NHS Rotherham Clinical Commissioning Group

LMC officers – 20 May 2019

Operational Executive – 24 May 2019

Strategic Clinical Executive – 29 May 2019

Primary Care Sub-Group – 29 May 2019

GP members committee – 26 June 2019

Primary Care Committee - 10 July 2019

Governing Body – 4 September 2019

Revised GP Strategy for Rotherham

Lead Executive:	Chris Edwards, Chief Officer
Lead Officer:	Jacqui Tuffnell, Head of Commissioning
Lead GP:	Dr Avanthi Gunasekera, SCE Lead for Primary Care

Purpose:

The GP strategy has been revised to incorporate the requirements identified in the new GP contract document, 'Investment and Evolution'.

Background:

Delegation responsibility:

Please tick which area of delegated responsibility this paper covers:

Commissioning, procurement and management of GMS,PMS and APMS contracts including taking contractual action	
Newly designed enhanced services (including DES)	
Local incentive schemes	
Discretionary payments	
Commissioning urgent care for out of area registered patients	
Planning Primary medical care services (PMCS)	√
Managing practices with CQC concerns	
Decisions on premise cost directions	
Planning the commissioning of PMCS	
Manage the delegated allocation for commissioning of PMCS	
Assurance to the governing body on the quality and safety of PMCS	

Analysis of key issues and of risks

Our interim GP strategy was developed in March 2015 and significant progress has been made in implementing change in General Practice. RCCG has a commitment to 'one plan' however because of the delegation arrangements in relation to primary care commissioning it is acknowledged that a separate GP strategy is required. The General Practice Forward View (GPFV) has provided further impetus for implementing change

at increased pace as funding streams were identified to enable delivery of the programme. In January 2019 the NHS published its Long Term Plan and general practice is key to delivering the plan. The South Yorkshire and Bassetlaw Integrated Care System are required to have a Primary Care strategy by July 2019 and therefore require place positions to inform the strategy, the Rotherham GP strategy has therefore been reviewed to incorporate the requirements identified within the plan and specifically the five year framework for GP contract reform 'Investment and evolution' was also published to achieve five main goals:

1. Secure and guarantee the necessary extra investment;
2. Make practical changes to help solve the big challenges facing general practice, not least workforce and workload;
3. Deliver the expansion in services and improvements in care quality and outcomes set out in The NHS Long Term Plan, phased over a realistic timeframe;
4. Ensure and show value for money for taxpayers and the rest of the NHS, bearing in mind the scale of investment;
5. Get better at developing, testing and costing future potential changes before rolling them out nationwide.

Specifically, the agreement addressed the following:

Address workload issues resulting from workforce shortfall

There will be a new *Additional roles reimbursement scheme* which will guarantee funding for an estimated additional 20,000 staff by 2023/24. The scheme will meet a recurrent 70% of the costs of additional clinical pharmacists, physician associates, first contact physiotherapists and first contact community paramedics and 100% of the costs of additional social prescribing link workers.

A permanent solution to indemnity costs and coverage

A new centrally funded clinical negligence scheme for general practice will commence in April 2019. All of general practice will be covered including out of hours and all staff groups. The scheme is funded through a one-off permanent adjustment to the global sum.

Improvement to the Quality and Outcomes Framework (QOF)

A number of indicators are being retired to create a new Quality Improvement domain. The first two quality improvement modules for 2019/20 are prescribing safety and end

of life care. There will also be changes to the current indicators to ensure they are clinically appropriate related to diabetes, blood pressure control and cervical screening. Exception reporting will be replaced by a more precise approach of the Personalised Care Adjustment.

Automatic entitlement to a new Primary Care Network Contract

Primary Care Networks (PCN) are essential building blocks of every integrated care system in the NHS Long Term Plan. A new network contract directed enhanced service (DES) will see general practice taking a leading role in every PCN. Eligibility depends on meeting registration requirements. 100% geographical coverages of the Network Contract DES is expected by July 2019 so that no patients or practices are disadvantaged. Each network must have a named accountable clinical director and a network agreement. A new primary care network development programme will be centrally funded and delivered through integrated care systems.

Supporting joined-up urgent care services

The LTP envisages PCNs joining up the delivery of urgent care in the community. Funding and responsibility for providing the current CCG commissioning enhanced access services transfers to the network contract DES by April 2021. From July 2019 the extended hours DES requirements are introduced across every network until March 2021.GP activity and waiting times dates will be published monthly from 2021 alongside hospital data.

Enabling practices and patients to benefit from digital technologies

NHS England will continue to ensure and fund IT infrastructure support including through the new GP IT Futures programme which replaces the current GP systems of choice. Additional national funding will also provide PCNs with access to digital-first support from April 2021. All patients will have the right to digital first primary care, including web and video consultations by April 2021. All patients will have access to their full records from 2020 and be able to order repeat prescriptions electronically as a default from April 2019. Additional funding will be added to the global sum for the next 3 years to recognise the income loss and workload from subject access requests.

Delivery of new services to achieve NHS long term plan commitments

The annual increase in funding for the Additional roles reimbursement scheme is

subject to agreeing seven national 'network service specifications' and their subsequent delivery. Five of the seven commence by April 2020:

1. Structured medication reviews
2. Enhanced health in care homes
3. Anticipatory care (with community services)
4. Personalised care
5. Supporting early cancer diagnosis

The remaining two, cardio-vascular disease case finding and locally agreed action to tackle inequalities commenced by 2021. By 2020 there will be a new Network Dashboard covering population health, urgent and anticipatory care, prescribing and hospital use. A national network investment and impact fund will start in 2020 which is intended to help networks make faster progress against the dashboard and NHS LTP goals.

Five year funding clarity and certainty for practices

GPC England and NHS England have agreed that no additional national money is expected for practice or network contract entitlements until 2024/25. Funding for the practice contract is now agreed for each of the next five years and increases by £978 million in 2023/24

Testing future contract changes prior to introduction

A new testbed programme will be established to provide real-world assessment. Different clusters of GP practices in PCNs will each develop or test a specific draft contract change such as a service specification, QOF indicator or QI module. Network participation in research will also be encouraged from 2020/21.

Rotherham response to the NHS long term plan

Our GP strategy has always identified the following:

The CCG has an overall vision of working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities. Primary care, defined for this purpose as care that can be provided out of hospital by GPs and the teams they employ, is at the heart of the NHS and will play a central role in achieving this aim by ensuring a co-ordinated service for patients, centred on the needs of the people that we serve and not silo organisations.

Therefore the national changes to general practice support the direction of travel which RCCG has been taking. We have fantastic examples of care in Rotherham but as our population increases and ages, it is critical that we respond by providing services in

different ways to ensure we continue to sustain and improve during challenging times. Our key challenges within GP services include our own ageing workforce. Over 33% of GPs in Rotherham are due to retire in the next 3 years with limited availability of trainees to fill vacancies.

This strategy is a key component to ensure we continue to mould our journey to deliver our priorities and what we will do to make the vision a reality. The strategy aligns with the Health & Wellbeing board priorities, the CCG's commissioning plan, the General Practice Forward View (GPFV) and the Investment and evolution: Five year framework for GP contract reform to implement the NHS Long Term Plan. Investment and evolution goes further to recognise the pressure general practice is under following years of relative under investment and sets out a national programme to invest £4.5billion. The strategy should also be considered as an enabler for, and read in conjunction with the RCCG Better Care Fund (iBCF) plan which is a pooled budget of £33.4 million for health and social care.

We have developed our strategy by reflecting on feedback from our patients and the wider primary healthcare teams at market place and development events held in June 2015, November 2015, July 2016 July 2017 and July 2018 as well as considering the challenges facing general practice. It is acknowledged that there will need to be further review of the strategy over the next 12 months to acknowledge the changing landscape associated with the development of the Primary Care Networks.

Over the course of the next 3 years, RCCG will continue its strategy to invest in primary care as follows:

- Support the development of Primary Care Networks to enable practices to work at scale and ensure a sustainable general practice infrastructure – a minimum of £1.50 per head will be invested;
- Continue to reinvest £1.94m monies released from PMS changes in the form of a quality contract for general practice and new local enhanced service schemes;
- We will continue our strategy to support practices with increasing telephone consultation and delivering new methods of consultation;
- We will continue to invest (current £2.4m) in local enhanced schemes, delivering care closer to home and improving the management of patients to avoid admission;
- We will build on the achievements from the Productive General Practice

Programme for all Rotherham practices by continuing to support Practice manager development;

- We will support primary care networks to consider skill-mix and to utilise new roles within the practice e.g. pharmacists, physiotherapists, emergency care practitioners, associate physicians, mental health workers, social prescribing link workers;
- We will utilise monies to ensure GP leaders are identified and upskilled to support their clinical colleagues in radical changes within practices;
- We will continue to upskill reception and administrative staff to feel able to care navigate and deal competently with medical documentation;
- The CCG will work with primary care networks to review the extended access offer within Rotherham alongside the GP out of hours services and primary care streaming to ensure it is a co-ordinated, effective offer for the Rotherham population
- We will review our key IT enablers including, Rotherham Health Record, the Rotherham Health APP which encompasses e-consultation, record review, direct booking of appointments, repeat prescriptions and ultimately provides the facility for online consultation with clinicians. The aim is to develop this further with the Rotherham place.

Patient, Public and Stakeholder Involvement:

The draft strategy has been circulated to key stakeholders:

Local medical committee
Healthwatch
Health and Wellbeing board
Connect Healthcare Rotherham
GP members committee
Primary Care Network Clinical Directors

Equality Impact:

Not applicable.

Financial Implications:

These will be considered alongside the allocation provided to RCCG for delivery.

Human Resource Implications:

Not applicable.

Procurement Advice:
Not applicable.
Data Protection Impact Assessment:
Not applicable.
Approval history:
Primary Care Committee Primary Care Sub Group LMC officers meeting Confidential Primary Care Committee Primary Care Network Clinical Directors Healthwatch
Recommendations:
It is recommended that the committee discuss and support the amendments to the GP strategy
Paper is for approval

investor in excellence

NHS
Rotherham
Clinical Commissioning Group

Strategy for General Practice

Revised July 2019

Date of next review: July 2021

1. Our vision for general practice within Rotherham

Plans and services of all commissioners and health and social service providers in Rotherham are prioritised by needs identified in our Joint Strategic Needs Assessment and the four key Rotherham Health and Wellbeing (H & WB) Strategic aims:

- **Aim 1:** All children get the best start in life and go on to achieve their potential
- **Aim 2:** All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
- **Aim 3:** All Rotherham people live well for longer
- **Aim 4:** All Rotherham people live in healthy, safe and resilient communities

The CCG will work with primary care networks to transform services over the next 3 years to achieve the following key outcomes:

- Improved consistency in access to general practice – all Rotherham patients able to access primary care for urgent issues within 24 hours, routine appointments within 5 working days and able to book appointments with the extended access hubs
- A combined, collaborative workforce across primary, secondary and community care providing a seamless pathway for patients with GPs as the linchpin for care
- Patients able to self-manage their conditions from home utilising technology to connect with healthcare professionals
- Supporting population health management to increase additional years of life across the community
- All patients will be able to access equivalent services within their geography
- We will increase the wider workforce within general practice to improve consistency in patient experience

2. Introduction

Rotherham Clinical Commissioning Group (CCG) is responsible for commissioning the majority of health services for Rotherham patients, its overall strategy is available on the following link:

http://www.rotherhamccg.nhs.uk/our-plan.htm

Rotherham Integrated Care Partnership

The Rotherham Integrated Health and Social Care Place Plan summarises local ambitions for bringing together health and social care as one single system. The Plan has been jointly produced by RCCG, The Rotherham Foundation Trust (TRFT), Rotherham Metropolitan Borough Council (RMBC),Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), Connect Healthcare Rotherham (GP Federation) and Voluntary Action Rotherham (VAR). The key principles are to:

- Focus on people rather than organisations, pulling pathways together and integrating them around people's homes and localities; we will adopt a way or working which promotes continuous engagement with and involvement of local people to inform this.

- Actively encourage prevention, self –management and early intervention to promote independence and support recovery, and be fair to ensure that all the people of Rotherham can have timely access to the support they require to retain independence.

- Design pathways together and collaborate, agreeing how we do pathways once collectively, to make our current and future services work better.

- Be innovative, using international evidence and proven best practice to shape our pathways to achieve the best outcomes for people in the most cost effective way.

- Strive for the best quality services based on the outcomes we want within the resource available.

- Be financially sustainable and this must be secured through our plans and pathway reform.

- Align relevant health and social care budgets together so we can buy health, care and support services once for a place in a joined up way.

The Plan has a transformational approach which has identified five closely interlinked transformational workstreams to maximise the value of collective action and transform the Rotherham health and care system in order to reduce demand for acute services, achieve clinical and financial sustainability and thus close the three gaps. These five transformational workstreams align to the H&WB Strategy and will underpin its delivery:

- Children and Young People
- Mental Health
- Learning Disabilities
- Urgent Care
- Community Care

Rotherham is part of the South Yorkshire and Bassetlaw Integrated Care System (ICS) and this local strategy will be incorporated into the wider ICS Primary Care Strategy.

