion of the Florence system to primary care	• Increase self-management (SI) Reducing practice demand for patient cohort(SI)	We have no information but understand they are doing their own evaluation.		Kathryn Robertshaw k.robertshaw@nhs.net 0114 2716177 Primary Care Sheffield John Radford radford.whirlow6@blueyonder.co.uk; john.radford@nhs.net 07799 648936 David Craig d.craig2@nhs.net 0114 271 1900 Sheffield Teaching Hospitals (community directorate)
5	Community Volunteer Scheme	Research / Audit	no information at all and we understand the money is being used elsewhere		
15	Integrated Care Management Teams	• System and Workforce development (SI) Mapping of Services (SI)	we have no information or contracts on this project.		•

No Evaluation beyond the qualitative component required by SHU - please confirm

No.	Project Title	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)	contract specification of data to be provided	SHU's role
1	Enhancing Primary Care Contract	• Strategic practice engagement at scale • Providing time, facilitation and practical support for Practice Development and federated working (SI)	D the contact as PMCF - reason for contact - new / follow-up - date & time of contact - elapsed time between call and seen - patients seen versus planned number - could not be seen • - no-shows / dropped calls - patient's problem resolved / episode completed & closed - identified another issue needing action other than the presenting problem - referral to patient's GP / practice - referral on to another service (& service type) - tests ordered a measure of patient experience using:-PMCF patient / client / carer questionnaire(s) or incorporation of PMCF key questions within existing surveys	*SHU not doing anything because there is a national evaluation.* *The national evaluation is collecting data and it is not yet clear what data will be made available to the programmes. Currently we THINK it will be aggregate data only at the practice level. We MIGHT be able to do something further with this but will have to experiment.*
11	Training Community Nurses to provide IAPT interventions for housebound	• Improving access for housebound patients with a mix of physical and mental health needs (SI) Workforce development (WD)	We have no information or contracts on this project. Being evaluated by ScHARR as part of the CLAHRC Mental Health theme	

No.	Project Title	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)	contract specification of data to be provided	SHU's role
	patients			
12	Primary Care Pharmacy Programme (PCPP)	• Improved patient outcomes on long term medication (SI) • Reduce prescribing spend (IS) • Reducing medication related admissions / readmissions (IS) • Release of GP time (IS) Testing benefits of working with clinical pharmacists (WD)	The provider collects data a reports - practice or community pharmacist - source of referral - what pharmacist did This is converted into an estimate of GP time saved.	With NHS number should be able to: • show a reduction in A&E visits and/or hospital admissions • show a reduction in GP visits for medication reviews/renewals??
13	Interoperability and use of the Medical Interoperability Gateway (MIG)	• Patient Safety (SI) • Reduced duplication and save clinician time (IS) Improved Communication and collaboration (SI)	We have no information or contracts on this project.	

No.	Project Title	Benefit: Invest to Save (IS) Service Improvement (SI) Workforce Development (WD)	contract specification of data to be provided	SHU's role
14	WebGP	• Improved supported self-care (SI) Reduced demand for GP /practice nurse appointments (IS)	We have no information or contracts on this project.	

Appendix 6: Risk Register

Reflecting on our experience of conducting research of this type, we have identified key risks, their potential impacts, and mitigation strategies. These are outlined in the table below.

Potential Risk	Likelihood	Impact	Assessment at interim report
Quality of available data	Moderate	Moderate	Data mapping continues. Section 2.3 presents the current state of play. As long as the NHS number can be provided and linked to the data collected the secondary care data can be linked.
Consistency of data from provider services	Moderate	High	still under review but while the data may be consistent for most projects, it is not homogenous across the projects and therefore projects cannot be compared.
Missing data (incl. demographic data)	Moderate	High	not resolved or fully addressed yet.
Access to comparator data via CSU	Low	Moderate	John Soady is examining existing data sharing contracts with CSU to determine if the data collected in each project is covered. A data steward for each project needs to be identified
Project staff turnover	Low	Low	no staff changes
Ability to deliver outputs to the timescale	Low	Moderate	limited by data governance problems. All other project components on track.
Technical constraints	Low	Low	This has not yet resolved. Mapping document produced and actions identified
Willingness of stakeholders to engage in evaluation	Low	Moderate	To date - little resistance. Data may provide a different story.

Potential Risk	Likelihood	Impact	Assessment at interim report
confidentiality and security of data	Low	High	maintained with a Home Office level secure server and data will be psuedonymised
Exclusion of key stakeholders	Low	Low	We are monitoring GP collaboration but others have fully collaborated.