General practice is the bedrock of the NHS and the NHS relies on it to survive and thrive. In January 2019 the NHS published its Long Term Plan (LTP) and general practice is key to delivering the plan. The LTP sets out the key ambitions for the NHS over the next 10 years. These key ambitions include:

Boosting 'out-of-hospital' care and finally dissolving the historic divide between primary and community health services

Redesigning and reducing pressure on emergency hospital services

People will get more control over their own health, and more personalised care when they need it

Digitally-enabled primary and outpatient care will go mainstream across the NHS

Local NHS organisations increasingly focused on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICS)

Improving urgent community response and recovery services

Developing Primary Care Networks of primary and integrating community teams

Providing guaranteed NHS support for care homes

Supporting people to age well

Increasing patient choice

Provision of same day emergency care

Reducing delays in patients going home

Digitalisation of Primary and Outpatient care

Integrated Care systems everywhere by 2021 – focussing on population health

A five year framework for GP contract reform 'Investment and evolution' was also published to achieve five main goals:

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GPC England and NHS England have agreed that no additional national money is expected for practice or network contract entitlements until 2024/25. Funding for the practice contract is now agreed for each of the next five years and increases by £978 million in 2023/24 as below:

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Practice contract baseline	£8.007m	£8,116m	£8,303m	£8,532m	£8,748m	£8,985m
Cumulative increase		£109m	£296m	£525m	£741m	£978m
% annual increase		1.4%	2.3%	2.8%	2.5%	2.7%

Testing future contract changes prior to introduction

A new testbed programme will be established to provide real-world assessment. Different clusters of GP practices in PCNs will each develop or test a specific draft contract change

such as a service specification, QOF indicator or QI module. Network participation in research will also be encouraged from 2020/21.

Rotherham response to the NHS long term plan

Our GP strategy has always identified the following:

The CCG has an overall vision of working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities. Primary care, defined for this purpose as care that can be provided out of hospital by GPs and the teams they employ, is at the heart of the NHS and will play a central role in achieving this aim by ensuring a co-ordinated service for patients, centred on the needs of the people that we serve and not silo organisations.

Therefore the national changes to general practice support the direction of travel which RCCG has been taking. We have fantastic examples of care in Rotherham but as our population increases and ages, as outlined in the Joint Strategic Needs Assessment (JSNA) it is critical that we respond by providing services in different ways to ensure we continue to sustain and improve during challenging times. Our key challenges within GP services include our own ageing workforce. Over 33% of GPs in Rotherham are due to retire in the next 3 years with limited availability of trainees to fill vacancies.

This strategy is a key component to ensure we continue to mould our journey to deliver our priorities and what we will do to make the vision a reality. The strategy aligns with the Health & Wellbeing board priorities, the CCG's commissioning plan, the General Practice Forward View (GPFV) and the Investment and evolution: Five year framework for GP contract reform to implement the NHS Long Term Plan. Investment and evolution goes further to recognise the pressure general practice is under following years of relative under investment and sets out a national programme to invest £4.5billion. The strategy should also be considered as an enabler for, and read in conjunction with the RCCG Better Care Fund (iBCF) plan which is a pooled budget of £33.4 million for health and social care.

There are some considerable challenges to be overcome as we move towards delivery of our vision. Almost two-thirds of our population live with health-related problems. More people are living longer with more chronic diseases and medical treatments are getting more complex and expensive. We have to deliver healthcare differently as funds are not

growing to deliver in its current format which could increase inequity in funding if it is not managed effectively.

We will improve healthy life expectancy for the most vulnerable in society by ensuring activities focused on prevention, improvements to knowledge of and access to services, self-management abilities, and service outcomes are targeted at those who are most disadvantaged in the population. This could be due to deprivation, ethnicity, sexuality, gender, mental health status, physical or learning disability, caring responsibility, or housing status (homelessness) across the life-course in order to address the most significant health inequalities between Rotherham's most and least deprived communities. We will continue to work with RMBC to ensure 'Making Every Contact Counts' is embedded across organisations and supporting referral to services (where appropriate).

We will continue to support our practices to reduce antibiotic prescribing and reducing antimicrobial resistance.

We have developed our strategy by reflecting on feedback from our patients and the wider primary healthcare teams at market place and development events held in June 2015, November 2015, July 2016 July 2017 and July 2018 as well as considering the challenges facing general practice.

Our interim strategy was developed in March 2015 and significant progress has been made in implementing change in General Practice. The GPFV has provided further impetus for implementing change at increased pace as funding streams were identified to enable delivery of the programme. The Investment and evolution document provides further opportunity to deliver change more quickly particularly to support the workforce and rising demand challenges.

3. Executive summary

Over the course of the next 3 years, RCCG will continue its strategy to invest in primary care as follows:

- Support the development of Primary Care Networks to enable practices to work at scale and ensure a sustainable general practice infrastructure – a minimum of £1.50 per head will be invested;
- Continue to reinvest £1.94m monies released from PMS changes in the form of a quality contract for general practice and new local enhanced service schemes;

- We will continue our strategy to support practices with increasing telephone consultation and delivering new methods of consultation;
- We will continue to invest (current £2.4m) in local enhanced schemes, delivering care closer to home and improving the management of patients to avoid admission;
- We will build on the achievements from the Productive General Practice Programme for all Rotherham practices by continuing to support Practice manager development;
- We will support primary care networks to consider skill-mix and to utilise new roles within the practice e.g. pharmacists, physiotherapists, emergency care practitioners, associate physicians, mental health workers, social prescribing link workers;
- We will utilise monies to ensure GP leaders are identified and upskilled to support their clinical colleagues in radical changes within practices;
- We will continue to upskill reception and administrative staff to feel able to care navigate and deal competently with medical documentation;
- The CCG will work with primary care networks to review the extended access offer within Rotherham alongside the GP out of hours services and primary care streaming to ensure it is a co-ordinated, effective offer for the Rotherham population
- We will review our key IT enablers including, Rotherham Health Record, the Rotherham Health APP which encompasses e-consultation, record review, direct booking of appointments, repeat prescriptions and ultimately provides the facility for online consultation with clinicians. The aim is to develop this further with the Rotherham place.

4. Context

4.1 Profile of Primary Medical Care in Rotherham

90% of all NHS contacts are with general practice.

There are around 1.6M GP consultations every year in Rotherham with each patient seeing their general practice 6 times per year on average.

Rotherham's resident population is estimated at 261,000 (as identified in the JSNA) who are cared for by a total of 30 GP practices (as at April 2019) alongside a centrally based Urgent and Emergency Care Centre providing 24 hour/7 day access. At the present time,

four GP practices in Rotherham are ‘singlehanded’ compared to 26 practices with multiple GP partners or which are alternative providers.

National average list size	8360
Rotherham average list size	8811
National average number of patients per WTE GP	1290
Rotherham average number of patients per WTE GP	1690

The CCG currently has 15 training practices and all Rotherham training places have been filled this year. This is important as training practices play a significant role in supporting new GPs and encouraging them to stay in the area once they are qualified.

With regard to type of contract there are:

23 Personal Medical Services (PMS) practices

6 General Medical Services (GMS) practices

1 Alternative Provider Medical Services (APMS) practices (covering 3 practices)

A Community Interest Company (CIC), Connect Healthcare Rotherham, which is CQC registered is in place which enables all 30 practices to work collectively and be able to respond to the demands facing general practice. All 30 practices have signed up to the Federation. The CIC currently has a GP leading as Medical Director, a Head of Federation, Lead Development Nurse, Service Development Manager and administrative support. The CIC is now equipped to support the Primary Care Networks model and currently holds contracts to deliver extended access and physio first.

4.2 Current and future General Practice

Whilst media attention is often focused on the challenges facing the heath service, it must be acknowledged that there is excellent work taking place in general practice, day in, day out to ensure patients receive high quality care. As a principle, it was agreed that these should be protected and preserved when thinking about any future model of care. They included:-

- GPs holding longer term contracts that build real commitment to the local Community and/or configuring under different forms e.g. Primary Care Networks;
- Registered list that leads to continuity of relationships and care•;

- GP acting as the coordinator of care between other health and social care Settings;
- Appetite for innovative ways of working;
- Keen to learn new skills through educational programmes designed by local GPs;
- Practices working together to share good practice and learning;
- Secondary to primary care Local Enhanced Service agreement where practices have agreed to work together to provide services for all patients when individual practices have not got capacity or skills;
- The delivery of high quality care e.g. anticoagulation, where the increased service quality being delivered is outstanding.

General practice incorporates the essential values of personal care, continuity of care, generalist skills and a holistic approach to patients. Prevention and the treatment of ill health both have equal priority and consider the social and environmental factors which impact.

In 2017 the provider locality structure in Rotherham was amended to reflect the geography of the district nursing teams. The primary care network structure will continue to be geography based with a minimum population base of 30,000.

As one of the current localities is less than 30,000 and would not therefore be eligible for the benefits associated with being a network e.g. additional roles, network DES. The network structure for Rotherham has been determined by the practices acknowledging the geography requirements:

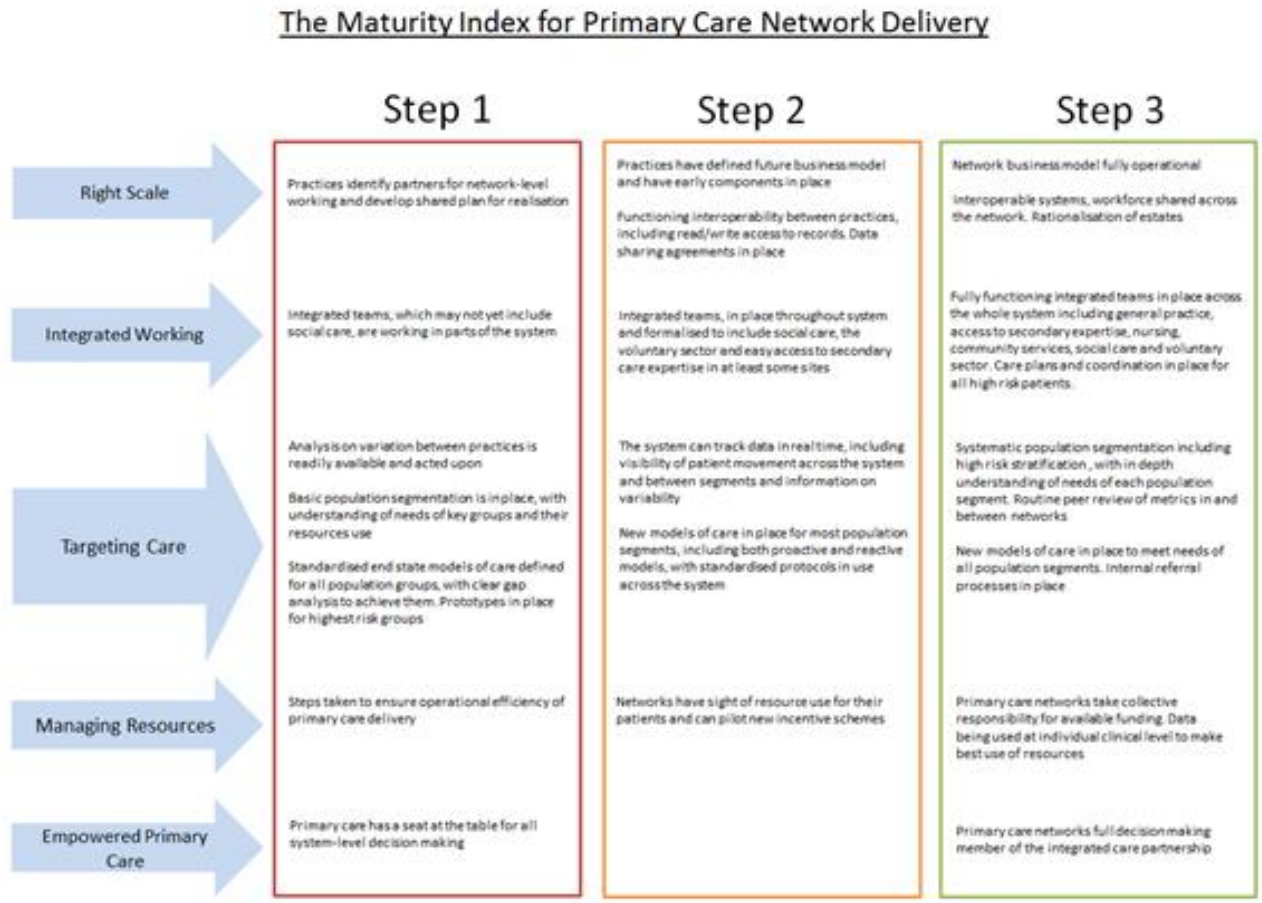
Primary Care Network	Practice	Population (Raw)	
Rotherham Central North	Woodstock Bower	11280	
	Broom Lane	13203	
	Broom Valley	1798	
	Greasbrough	3430	
	Greenside	5950	35661

Raven	Stag	11527	
	Treeton	6473	
	Thorpe Hesley	5759	
	Gateway	7173	
	Brinsworth & Whiston	9819	40751
Maltby/Wickersley	Wickersley	6995	
	Morthen Road	11680	
	Braithwell	3347	
	Queen's	1491	
	Blyth Road	5948	
	Manor Field	6363	35824
Rother Valley South	Dinnington	20789	
	Village	7250	
	Kiveton Park	11340	
	Swallownest	16594	55973
Wentworth 1	High Street	7929	
	Parkgate	6163	
	Magna	12971	
	Rawmarsh	3997	
	York Road	4618	
	Shakespeare Road	5382	41060
Health Village/Dearne Valley	St Anns	17594	
	Market	11622	
	Clifton	13257	
	Crown Street	9137	51610

Primary care networks are key to delivering the neighbourhood based approach provided that they embrace full integration with non GP practice stakeholders. Connect Healthcare Rotherham had already been commissioned to support practice groupings and will continue to provide a role to support the development of the primary care networks.

The long terms plan and subsequent investment and evolution document provide further strategic direction to support the ongoing development and maintenance of primary care networks. In 19/20 £2.50 per head has been allocated (£1 per head non-recurrently from the Integrated Care System and £1.50 recurrently from the CCG allocation). The purpose of the funding is to support the delivery of the PCN maturity matrix, pilot new ways of working, development of the PCN leaders and infrastructure, further development of risk

stratification and population health segmentation and to ensure the network agreement is used to strengthen collaboration.



4.3 Changes to Contractual Arrangements

NHS England have nationally lead changes to the payment arrangements for general practice to apply the principles of equitable funding. The aim of which is to move to a position where all practices (whether GMS, PMS or APMS) receive the same core funding for providing the core services expected of all GP practice. The review of PMS funding, determined that any additional funding above this must be clearly linked to enhanced quality of services or the specific needs of a local population. Also that practices should have an equal opportunity to earn premium funding if they meet the necessary criteria.

On a positive note, the funding released from the PMS review has remained within Rotherham and has been reinvested back into Rotherham primary care to achieve the following:

- Reflect joint area team/CCG strategic plans for primary care – supporting an integrated approach to delivering community based services;
- Secure services or outcomes that go beyond what is expected of core general practice – ensuring premium funding is tangibly linked to providing a wider range of services or providing services to higher quality standards;
- Help reduce health inequalities;
- Give equality of opportunity to all GP practices;
- Support fairer distribution of funding at a locality level.

The GMS monies released from MPIG removal did not remain within Rotherham have been reinvested into the 'global sum' for general practice (equitable funding level).

The Rotherham approach to PMS reinvestment has included the development of a quality contract which consists of 13 standards and was fully in place by April 2018. The quality contract is now reviewed annually to ensure the standards remain appropriate and are not duplicated in the national contract.

5. Our Key Priority Areas

5.1 Population Health Management

Rotherham CCG is committed to a population health approach, improving the physical and mental health outcomes and reducing health inequalities across defined populations. The Primary Care Network structure supports this approach by bringing together partner organisations to reduce the occurrence of ill health.

Population health management improves population health by utilising data to drive the planning and delivery of care to achieve maximum impact. It includes segmentation of the population and risk stratification to identify at risk cohorts and design/target interventions to prevent ill health and reduce unwarranted variations in outcomes.

Rotherham has been undertaking risk stratification in general practice for several years and is working with the hospital to achieve segmented data this year. Multiple sources of data are being pulled together to provide a clear picture of the Primary Care Network's

population. A primary care and quality contract dashboard are already in place providing the Primary Care Committee with oversight of variation of behaviour between GP practices. This also enables the committee to understand any barriers within General Practice.

The long term plan also facilitates development of the following:

- All screening and vaccination programmes designed to support a narrowing of health inequalities.
- Implementing an enhanced and targeted continuity of carer model in maternity services to help improve outcomes for the most vulnerable mothers and babies to help reduce pre-term births, hospital admissions, the need for intervention during labour, and women's experience of care
- Access to specialist homelessness NHS mental health support for rough sleepers, integrated with existing outreach services
- Identifying and supporting carers, particularly those from vulnerable communities through the use of CQC Quality marks for carer-friendly GP practices and the adoption of carer's passports
- Developments to electronic health records to allow people to share their caring status with healthcare professionals wherever they present.
- Rolling out 'top tips' developed by Young Carers for general practice on access to preventive health, social prescribing, and timely referral to local support services
- Expansion of NHS specialist clinics to help more people with serious gambling problems

5.2 Quality Driven Services

A high-quality service can only be delivered if there is a focus on three key quality dimensions: clinical effectiveness, safety and patient experience. It is crucial that the economic challenge does not change this focus. We will, therefore continue to support innovation in clinical practice and develop pathways that improve effectiveness and that enhance the patient experience as well as providing value for money. The CCG already supports protected learning time every month, for all GP practices and sufficient time for localities to ensure they are clinically and professionally updated. There are four core

components to this focus: quality, innovation, prevention and productivity. The CCG will continue to review benchmarking and learning from peers to support this agenda.

Funding for all practices should be equitable for delivery of service and also demonstrate value for money. Core contract activities will be remunerated in line with national agreements. Benchmarking information using nationally available data, comparing practice quality and productivity within our area and externally, will be used to ensure value for money.

We will look to achieve best value for money, driving efficiencies in the way general practice is delivered. The quality contract also provides the platform for defining more clearly the quality requirements from practices and relevant training and support is being provided (for example diabetes specific PLTC, reception team training in relation to customer care, carers and dementia) to ensure practices feel sufficiently competent. Local practices have already embraced the opportunities to be more efficient in medicines management and prescribing and are continuing to fully support a waste campaign which includes practices taking more control of what is dispensed to their patients.

The CCG already undertakes quality peer review visits to all GP practices and has developed a framework to support practices where there are quality concerns co-commissioning principles. The Care Quality Commission (CQC) has continued its programme of revisits in Rotherham, and currently only one practice 'requires improvement', 28 being 'good' and one 'outstanding' The CCG work collaboratively with practices where any required improvements are identified.

5.3 Services as local as possible

Our main aim is for general practice to sit at the heart of a patients care. Currently, when a patient requires secondary care intervention, care is handed over to the 'specialist' and handed back once treatment is complete or where protocols exist for care to continue in the community. Often patients could be more appropriately managed by their GP who has a holistic understanding of the patient and therefore increasing used of shared care protocols is a key aim of this strategy. This fits well with planning guidance which identifies changes to outpatient follow-up to encourage discharge back to primary care as soon as is feasible. This is difficult to achieve when there are capacity issues therefore patient

management will take on a variety of forms e.g. skype and telephone consultations and utilising our upskilled nursing workforce (cross reference to workforce 5.5 page 20).

The Rotherham place plan has identified 22 **priorities** to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services and achieve clinical and financial sustainability. We note that even though the priorities are presented as separate initiatives, they are all very closely interlinked.

Children and Young People's Transformation

- Priority 1: Implementation of CAMHS Transformation
- Priority 2: Maternity and Better Births
- Priority 3: Oversee delivery of the 0-19 healthy child pathway services
- Priority 4: Children's Acute and Community Integration
- Priority 5: Special Education Needs and Disability (SEND) – Journey to Excellence
- Priority 6: Implement 'Signs of Safety' for Children and Young People across partner organisations
- Priority 7: Preparing for Adulthood (Transitions)

Mental Health and Learning Disability Transformation

- Priority 1: Deliver improved outcomes and performance in the Improving Access to Psychological Therapies (IAPT) service
- Priority 2: Improve dementia diagnosis and support
- Priority 3: Deliver CORE 24 standards for liaison mental health service
- Priority 4: Transform the service at Woodlands 'Ferns ward'
- Priority 5: Improve community crisis response and intervention for mental health
- Priority 6: Better Mental Health for All
- Priority 7: Oversee delivery of Learning Disability Transforming Care
- Priority 8: Support the Implementation of the My Front Door – Learning Disability Strategy
- Priority 9: Support the Development of Autism Strategy

Urgent and community Transformation

Priority 1: Integrated Point of Contact

Priority 2: Integrated Rapid Response

Priority 3: Integrated Discharge Service

Priority 4: Integrated Localities

Priority 5: Develop a Reablement and Intermediate Care Offer

Priority 6: Develop a Coordinated Approach to Care Home Support

General Practice is already supporting these priorities and also supporting services traditionally which have been provided by secondary care. These include:

DMARD monitoring
Anti-coagulation monitoring
CEA monitoring
Testosterone monitoring
Transgender monitoring
Dementia reviews
Suturing and complex dressings following procedures in secondary care

The intention is to continue this journey with a desire that with the practices having continuing responsibility for the patient, the requirement for follow-up care within secondary care, particularly after surgical procedures will significantly diminish. This is a significant change for both primary and secondary care and links to the requirement to ensure that primary care is sufficiently resourced to manage this commitment. Section 5.5, in relation to workforce describes how the CCG is working with providers to upskill and have sufficient numbers to ensure the service is robust.

The CCG has also committed to the provision of 'social prescribing' to support patients requiring healthcare which enables GPs and other clinicians within practices to refer patients to other appropriate services for issues which whilst not directly clinical and have impact on their health and wellbeing. These include housing, debt, loneliness. Rotherham CCG has also increased this service to support individuals with mental health issues.

5.4 Equality of Service Provision – Enhanced Services

GPs are contracted to provide “core services‟ (essential and additional) to their patients. The extra services they can provide on top of these are called “enhanced services‟ which are voluntary but, if taken up, often add to the quality of care. The CCG is committed to maximising the uptake of enhanced services and as part of the quality contract arrangements, it will be mandatory for practices (or to have appropriate sub-contract arrangements in place) to undertake all the local enhanced services considered core quality.

Enhanced services address gaps in essential services or deliver higher than specified standards, with the aim of helping the CCG to reduce demand on secondary care and other health services. Enhanced services expand the range of services to meet local need, improve convenience and extend choice. The total investment by the CCG in 2018/19 was £2.75m (excluding the quality contract payment). The number and variety of schemes has increased over the years as local enhanced services have been developed and the local enhanced services which are available to the whole Rotherham population are:

- Case management
- Anticoagulation
- Aural care
- DMARDs (Rheumatology monitoring)
- PSA
- Testosterone
- Suture removal
- Dementia
- CEA monitoring
- Minor Surgery
- Ring Pessary
- Transgender
- Phlebotomy

The CCG also encouraged practices to align with care homes across Rotherham to reduce the number of GPs visiting and improve the quality of care patients receive in care homes. All nursing and residential care homes are now aligned and weekly clinic/ward visits take place in order to manage patients conditions proactively.

In addition to this the CCG also has Local Incentive Scheme (LIS) which ensure that practices remain up to date with current practice. In addition to the GPFV requirements RCCG has also been:

- Supporting nurse education within practices
- Releasing GP leaders to make this significant change within practices
- Developing Practice Managers to lead different business models in the future
- Working with the Federation and ATP programme to support practices to host and then employ different workforce roles e.g. Healthcare assistants, apprenticeships, clinical pharmacists and Physician Associates.
- We are piloting Physio 1st to understand the impact this has on the workload of GPs and secondary care and hope Primary Care Networks will invest in these roles when the additional roles reimbursement is implemented

The CCG is responsible for providing services for all Rotherham patients so developing the capacity to help all eligible patients will be an important consideration when planning future expansions of general practice services.

5.5 Increasing Appropriate Capacity and Capability

Fewer trainees are choosing general practice when they qualify and more GPs are choosing to retire earlier than normal retirement age. Rotherham has a good track record of attracting trainees, predominantly due to a good reputation for education but also the proximity to Sheffield.

Overall, whilst we are currently slightly better than the Yorkshire and Humber average in relation to numbers of GPs and qualified nurses, we have a very worrying age profile of 18% of GPs, 33% of Practice Nurses and 40% of Practice Management/Admin being aged 55 or over.

The primary care workforce is changing. An increasing number of GPs are working outside the traditional model with more sessional and locum GPs and utilisation of different professions, more typically nursing to undertake traditionally GP roles. The gender balance between male and female doctors is also changing which is also impacting on workforce

availability as traditionally female GPs have chosen to work part-time however more male GPs are choosing to work more flexibly. The success of the CCG will be dependent on its ability to embrace, utilise and develop potential across its whole clinical and non-clinical workforce. It will also work with provider organisations and the local authority to harness the skills of the wider primary care health and social care teams including district nursing, social work, pharmacy, podiatry, physiotherapy and others. A workforce plan is in place and incorporates the national 10 point plan – Building the workforce – new deal for GPs. This includes our plans for training administrative staff, upskilling unqualified staff and developing our Practice Managers to have the skills to lead new organisational formats. Rotherham participates in the South Yorkshire and Bassetlaw Workforce Group and is committed to the Integrated Care System plan for primary care which has been co-produced by the group and Health Education England. The workforce plan for Rotherham is included at Appendix 1.

10 practices have committed to the student nurse training scheme and 8 practices now have apprenticeships. 12 more practices have participated in a local healthcare apprenticeship scheme with its aim to increase the numbers of healthcare assistants across the practices. 10 practices have shown an interest in mentoring newly qualified student nurses as there is commitment to capturing the workforce early in their career instead of general practice being seen as somewhere secondary care or community nurses go later in their career. Four practices have already directly employed clinical pharmacists in their new workforce models, undertaking medication reviews and long term condition management. The Federation were recently successful in a bid to NHSE to extend the pharmacist workforce into more practices who are keen to adopt these new roles.

Whilst some practices have recognised the need to continually train and develop staff to enable nurses and other clinicians to feel empowered and competent to take on new roles, there are practices who have not felt able to fund and/or release time for training to the level required for the cascade of duties from GPs. All practices in Rotherham recognise that the traditional GP practice model has to change and many are already embracing the benefits of skill mix changes to fully utilise the skills of qualified and unqualified nurses. However, there are practices that require support with this both financially and physical presence as primary care does not have the benefit secondary care has of education teams co-ordinating training. As part of the Federation development, a Lead

Development Nurse role has been created and recruited to provide leadership and ensure General Practice nursing teams across Rotherham are equipped to deliver the current and future primary care agenda. This role also provides an initial point of contact for future work developing stronger links between all nursing teams across the Borough. It is recognised that collective leadership is not present across general practice nursing teams and the value of experienced able leadership is widely recognised and well documented. The workforce report details the current risk we have of 22% of the workforce who are able to retire and have the most knowledge, it is critical that we ensure the current workforce is upskilled along with the work already taking place to attract newly qualified nurses into general practice. As detailed above, we have 10 practices providing placements for student nurses to develop the primary care workforce of the future and also intend to extend training to offer opportunities to secondary care nurses who longer term would wish to work within primary care but as they are normally specialty specific, do not meet the criteria for application. As our plan as an STP is to reduce bed bases and manage patients more within an integrated community environment, we need to start to enable current secondary care staff to access training as in reality it takes at least 2 years for staff to be fully confident in primary care as there is such a breadth of knowledge to gain. Non-recurrent funding has been provided to the Federation to create 2 roles for individuals from other sectors to be upskilled in primary care and this has been extremely successful with both individuals securing practice nurse roles substantively. RCCG is keen to participate in a similar wider scheme to upskill newly qualified nurses.

We already have a significant number of high quality, committed and dedicated administrative staff who support and care for our patients. But we recognise that their roles could be enhanced to provide more support whilst also enabling this workforce to be more empowered and therefore more likely to be retained. We will continue to facilitate training sessions in relation to care navigation and medical documentation along with customer care, dementia and carer awareness.

The CCG has met with local universities regarding physician associate training and promoted this with practices. Key concerns remain in relation to the roles being paid at the same or even higher level than Advanced Nurse Practitioners who it is currently considered require less direction and are able to prescribe and order x-rays. The CCG continues to encourage practices to consider these roles and the Investment and Evolution

document should support and encourage networks to consider these roles. The CCG is also an active member of the Primary Care Workforce Group (South Yorkshire and Bassetlaw) and the ICS plans for workforce. The CCG and the Federation will work with the ATP regarding opportunities to support practices with training and recruiting to these new roles.

At the moment, health and wellbeing support within general practice is provided on an informal basis and needs to improve. The CCG is keen to implement the resources identified in GPFV to support GPs in relation to their health and wellbeing. The CCG will work with the LMC and Federation to understand the need for this support within Rotherham and actively pursue funding as it becomes available.

The CCG has training leads and spends time with new trainees identifying and promoting the different opportunities for work within Rotherham. These include portfolio careers enabling new GPs to have more varied roles by also working in secondary care or having a particular specialised interest developed.

Rotherham has undertaken a whole-scale programme of Productive General Practice providing intensive support to release 'Time to Care' across all practices. From previous programmes, this releases on average 10% of practice time as well as supporting individuals to consider their individual practices to ensure they are as efficient as feasible.

Practice size and sustainability is an important consideration. Rotherham has historically benefitted from having high quality services provided by practices of different sizes. In May 2015 the CCG Governing Body took the view that as opportunities arise the CCG will work to encourage small practices to work closer together in order to provide more sustainable services. Since January 2015 to number of practices has reduced from 36 to 30 and work continues with the CIC to support practices unable to deliver certain services because of their scale.

5.6 Primary Care Access Arrangements

Primary care access arrangements are set out in the GMS contract. This defines core hours as the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday, except Bank holidays. The contractor must provide essential services at such times

within core hours, as are appropriate to meet the reasonable needs of its patients. Practices offer a variety of systems for walk in access, telephone triage, same day and pre-booked appointments. Some practices close for one afternoon a month in order to have protected learning time however many increase their capacity during that week to ensure the same number of appointments are offered and our ambition is to ensure consistency across practices. Where practices are closed, arrangements are in place for patients to access the out of hour's service during this period.

All practices are able to text remind patients of their appointments and RCCG has enabled increased functionality with MJOG for patients to report blood pressure readings which has also enabled access for patients to text cancellations direct to the clinical system which is having significant success in the practices which are piloting this arrangement. All practices (except one) achieved the initial 10% target for online services. Almost all practices have achieved the 20% target and a significant number are achieving much more than 20%.

It is acknowledged that access is one of the most significant concerns for the general public. As detailed below, the area requiring most focus is patient experience of making an appointment. From triangulating this data, we have commenced work with practices about their capacity for patients contacting their surgeries along with the service received once their call has been answered.

We have focused on improving this area and access is a key standard in the new quality contract and Since April 2017 all practices have committed to the following:

1. Practices will offer sufficient capacity to achieve
    a. Urgent access within 1 working day
    b. An appointment for patients within 5 days when their condition is routine.
    c. Follow-up appointments within a two day window of when the clinician identified i.e. if a 1 month follow-up, the appointment offered will be no more than 1 month and 5 working days.
2. It is a requirement that there is a minimum of 75 contacts per 1000 patients per week. Contacts may be provided by a GP (or training GP) and/or Nurse Practitioner (who is qualified to diagnose) and may be face to face or by telephone (triage followed by face to face consultation will be deemed as one episode).
3. Practices are required to have reviewed their capacity and demand and to ensure

they are resourcing to meet this demand. This includes:

- provision of capacity in alternative ways e.g. virtual (telephone) and using alternative roles.
- 10 bookable sessions (am/pm)
- offer access to both male and female clinicians.

4. Offer pre-bookable appointments 1 month in advance at main sites where clinically required.
5. Ensure acutely ill children under 12 are assessed by a clinician on the same day
6. Accept deflections from Yorkshire Ambulance Service (YAS).
7. Provide an in hours home visiting service for those patients presenting with an urgent clinical need requiring a home visit who live within the practice boundary but are registered with a practice outside of Rotherham CCG Boundary in accordance with GP choice requirements with associated payments (currently £60 per home visit). It is not anticipated that demands for such visits will exceed one per month.
8. Improve on patient survey measures

Integration with GP out-of-hours providers and other urgent care services will help to reduce duplication and confusion about how best to access urgent care. This arrangement has been continued for patients requiring urgent primary care within the Emergency Centre arrangements. Three GP hubs (North, South and Central) are now in place to enable patients with commitments within the week, to access general practice at the weekend in addition to the current arrangements of extended access (morning and evening weekday). The Central GP hub offers a Saturday and Sunday service as well providing extended access for population not covered by the Directed Enhanced Services in the week, North and South are open on Saturdays. All three hubs offer routine and urgent appointments.

From 2021 the Primary Care Networks will be responsible for a core access offer to their patients which includes the extended access DES as well as the extended access service.

Action cards have been developed to improve the escalation arrangements across Rotherham and ensure there is clarity of the required actions which can be taken in primary care to support e.g. supporting escalated discharge, ensuring all alternatives to admission are explored and converting non-clinical time to clinical at real times of pressure.

5.7 New Models of Care

The CCG has committed to transforming community services and already seen significant improvement to out of hospital care, focus is currently on the following:

- Better quality community nursing services
- Supported discharge and admission prevention
- Enhancing the Care Co-ordination Centre
- An integrated out of hours service

A pilot was undertaken in 2016/17 of integrating community, mental health, social care, palliative care and social prescribing teams further and also includes the availability of secondary care specialists in primary care settings. This enhanced care was provided in the home setting regardless of place of residence meaning those people who live in care homes were able to access enhanced community and home based care. An effective case management Local Enhanced Service is already in place providing effective management of more than 12,000 patients who are at highest risk of hospital admission. Rotherham has also aligned care homes in Rotherham with general practices to strengthen relationships and improve continuity of care. Almost all care homes are aligned with 1 practice although the bigger homes have more than 1 as it would not be feasible for 1 practice to manage on their own. Practices are required to provide additional input to the care home to ensure there is a proactive instead of reactive management of patients which in the early stages is starting to show reduced admissions to hospital. Those practices with access to clinical pharmacists are also using these new roles to review medicines with the care homes and support the management of long term conditions.

Primary Care Networks will be expected to integrate and lead community services for their population. It is expected that this will expedite integration. Clinical Directors will have at least one day per week dedicated to developing their network which will include leading their integration. Inability to release GPs to date has been a limiting factor in enabling integration.

5.8 Self Care

The aim of self care is to prevent patient's conditions from deteriorating to facilitate them being able to remain at home, in familiar surroundings but with the knowledge that their condition is well managed. As well as the changes outlined above, which facilitate the most effective arrangements for long term care, patients and carers will be supported to take control of their long-term conditions through a variety of different ways. Case management and social prescribing are already in place to support patients. Community transformation projects in addition to Primary Care Networks will also refocus community nursing and social work time to input into patient reviews so all the patients' needs are considered.

The CCG is also now using technology to assist patients to manage their conditions for example blood pressure monitoring at home with results reported directly into the GP to take action where results are abnormal.

Education will be a key component to self care, to empower patients and their carers to manage their conditions and to take a more active role in consultations and decisions about their care. RMBC have commissioned services to support self care e.g. Get health Rotherham and the CCG commission the National Diabetes Prevention Programme, Cardiac Rehabilitation, Pulmonary Rehabilitation along with other programmes to support patient to manage their conditions but we must work harder to devise innovative ways of reaching our population. This area is also now being considered as part of the wider work of the ICS as detailed in section 6.3.

RCCG has procured an APP and roll-out to all practices has now been achieved with only one practice not participating. There is a programme of communication to increase public uptake of the APP.

Rotherham is also always horizon scanning and implemented smart inhaler concepts which has current positive evidence of reducing exacerbations and 50% improvement in inhaler usage. A review of the respiratory pathway is currently in progress and is likely to support improvement in primary care management of respiratory diseases, providing more support and education.

5.9 Robust Performance Management

As a CCG with delegated responsibility, we have authority for GP and Co-commissioning.

In addition to this, the CCG has developed a performance dashboard that provides the primary care committee with an effective tool for high level monitoring of general practice key performance indicators. Data alone is not an indication of poor service provision however this enables the primary care committee to focus attention on practices that are outlying to ensure that the primary care team are triangulating with other local intelligence to take the necessary steps and provide the committee with an appropriate level of assurance.

The CCG has an annual programme of supportive quality visits with a revised structure and positive feedback from practices visited to date.

This also supports the published commissioning and quality principles for primary care. These identify the processes which will be followed in circumstances where the key performance indicators are not being achieved.

5.10 Continued Improvements to Medicines Management

The CCG is responsible for all GP prescriptions issued by its member practices. In 2019/20, the CCG will spend £49.4million on prescriptions and on commissioned services (nutrition and continence). The CCG is focused on ensuring all patients are receiving the right medications, at the right time, to date efficiency savings of over £3m per year have been achieved. A Prescribing Local Incentive Scheme commenced in 2014/15 and is reviewed regularly to ensure more effective practice is achieved.

The CCG has invested in technician support for practices and care homes to release GP time and ensuring patients medications are regularly reviewed to prevent wastage.

5.10 Engaging Patients to Ensure Patient Pathways are Optimised

Rotherham CCG is committed to active and meaningful engagement with all its patients and potential patients Link to engagement and communications plan. We will use the opportunities created through the establishment of Primary Care Networks to explore with communities and partners additional mechanisms for engagement, focusing on neighbourhoods, and potentially overlooked populations experiencing health inequalities. In particular we will consider how techniques such as asset-based approaches can potentially support effective co-creation and co-design to tackle issues important to all.

Patient Participation Groups (PPG) have been in existence for several years; the changes to primary care commissioning will mean that the CCG can more effectively:

- Work with practices to ensure that wherever possible, practices have an active PPG, operating to acknowledged good practice (https://napp.org.uk/)
- That PPGs are supported through the PPG Network with information, shared good practice, and the opportunity to consider wider, cross Rotherham issues

However, PPGs are only one mechanism for patient and public engagement and experience. The CCG also aims to extend engagement, and work with a variety of organisations to improve the patient voice for specific communities, both geographical and communities of interest, for example people with specific long term conditions. If the CCG is to develop new ways of working; it will be vital to ensure that patient experience actively and meaningfully informs new systems and processes. This cannot be done in one way, and may involve any of the following:

- Condition specific focus groups
- Patient interviews and/or diaries
- Patient experience – from survey work, consultations, and other feedback (i.e. social media, complaints and issues raised with other bodies such as Healthwatch)

6. Enablers to Delivering our Strategy

6.1 Development of the primary care model(Federation/Community Interest Company)

As identified in section 4.1, Rotherham currently has a Federation (CIC) in place which enables all 29 practices to work collectively and be able to respond to the demands facing general practice. The Federation now has a GP leading, supported by a Head of Federation, Lead Development Nurse and supporting administrative infrastructure.

The Federation now hold the contract for extended hours and are responsible for developing primary care in Rotherham in areas like practice manager development, leadership and quality contract improvements.

The Federation plays a key role in the development of the Rotherham Integrated Care Partnership, with attendance at weekly meetings to contribute and also be held to account on key areas for delivery.

6.2 Primary Care Estates and Premises

The CQC has a mandate for ensuring that essential standards of quality and safety are met.

However, the CCG undertakes quality visits which encourage practices to offer premises that:

- Deliver care in the right place with the right access
- Provide the patient with an environment that is fit for purpose
- Ensures easy access with clear sign posting
- Meets all statutory and mandatory requirements including compliance with all relevant disability, fire, health and safety legislation

Rotherham Metropolitan Borough Council are currently reviewing all ‘government’ estate to ensure it is fit for purpose and utilised appropriately across all services. Whilst this is welcomed by the CCG, many general practices are privately owned by partners in the practice and will not therefore be captured under this review. NHS England, in 2016 procured site surveys of all GP practices to provide CCGs with an assessment of the current estate suitability for primary care.

A strategic plan for Rotherham estates was initially developed and during 2018 a more comprehensive primary care estates strategy was developed and is included at Appendix 5. RCCG receive requests from practices regarding increasing their footprints however, whilst pressure at days/times of the week is acknowledged, evidence that use of practices across the whole working week and sharing estate across practices is not in place. The strategic direction of RCCG is to maximise these opportunities before considering requests for extended estate. RCCG is also reviewing its strategic plan to provide more detail regarding the estate opportunities. The additional workforce implications will need to be carefully considered across the Primary Care Networks to ensure there is sufficient capacity.

The strategic direction is towards larger practices and configurations of practices, able to provide a range of general medical services, enhanced services and community based healthcare. Discussions are ongoing with practices to deliver the recommendations from the primary care estates strategy.

6.3 Information Management and Technology

Technology emerging through our flag ship Sheffield City Region Testbed programme will drive innovation and act as a primary delivery vehicle for identifying, implementing and evaluating new technologies which meet local need. Other leading initiatives across South Yorkshire and Bassetlaw have included the significant collaboration between our local provider organisations, developing innovation in the way they work together across key

clinical areas. The following planning assumptions and objectives have been defined:

Planning Assumptions	Objectives
1. New Models of Care (NMC) will increase care delivered across provider networks/chains	1. Implement an integrated digital health record, paper free at the point of care where information is captured only once only and widely available.
2. Patients will experience care in more locations out of hospital, including home	
3. Current paper based information will significantly limit implementation of NMC	
4. Use of wearable tech to manage personal health and wellbeing will grow significantly over the next 5 years.	2. Support citizens to use digital technologies to manage their own health and wellbeing and develop capability to connect information sharing with the primary care team
5. The SCR Testbed and other leading technology pilots in SY&B will drive a significant increase in the number of people using digital technology to manage their own care	3. Develop a culture with providers of working with innovators to embed technology as a key enabler to independence and reduce the risks of avoidable admissions, particularly for citizens with multiple LTC's
6. As a consequence of all of the above, considerably more data will be generated than at present.	4. Establish an advanced data analytics capability to support improvements in population health planning, risk stratification, at risk patient management and provide real-time analysis and decision support.
7. Investment will use the outputs of the Digital Roadmaps and digital maturity assessment to inform investment needs that will have a net positive ROI and reduce/avoid costs	5. Improve system wide operational efficiency, safety, patient experience and reduce duplication and waste by improving digital maturity to a level that supports care delivery as part of a more distributed healthcare system

Rotherham has led the way with a Clinical Portal (the Rotherham Health Record) supporting primary, acute and secondary care clinical information to be accessible from any web connected device and integrated into clinical systems.

This enables community teams to support early discharge, locality management of patients, and GPs to have a detailed view of hospital information about their patients. Rotherham's Clinical lead for IT will also help drive forward the following ICS wide projects:

- Segmented health and wellbeing data could provide early warning alerts to patients and their GP's to allow early intervention avoiding hospital attendance and more costly treatment.
- Interoperability and data sharing between providers will improve the effectiveness of primary care with a full medical record and test results available at every consultation.
- Better integration of care provided across the patient pathway but with particular benefits in community care.
- Access to shared care records will revolutionise in and out of hours care, supporting access to relevant intelligence about patients when needed not when services are 'open for business'.

- Self care and better coordinated care, particularly for people with chronic disease and long term conditions, will mean more people will be managed in their homes or in the community without the need to attend hospital for admission or in outpatients.
- Digital health supporting new forms of consultation including phone, text message, e-consultation, video consultation and in some cases group consultations that could include other relevant health professionals and experienced patients for LTC management. This includes the development of accessibility to more senior/expert decision makers for support and advice as and when needed in order to maintain patient care outside a hospital environment.
- Greater integration for all the primary care team through coordinated administration systems, real time information exchange and single integrated healthcare record.
- Further support for sharing of sensitive information and speeding up referrals between public sector and voluntary, charitable and other community based agencies to meet the needs of individuals including police, fire, and employment agencies for example.
- Promotion of mobility of our workforce through increased deployment of mobile devices as well as supporting software in combination with Wi-Fi to support truly agile working within the patient's home as well as across health and care settings (e.g. comprehensive access to NHS Roam across all health and care sites within the SYB footprint).
- Active signposting of available services including on-line, telephone, video, better reception navigation and one to one consultation through on-line portals.
- Reducing DNA's through easy access to GP booking systems, reminders, patient self-recording.
- A reduction in paper work and other non-digital data transport will mean gains in operational efficiency.
- There are benefits from improved access to services for patients and citizens. This ranges from access to community services (e.g. via e-booking, telephone consultations, skype consultations, patient online) to access to secondary care via e-referrals.
- Better access to patients of expert decision support systems and help to navigate to lower cost health advice and delivery channels could reduce demand for primary care services.

- Supporting working across emerging GP federations through the integrated digital care record, shared practice administration systems etc. supporting greater efficiencies in the management as well as delivery of community based services.
- Greater integration of care means that it is more likely A&E or hospital admission will be avoided as deteriorating patients are picked up earlier with an appropriate intervention at that time.
- Remote monitoring linked to intelligent alerts means that patients, their carers as well as community based teams can focus on priorities knowing that they will be alerted if a patient starts to deteriorate. Alerts will enable specialist outreach teams (e.g. cardio, oncology, vascular) to be auto alerted on their patient events, such as hospital admission, or deterioration. Local community/locality/hospice teams can be alerted if patients attend unscheduled care etc. which can support care planning, especially in relation to End of Life care pathways.
- Better tracking and scheduling of staff resource through geographical tracking technology used extensively by distributed service providers.

The CCG has also developed its IT strategy through consultation with GPs, RMBC and providers and the following identified the key areas where IT development will support the general practice agenda. The new GP IT operating model requires all practices to sign new CCG/practice agreements by December 2019. All devices will be upgraded to Windows 10 by January 2020 and any linked equipment will need to be compliant.

The standards for paper light are being reviewed to reflect the digitising of the NHS record, faxes are to be removed from use for NHS purposes by April 2020.

The CCG is committed to ensuring that all patients have equal access to internet based services, in particular the ability to book appointments online, provide access to medical records and order repeat prescriptions. A Rotherham Health 'APP' has been developed to enable patients to check their symptoms, book, order and ultimately have a virtual consultation with a clinician. This technology is being further developed to link with secondary care and local authority services enabling one simple APP for all services. Practices will have to ensure that at least 25% of appointments are available for online bookings by July 2019 and that NHS 111 have access to 1 appointment per day per 3000 population for direct booking in 19/20.

All clinicians within GP practices have been provided with laptops to support remote working.

NHS England North region commissioned the Apex Insight tool providing workforce and workload data for each practice, this is in the process of being rolled out across South Yorkshire and Bassetlaw. This will provide practices with valuable information about managing their workload and workforce data which can be analysed on a Rotherham basis.

The CCG will also ensure there is access to a Data Protection Officer function which aligns to the LMC DPO role.

6.4 Wider primary care contribution

The CCG is working with NHS England to ensure services both compliment and collaborate with each other. 7 day dental services are in operation via NHS 111, a number of emergency care attendances relate to dental care therefore these services are essential. The CCG has recently procured a Minor Eye Conditions scheme which will commence in the summer of 2019 within primary care providing care closer to home. We will also liaise with the LEHN on developing better services for patients with short waiting times and reducing cost.

As detailed in section 5.9, the CCG already works in collaboration with local pharmacies. A number of pharmacies also support the flu campaign across Rotherham.

7. Governance arrangements

The primary care committee is responsible for ensuring delivery of this strategy. The primary care committee programme of work has been updated to reflect the timescales and commitments detailed in this strategy. The programme of work is timetabled for quarterly review at the committee to ensure timescales are being achieved and also support where there are any difficulties being encountered.

Appendix 1

NHS
Rotherham
Clinical Commissioning Group

GENERAL PRACTICE WORKFORCE PLANNING & REDESIGN

1.0 Introduction

1.1 A third of babies born this year will see their 100th birthday in contrast to 1948 when 50% died before age 45. This evidences the significant improvements seen in healthcare over the last 60 years however it poses a significant risk to our workforce in managing this increased demand. The reality is that less trainees are choosing general practices when they qualify and more GPs are choosing to retire earlier than normal retirement age. The gender balance between male and female doctors is also changing which is also impacting on workforce availability as traditionally female GPs in Rotherham choose to work part-time.

1.2 NHS England has produced a 10 point action plan – Building the workforce, a new deal for GPs to support addressing these workforce issues however, as this is a national document and targeted at the most under-doctored areas first, it is essential that Rotherham CCG has its own strategy which is compliant with the national action plan. NHS England have also now produced a new contract arrangement 'Investment and Evolution' offering opportunities to increase the pace of change and financial support for Primary Care Networks to invest in wider roles to support general practice.

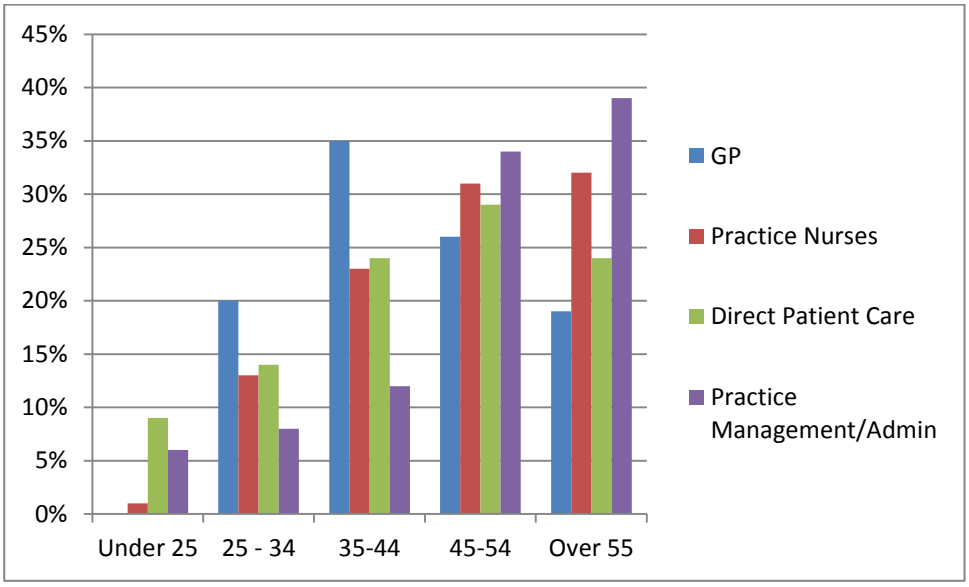
1.3 The current silo working of practices is also unsustainable as we move more and more to delivery of equitable services and increased services closer to home. Significant progress is now being made in relation to the delivery of services across Rotherham with 6 Primary Care Networks now in place developing strategies for their population.

2.0 Current position

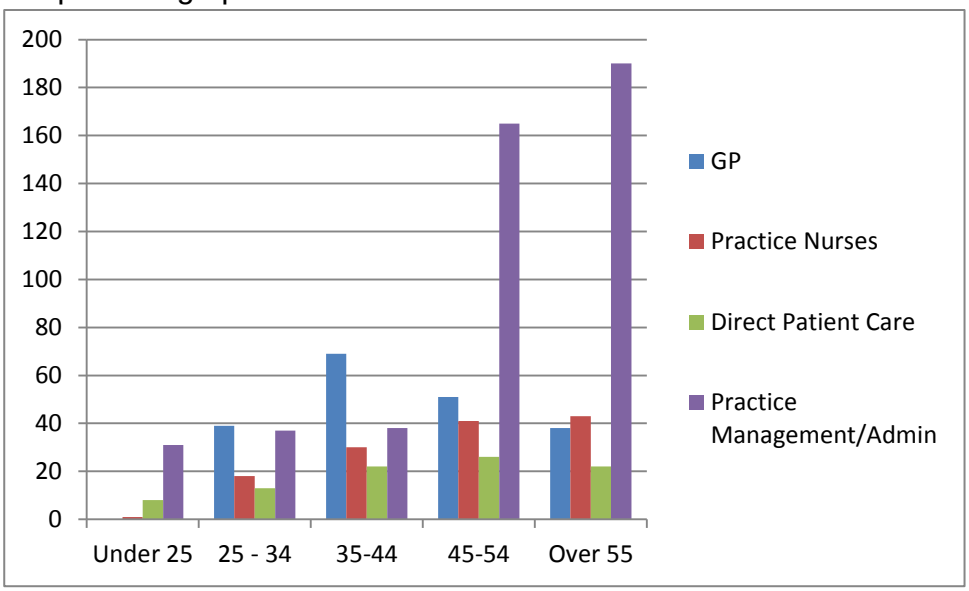
2.1 Rotherham currently has 30 general practices which consist of 23 PMS, 1 APMS and 6 GMS practices. Rotherham CCG has been encouraging practices to utilise the Yorkshire & Humber Health Education England workforce tool to enable a broader understanding of workforce issues and to date 28 practices are utilising the tool. For the purposes of this plan therefore we have to assume the picture across Rotherham is consistent with the data we have and extrapolate. Rotherham is currently rolling out the APEX Insight workforce tool which will in time provide much more robust information to support workforce planning.

2.2 From current data 35 GPs in Rotherham are over 55 and 19 GPs are over 50, whilst small numbers are continuing to practice way beyond 65, with changes to pension taxation, there is high potential of GPs choosing to retire or reduce working hours much earlier than originally planned. At present, we intake on average 13 GP trainees into Rotherham each year and approximately 50% are appointed to posts in the Rotherham area. On this basis therefore, without any intervention we currently have 8wte GP vacancies and are predicted to have a shortfall of a further 15wte by 2020 (or earlier).

Graph 1 – Age profile -percentage



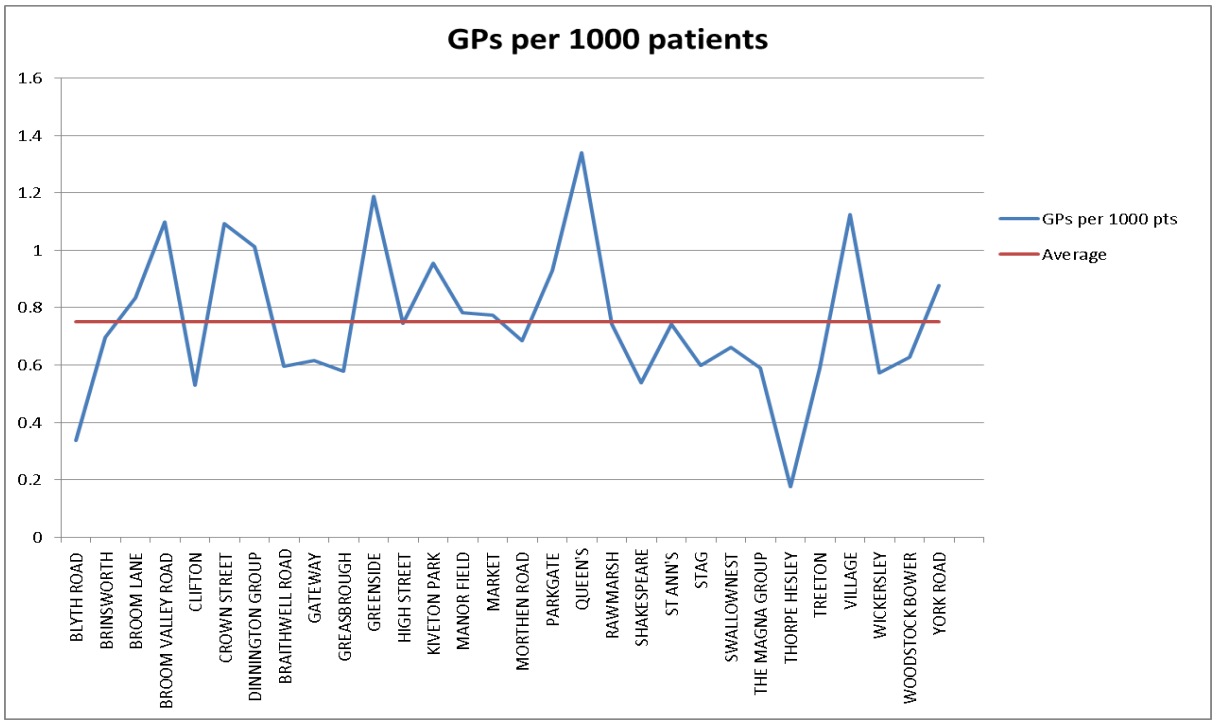
Graph 2 – Age profile - numbers



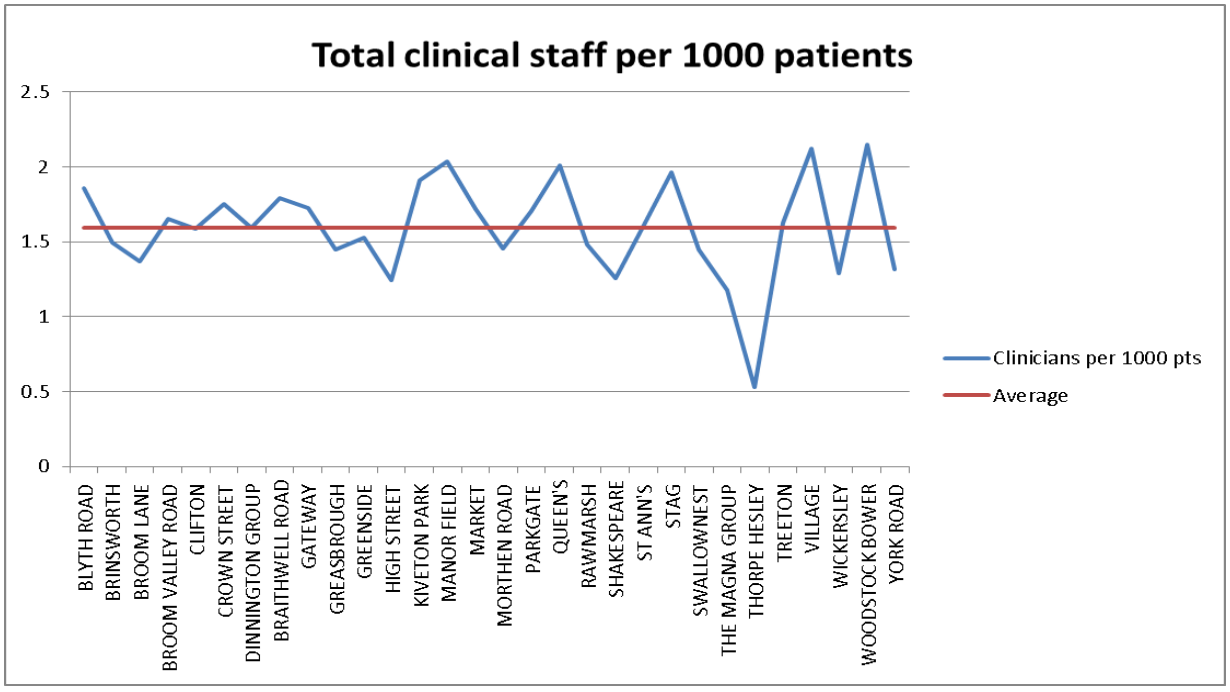
In relation to particularly 'under-doctored' practices, it is of concern that over 50% of practices are below Rotherham average of 0.7wte GPs per 1000 patients. It also shows the significant differences between the staffing profile of practices. Clifton, Thorpe Hesley, Village and Woodstock Bower have a higher than average nursing

workforce evidencing an increased nursing workforce to manage their overall demand. The practices of concern are where they have insufficient GP capacity and from review do not appear to be backfilling with a nursing workforce (they could however have more innovative models around therapy and pharmacy we are not aware of). This indicates disproportionate investment in workforce which must be addressed

Graph 3- GPs per 1000 patients in Rotherham



Graph 4 – Clinicians per 1000 patients in Rotherham



3.0 Models of workforce

3.1 Recruitment and retention issues within general practices are well understood, and many practices in Rotherham have already risen to the challenge by reviewing their skill mix and supporting the training and development of both medical and nursing disciplines. However this is not across the board and other than the social enterprise model, there are very small numbers of practices sharing resources (clinical or non-clinical) to deliver their activity. Capacity planning within practices is also limited which makes the following very difficult:

Maximising the supply of GPs and Practice Nurses	**Enabling Skill Mix: distributing the practice workload differently**
Bringing other professionals/healthcare workers into the practice	**Developing new roles as alternatives to the existing GP workforce**
Making it happen – the enabling works	

Radical new models of primary care workforce are emerging, Health Education England reported recently that from data returns, they are seeing the following models emerge:

	GP	Practice Nurse/Advanced Clinical Practitioner	Healthcare Assistant
The conservative model (replacing like for like)	4	2	1
Practices under pressure (evolutionary change)	3	3	2
The extreme scenario (workforce transformation)	1	2	4

In January 2019, NHS England launched a new GP contract, Investment and Evolution which includes funding for Primary Care Networks to employ alternative roles to support general practice. Primary Care Networks are evolving from the current localities across Rotherham. The new funded roles are as follows:

2019/20 - Clinical Pharmacists – 70% funded
Social prescribing link workers – 100% funded

2020/21 - First contact Physiotherapists – 70% funded
Physician Associates – 70% funded

2021/22 - First contact community paramedic – 70% funded

The Primary Care Networks will define their requirements.

3.2 **Developing nursing**

Practices are also now extending their use of nurses to support practice workload however more can be achieved from the use of Band 1-4 roles within practices. Practices need to operate more clearly defined roles to ensure minutes, which add up to hours are undertaken by the most suitable post within the practice. It is acknowledged that it is difficult to 'carve' staff time out in this way but not unachievable. Enhanced job satisfaction is achieved by enhancing nursing roles so long as the requisite training and education is provided to ensure the team feel sufficiently competent to undertake. We will utilise GPFV funding to support Bands 1-4 to be developed within practices. This will work alongside support with ATP programme in encouraging more practices within Rotherham to train student nurses and employ newly qualified nurses to ensure primary care is seen as a career opportunity from the start and not at the end.

3.3 **Associate Physicians**

Rotherham CCG is supportive of Sheffield Hallam and Sheffield University who provide Physician Associate training. This is a 2 year programme which Y & H HEE are now piloting funding a £10k bursary and provide training costs to practices who host trainees. It is hoped during this initial training period that issues relating to prescribing and imaging requesting along with regulation can be resolved. It is intended that this new role is utilised to support practices with an alternative model to advanced clinical nurse practitioners as these roles are also difficult to recruit to. They are not described in the model above as the training schemes are only just commencing in our locality. We will work with the ATP to see if support can be given to practices in a similar way as that for student nurses and newly qualified nurses as this is such a different concept for practices to understand.

3.4 **Practice based pharmacists**

This is already an alternative model being utilised within a number of practices across Rotherham. GPs felt that pharmacist support in practice particularly for medication reviews, management of long-term conditions, dealing with hospital discharge letters, managing house bounds and nursing home patients, health promotion along with involvement in managerial roles eg. QOP, CQC work and clinical governance could have a positive impact on GP workload. It has been agreed that the Medicines Management Team at the CCG will provide professional leadership and mentorship to the practice based pharmacists to ensure they do not become professionally isolated and potentially lead to retention issues.

3.5 **Social prescribing link workers**

Rotherham already has a successful social prescribing scheme in place supporting specific cohorts of patient (those at highest risk of admission and those with mental health issues). There is now the opportunity to extend this to a wider group of patients with needs which are beyond the arrangements within primary care.

3.6 **First contact physiotherapists**

Rotherham has been piloting the impact of using first contact physiotherapists to support the assessment of patients with musculoskeletal issues instead of GPs being required to see the patient to facilitate a referral for assessment. This is enabling a more timely assessment.

3.7 **First contact Paramedics**

Paramedics are highly trained health professionals who are able to support practices by responding to requests for home visits to assess patients and support patients in care homes as well as supporting urgent care within the practice.

3.5 **Developing our administrative workforce**

We already have a significant number of high quality, committed and dedicated administrative staff who support and care for our patients. But we recognise that

their roles could be enhanced to provide more support whilst also enabling this workforce to be more empowered and therefore more likely to be retained. We have utilised GPFV monies to facilitate training sessions in relation to care navigation and medical documentation along with customer care, dementia and carer awareness. We are also now training administrative staff to co-ordinate tele-dermatology referrals which provides patients with timely advice in relation to their dermatology condition.

3.6 **Developing our Practice Managers**

The shape of general practice is changing significantly and we our expectation and requirement of Practice Managers is rapidly changing. Some larger practices are changing their model to include specific Finance Managers as it is becoming increasingly difficult to lead on all the areas required within practices. We wish to support the development of this workforce using GPFV monies to enable them to feel sufficiently competent and able to review and embed new ways of working.

4.0 Rotherham workforce requirements

4.1 The CCG has taken a simplistic approach to assessing workforce requirements for the future as this looks at Rotherham as a whole and not in silos per practice. Based on current average information and the conservative model, Rotherham would require the following workforce:

260,000 patients – 173wte GPs, 87wte Advanced Nurse Practitioners/Associate Physicians/Pharmacist/AHPs/First contact practitioners, 43wte Healthcare/support assistants/phlebotomists, 286wte administrative support, 26wte Practice Managers, 13wte deputy practice/business managers.

4.2 Based on current average information and the evolutionary change model, Rotherham would require the following workforce:

260,000 patients - 130 wte GPs, 130wte Advanced Nurse Practitioners/Associate Physicians/Pharmacist/AHPs, 87wte Healthcare/support assistants/phlebotomists, 286wte administrative support, 26wte Practice Managers, 13wte deputy practice/business managers.

4.3 Based on current average information and the extreme change model, Rotherham would require the following workforce:

260,000 patients – 43wte GPs, 87wte Advanced Nurse Practitioners/Associate Physicians/Pharmacist/AHPs, 173wte Healthcare/support assistants/phlebotomists, 286wte administrative support, 26wte Practice Managers, 13wte deputy practice/business managers.

4.4 Our current workforce data (from data provided) is as follows

	GP HC	GP FTE	GPs per 1k PTs FTE	Pts Per GP FTE	Nurse FTE	Nurses Per 1k pts	Direct PT Care FTE	Direct Pt Care per 1k pts	Admin FTE	Admin Per 1k pts FTE	Practice Staff FTE	Practice Staff Per 1k pts FTE
Roth	6.56	5.14	0.58	1341	4.43	0.37	3.13	0.34	17.59	1.99	3.90	2.64
Eng	6.57	4.74	0.56	1,290	2.31	0.27	1.64	0.18	10.66	1.26	3.32	2.28

We therefore have 154.41 wte GPs, 96.97 wte nursing staff, 66.37 wte Direct Patient Care (HCAs, Physios, Pharmacists etc) and 337.39 wte administrative support staff and 43 wte Admin/Practice management.

The conservative model is not sustainable and it is therefore recommended that practices pursue the evolutionary model which makes much better use of the wider general practice workforce along with new roles. The extreme change model has not been evaluated and is not supported.
Rotherham is therefore severely lacking in qualified clinical practice staff and healthcare assistants when adopting the evolutionary model this is because most practices are continuing to follow the traditional (conservative) model which will be difficult to sustain long term.

4.4 It is essential that practices start to look collaboratively rather than individually at their workforce, there are significant efficiencies which can be achieved by working across traditional practice boundaries. Closer review of how the Federation can support this collaboration is required with hopefully joint working with the CCG to agree new working arrangements which are sustainable.

4.5 **Locum bank**

Clearly, longer term the intention is to create models which are less reliant on qualified doctors however in the interim, practices are using expensive locum agencies for their short term requirements which are high cost and at times lower quality. The impact is felt for the CCG as from peer review visits, it has become evident that when a locum is used, referrals to secondary care increase. There was clear support for a bank arrangement from current GP registrars who indicated that they were keen not to settle down into one practice at the end of training. The CCG wishes to encourage the Federation to host such a bank for the use of the Primary Care Networks. The intention is for the Federation to recruit full/part-time GPs who will receive a salary rather than payment for sessions to provide employment stability with flexibility in workplace. The full cost will be recharged to the user on a monthly basis with a year end adjustment to ensure the bank is self sufficient. This proposal also provides the opportunity to work in non-training practices to aid recruitment in practices less known to GP trainees.

4.6 The key concern about moving to new models of workforce are the transitional arrangements and ensuring quality of care is not compromised. It is hoped that the

additional roles reimbursement will enable practices and primary care networks to embed these new roles whilst changing working arrangements to accommodate the skills and experience of this group of staff.

5.0 Defining the required workforce

5.1 Capacity planning is an essential tool to ensure capacity is fully understood across general practice. As identified in the introduction, Practices are starting to receive the APEX tool which has been commissioned by NHS England North to support practices with skill mix, capacity and demand along with other components. This will also be utilised to define the impact of utilising different roles within practice e.g. using a pharmacist, associate physician, extending skills of healthcare assistants and potential impact of technology to ensure we develop practices which are fit for the future.

6.0 Technology

6.1 We have to fully exploit the technology which is available to us to free up capacity in general practice. The key systems identified from pilots as having most impact to date are telephone and self-care.

6.2 Telephone systems – evidence is identifying that significant GP time can be saved by a full telephone consultation system. In a recent engagement event, over 90% of the general public supported such a system. Concerns have been raised in relation to capacity to see if required and it is part of the system that sufficient slot capacity is carved out to see those patients who require a face to face on the same day. At present, practices are devising their own different ways of implementing telephone triage/consultation and it is recommended that an approach is agreed and implemented consistently (clearly with the ability to vary for clinical reasons).

6.3 A number of CCGs have implemented telehealth systems to support self care and reduce avoidable attendances in primary and secondary care. These systems can be targeted towards specific long term conditions, for example patients with Hypertension. The GP would target specific suitable patients and offer them the opportunity to sign up to use the system. A set hypertension protocol (following NICE guidelines) is pre-populated, but can be amended to the specific needs of the patient. The patient is then sent text messages requesting BP levels, the patient is then sent advice based on their readings, the advice could be to take the blood pressure on the other arm or immediately make an appointment. The Clinician can review the text messages (sent & received) as well as the data submitted on a chart, an email and / or text message alert can be sent to the clinician should any abnormal readings be submitted. The clinician has the option to send a free text SMS to the patient, for example, requesting they attend an appointment that has been booked for them.

Potential areas to target:

Anti-coagulation
Hypertension
Diabetes
COPD
Heart failure

A pilot of telehealth in five practices commenced in early 2016 and the evaluation identified issues with practice engagement. It is accepted that this is still workload for the practice but it does take less time than current monitoring arrangements. It is also feasible to consider practices collaborating to allocate a suitably qualified (Healthcare Assistant) clinician to this task for a higher population or a whole service can be 'bought in'. There are significant patient satisfaction benefits to operating this system. It is acknowledged that current payment arrangements for monitoring would need to be reviewed to incentivise use of technology.

7.0 Developing and retaining our workforce

7.1 It costs on average £30k every time we recruit a clinician in primary care (Lost output whilst new employee gets up to speed, induction, locum for any gaps in service and cost of recruiting). Understanding this investment is crucial along with acknowledging the personal and professional needs of our workforce. We understand that continuing to develop our workforce not only retains them within their organisation but also ensures the ability to develop services using a wider workforce. Traditionally we attract new GPs from the effectiveness of training, flexibility in sessions along with our proximity to Sheffield. We have started to accepted trainee nurses and preceptorship nurses to encourage qualifying nurses into the primary care field.

7.2 We expect each practice to ensure each member of staff receives mandatory training as required along with ensuring there is an annual development plan as part of a structured appraisal process. 37.5 hours structured training per wte each year which includes PLT attendance, robust mentoring/coaching and internal training.

7.3 RCCG supports the National GP retention scheme and has identified a small budget for consideration of requests on an annual basis. Work is also taking place in relation to a localised scheme which meets the needs of the Rotherham workforce. A key issue in relation to retaining GPs has related to indemnity and it is hoped that the changes to indemnity from April 2019 will enable more GPs to continue to work on more flexible terms to balance their work and home responsibilities.

Initial workforce plan agreed:	July 2015
Reviewed:	July 2019
Due for review:	July 2021
Reviewed by:	Head of Commissioning


Rotherham Primary Care Estates Strategy
November 2018

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1. EXECUTIVE SUMMARY

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Across the area covered by Rotherham Clinical Commissioning Group (CCG) there are over 50 General Practice premises ranging from rural branch surgeries, to large single or multiple practices in fully maintained buildings. In developing the Primary Care Estates Strategy, the general estates profile of each of the seven Localities was identified through asset mapping by practice and condition surveys including the results of available 6 facet surveys which assess them against the Schedule 1 Minimum Statutory and Contractual Standards for Practice Premises (NHS [General Medical Services] - Premises Costs Directions 2013).

The CCG has drawn up Commissioning Plans to address the health needs of their current population and take into account the available forecasts for their future demography in terms of both the number and age profile of the population and local housing development plans, to address the significant local challenges in terms of health outcomes and high levels of inequality, as well as an increasing and ageing population which will bring increased demand on health and social care including:

- Urgent care
- Long term Conditions e.g. diabetes, cardiovascular and respiratory
- Care out of hospital and closer to home
- Five Year Forward View - Primary care expansion models
- Mental Health & dementia

The CCG is continuing to develop its model for primary care in line with the NHS England Five Year Forward View.

This is resulting in the formation of groupings and federations of General Practices which prompts a change in approach to estate needs to underpin new models of care and should include consideration of the wider NHS estate in that area. The estates profiles generated in this Strategy were considered against these emerging commissioning intentions to identify the impact and issues on the current asset base and inform potential estate priorities for the CCG area.

Overall the condition of the primary care estate is fair to good. However, there are noticeable differences in condition and functionality which reflects historical decision making and investment in premises prior to the establishment of the CCG and the standard of operational estate management of each building. All buildings require ongoing effective estate management particularly for compliance with Fire, Health and Safety and Access in line with the Disability Discrimination

1. EXECUTIVE SUMMARY

Act (DDA) and backlog maintenance to achieve the Condition B standard.

In addition to the condition surveys, estimates were made against the NHS England Space Maxima Schedule (Premises Expert Advisory Panel) to assess current space within a building and identify potential constraints in being able to respond to any local population increases from planned housing development. The assessment of the primary care estate in each locality is detailed in separate sections of the report with an overview of the main priorities across each area and the actions to be undertaken.

The 5-year financial estimate for the whole CCG area provides a high-level summary in section 7. The total cost of the existing properties, subject to additional costs after surveys identified in the 6 Facet Surveys are completed is estimated at £1,882,377. The Improvement, Investment and Development element is estimated at a cost of £10,354,000. The final section summarises the recommended next steps in moving forward to realise the benefit from implementing the estate strategy. There remain some questions regarding the primary care estate at the time of writing this report as thinking from the work CCG is undertaking with their practices develops.

Priorities for each locality have been drawn up in the relevant sections of the report with recommendations for action which are based on both the surveys and other intelligence of public sector health premises in the area, known by Community Ventures. These priorities would be the basis for significant re-modelling to modernise the estate to be fit for the future service models. Some of the issues may be known locally such as utilisation in buildings, however others, where the focus has been on the re-development of other NHS or Local Authority premises or sites and the impact of significant housing development e.g. the Bassingthorpe Farm and Waverley may not be fully developed. These have been identified through this process as having specific impact on the delivery of both core and extended primary and community care issues and would benefit from further assessment across the wider public sector estate in each area.

The South Yorkshire and Bassetlaw STP identifies movement of services out of acute settings and the cross-sector estate financial savings delivered through ‘place-based plans’ with the local Strategic Estates Forum (SEG) being key to where the estates strategies of local partners are shared.

1. EXECUTIVE SUMMARY

There is the opportunity to link up with the Rotherham Metropolitan Borough Council and consider where the recommended feasibility work could be undertaken in partnership with the Local Authority under a 'One Public Estate' approach to maximise multi-service co-location / 'one stop shop' opportunities as part of community infrastructure integration. This could include agreeing S106 and CIL opportunities.

This strategy identifies priorities for General Practice to deliver an improved primary care estate for Rotherham and sets a direction of travel. In terms of the next steps, thinking from the work the CCG is undertaking with practices develops and additional estate assessment or feasibility work may be required.

In addition to the transfer of acute services to community settings a key element for the delivery of the strategy for the primary care estate is the recognition of the workforce development required to ensure primary care has the capacity, including the staffing numbers and skills, to deliver the revised models of care. For example, how much additional capacity may be gained within existing buildings, through closer working between practices, that offer further opportunities to group their estate needs. These can be applied to the priorities already identified within the strategy, on an ongoing basis.

NHS England and CCGs have overall responsibility for a range of direct commissioning functions to ensure delivery of improved health outcomes for their local populations which also include co-commissioning responsibilities for Primary Care.

Primary Care and General Practice does not operate in isolation and the scope and range of services offered in primary care is critical in meeting the challenges facing both the health and social care systems. Primary Care General Practices are commissioned to provide a range of services based on a registered patient list.

Developing and delivering a robust strategy for high quality primary care has interfaces and interdependencies across the whole health system including unplanned and planned services, health promotion and prevention, mental health care, social care and end of life care.

A key component for any service environment is having 'fit for purpose', CQC compliant premises in which to deliver patient care services. The traditional way of organising primary care premises has provided some stability to the NHS, but it can also result in inertia.

Many health services are now delivered peripatetically or from 'hot desks' in various locations, but General Practice is still largely delivered from consulting rooms in long established buildings.

Restrictions on established premises or from landlords can sometimes hamper attempts to deliver more integrated services.

As services continue to change, so too will the locations from which they are provided as health professionals look at ways to improve access to services. Many services are already provided in shopping centres, schools, football grounds and workplaces.

Changes in service models brought about by greater use of technology will also lead to changes in the way that premises are used in the future. Eventually, patients are likely to have more contacts with the service digitally than they do face-to-face with 'virtual' consultations being delivered by telephone, email or video conferencing through Telehealth, Skype, FaceTime etc.

In facilitate the shift of activity the primary care sector commissioners and providers need to consider how to:

- Make the most of how existing primary care buildings are used
- Minimise or eliminate empty space and "void" costs, and close or

remodel premises that are not up to standard

- Work with health and wider partners to better use all publicly owned or leased estate in the same communities
- Consider new build schemes to achieve rationalisation of historical estate to enhance service delivery and cost effectiveness.

As new commissioning models are developed through ambulatory care and particularly long-term conditions and urgent care, localities should consider the co-location of services that fall across primary care, community services and those elements of care currently delivered in secondary care that could be integrated into commissioning models for care closer to home.

The NHS reimburses the rent and rates for General Practices. The space paid for is mainly used Monday to Friday and the majority sits unused over the weekend. Consideration of buildings being able to absorb increased activity through changed commissioning or population increases, from localised housing development, will require the application of national guidance. The current maxima size schedule is summarised in the table opposite and needs to be used in considering options for primary care estate.

SCHEDULE 1A: Gross Internal Areas (GIA m²) - effective from 1 April 2013

Number of patients	2,000	4,000	6,000	8,000	10,000
Type of Premises (See notes (i) and (ii)	A	A	B	B	B
Gross Internal Area (GIA m²) Allowance	199	333	500	667	833

PREMISES FOR 10,001 – 20,000 registered patient list size

Number of patients	12,000	14,000	16,000	18,000	20,000
Type of Premises (See notes (i) and (ii)	B	B	B	B	B
Gross Internal Area (GIA m²) Allowance	916	1,000	1,083	1,167	1,250

Notes:

- Type A – Single storey premises
- Type B – Two storey premises with 1 staircase and 1 lift

Where a staircase or lift is not built the GIA allowance should be reduced accordingly.

3.1 National Policy Context

NHS England is responsible for arranging the provision of health services in England. The mandate to NHS England sets the Government's objectives and any requirements for NHS England, as well as its budget. In doing so, the mandate sets direction for the NHS, and helps ensure the NHS is accountable to Parliament and the public. Every year, the Secretary of State must publish a mandate to ensure that NHS England's objectives remain up to date.

This mandate is based on the shared priorities of Government and its partner organisations for health and care – the priorities we believe are central to delivering the changes needed to ensure the NHS is always there whenever people need it most. As leader of the commissioning system, but working with others, NHS England has a central role to play.

This mandate sets objectives for NHS England that reflects its contribution to these ambitions to 2020.

NHS England has seven key ambitions that underpin their operational activities:

Objective 1	Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.
Objective 2	Help create the safest, highest quality health and care service.
Objective 3	Balance the NHS budget and improve efficiency and productivity.
Objective 4	Lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.
Objective 5	Maintain and improve performance against core standards
Objective 6	Improve out-of-hospital care
Objective 7	Support research, innovation and growth

The NHS Mandate 2015 between the government and NHS England renews the focus of previous years, setting out an ambition for improving patient outcomes and reducing health inequalities. The mandate is underpinned by several frameworks including the *NHS Outcomes Framework* which has indicators grouped around five domains:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm

For each domain, there are a small number of over-arching indicators followed by a number of improvement areas.

3.2 Five Year Forward View

NHS England is responsible for the national policy on primary care which is discharged at local level through its regional teams and CCGs to commission and manage the contracts with independent practitioners. The role of primary care is identified in the NHS 6 characteristics and is key to a high quality, sustainable health and care system that England will have in five years. NHSE view it as a completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care with:

The prospect of resources being outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases presents a significant sustainability challenge to the way we commission care from providers, both currently and in the future.

The *NHS Five Year Forward View*, published in October 2014, is a collaboration with six leading NHS groups including Monitor, Health Education England, the NHS Trust Development Authority, Public Health England, the Care Quality Commission and NHS England. It

represents the first time the NHS has set out a clear sense of direction for the way services need to change and improve. The Five Year Forward View includes three key messages for the future of the NHS:

- **To get serious about prevention and improving the health and wellbeing of the nation,** by backing hard-hitting national action on obesity, smoking, alcohol and other major health risks, supporting people to take more control over their own care and improve partnerships with voluntary organisations and local communities.

- **Support for the development of new models of care**. Recognising there is not a 'one size fits all' care model for England, support the development of new care models and a new deal for primary care. National leaders working together to provide meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied.

- **A focus on efficiency and funding.** There are viable options for sustaining and improving the NHS over the next five years. However, this will require the NHS to achieve the very demanding efficiency aspirations set out in the Five Year Forward View as well as government investment.

The foundation of NHS care will remain list-based primary care. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The approach for primary care as part of the Five Year Forward View as follows:

- Wider primary care provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

Given the pressure Primary Care is under large practices or groups of smaller general practices are increasingly considering new models for providing general practice services, with potential benefits not only for patients accessing general practice, but also bringing services closer to patients with benefits to the wider NHS. This determination across local communities and partners to agree the best way to deliver services for

patients to meet these characteristics which best suits local geographies and capabilities impacts on the number, condition and type of estate required to support the new models.

3.3 Delivering the Five Year Forward View

Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 set out actions for delivering both the government's mandate and the *Five Year Forward View,* considering the 2015 spending review settlement. The settlement provides a basis on which to achieve the three interdependent and essential tasks: first, to implement the *Five Year Forward View*; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients. It included an £8.4 billion real terms increase nationally by 2020/21, aimed to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3.4 General Practice Forward View

The General Practice Forward View (GP Forward View), published in April 2016, committed to an extra £2.4 billion a year to support general practice services by 2020/21 to improve patient care and access and

invest in new ways of providing primary care.

Vision for General Practice

General Practice in 2020 will not look the same. The national policy drive is that it will:

- Be expected to work at scale making best use of new technologies
- Have achieved development and expansion of the workforce and better premises
- Offer improved signposting of patients to the most appropriate service for them or where appropriate supporting them to self-care
- See GPs working as part of a more joined up primary care workforce who will be able to devote the greatest amount of time to quality and health improvement for patients and local communities.

As part of this package NHS England is investing in a national sustainability and transformation package to support GP practices. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to speed up transformation of services.

3.5 Next Steps on the Five Year Forward View

In March 2017, NHS England published *Next steps on the Five Year Forward View,* which takes stock of progress at the half way point of the *Five Year Forward View* and sets out priorities for the next two years.

It recognises the benefits from constancy of purpose and that the challenges being tackled require sustained action over several years, its starting point is the current legislative framework, and the funding the NHS has been allocated. It does not aim to be a comprehensive description of all the planned improvements for the NHS (maternity and children's services, diabetes, dementia care, care for people with learning disabilities, tackling inequalities, end of life care, and improving quality in challenged providers) and is not all the actions being taken to give effect to the Government's 2017/18 Mandate to the NHS.

However, within the constraints of the requirement to deliver financial balance across the NHS, the main 2017/18 national service improvement priorities for the NHS are:

- **Improving A&E performance,** this also requires upgrading the wider urgent and emergency care system to manage demand growth and improve patient flow in partnership with local authority social care services
- **Strengthening access to high quality GP services and primary care**, which are far and away the largest point of interaction that patients have with the NHS each year
- **Improvements in cancer services and mental health** –common conditions which between them will affect most people over the course of their lives.

communityventures
original community developments

NHS
Rotherham
Clinical Commissioning Group

4.1 Health and Social Pen Picture of Rotherham

4.1.1 SOCIO-ECONOMIC PROFILE

The Metropolitan Borough of Rotherham occupies an area of 111 square miles, one of four metropolitan areas within South Yorkshire. It is bounded by Sheffield to the west, Barnsley to the north, Doncaster to the east and North East Derbyshire and Bassetlaw (Nottinghamshire) in the south. It falls within the defined Sheffield City Region boundary.

Rotherham is a diverse borough with a mixture of people, cultures and communities. There are densely populated multi-ethnic inner urban areas, large council-built housing estates, leafy private residential suburbs, industrial areas, rural villages and farms. The landscape of Rotherham is formed from Magnesian limestone in the east with its areas of large arable fields. There is a coal field landscape in the west of the borough, which has a mix of built-up areas, industrial land, farmed countryside, pockets of woodland and reclaimed land and urban influences are strong. About 70% of the Borough's land area is rural so the most notable feature of Rotherham is its extensive areas of open countryside, mainly agricultural with some parkland and woodland.

Rotherham is strategically located and well connected to other areas of the region and country via the M1 and M18, both of which run through the Borough, and by the rail network which links to Sheffield, Doncaster and Leeds. There are five airports within 50 miles of Rotherham including Robin Hood at Doncaster.

Rotherham developed from a small market town into a major industrial centre based on coal and steel. Most of the traditional industries of previous centuries no longer exist, and many old industrial areas have seen large scale regeneration such as at Manvers in the Dearne Valley, although there is still a steelworks at Aldwarke. This has had an impact on the employment opportunities in the area which are below regional and national levels

Around half of the Borough's population lives in the Rotherham urban area (including Rawmarsh and Wickersley), in the central part of the Borough. Most of the remainder live in numerous outlying small towns, villages and rural areas. About 15% of the population live in the northern Dearne Valley area which covers Wath, Swinton, Brampton and Wentworth. Around 35% live in the southern Rother Valley area which covers Maltby, Anston, Dinnington, Aston, Thurcroft and Wales.

4.1.2 HOUSING

Housing is also a key factor in the health and wellbeing of the local population as well as for the economic development of the area. Housing development is planned all over the Rotherham district. The most recent

Rotherham Local Plan, Sites and Policies adopted in June 2018 identifies sites throughout the area to realise circa 14,400 additional units which is summarised in the table below.

Area	No. of Units
Rotherham Urban Area (including Bassingthorpe Farm Strategic Allocation)	5,471
Dinnington, Anston and Laughton Common (including Dinnington East broad location for growth)	1,300
Wath-upon-Dearne, Brampton Bierlow and West Melton	1,300
Bramley, Wickersley and Ravenfield Common	800
Waverley	2,500
Maltby and Hellaby	700
Aston, Aughton and Swallownest	560
Swinton and Kilnhurst	560
Wales and Kiveton Park	370

Two key areas for large scale additional housing are Waverley and Bassingthorpe Farm.

At Waverley, a new community will be developed with 2,500 units. Of these, 1,100 built within the plan period to 2028 with a further 1,400 to follow.

Bassingthorpe Farm is located within 800 meters of the town centre and is identified as a ‘sustainable urban extension’ with 2,400 new homes with 1,100 being delivered by 2028 with the remaining 1,300 to follow within the next planning period.

A summary of the land availability for new housing and new employment opportunities from the Local Plan is included overleaf showing the distribution across the CCG area.

Local Plan: Availability of land

506

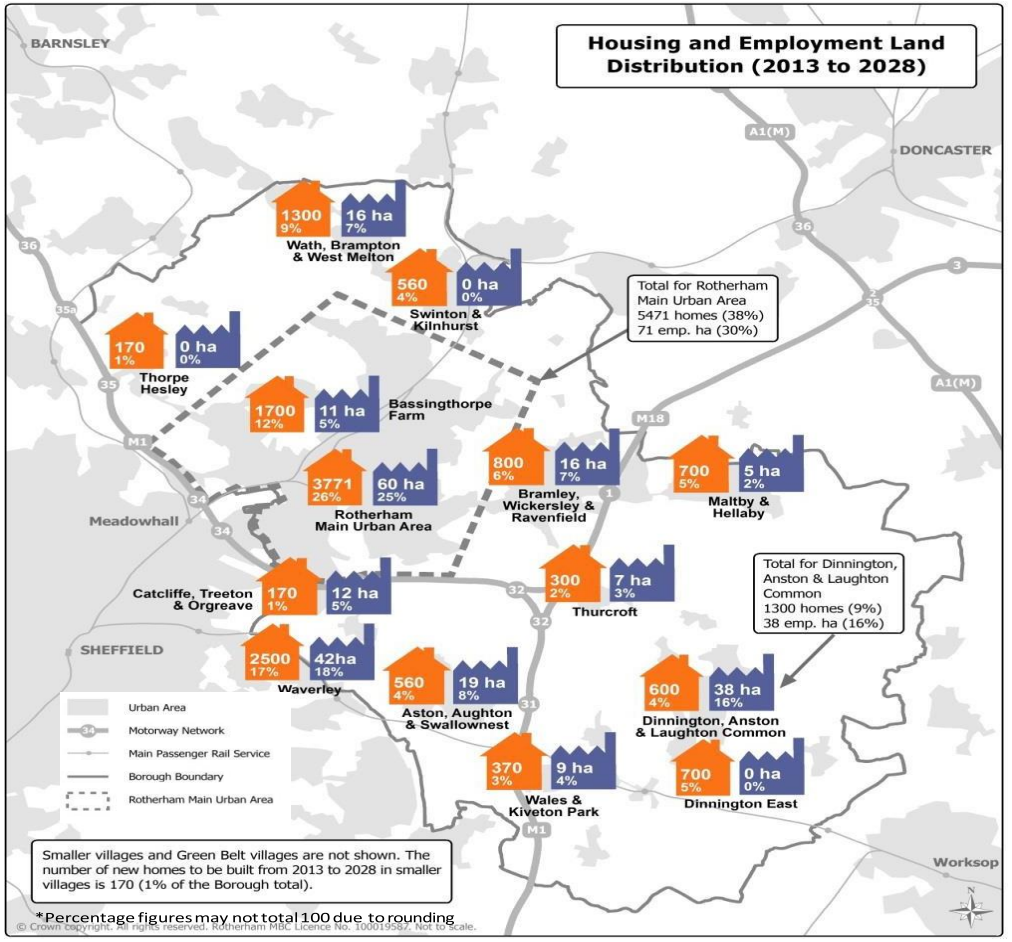
Number of new homes to be built in each community from 2013 to 2028 and percentage of Borough total

Total 14,371 homes

28 ha

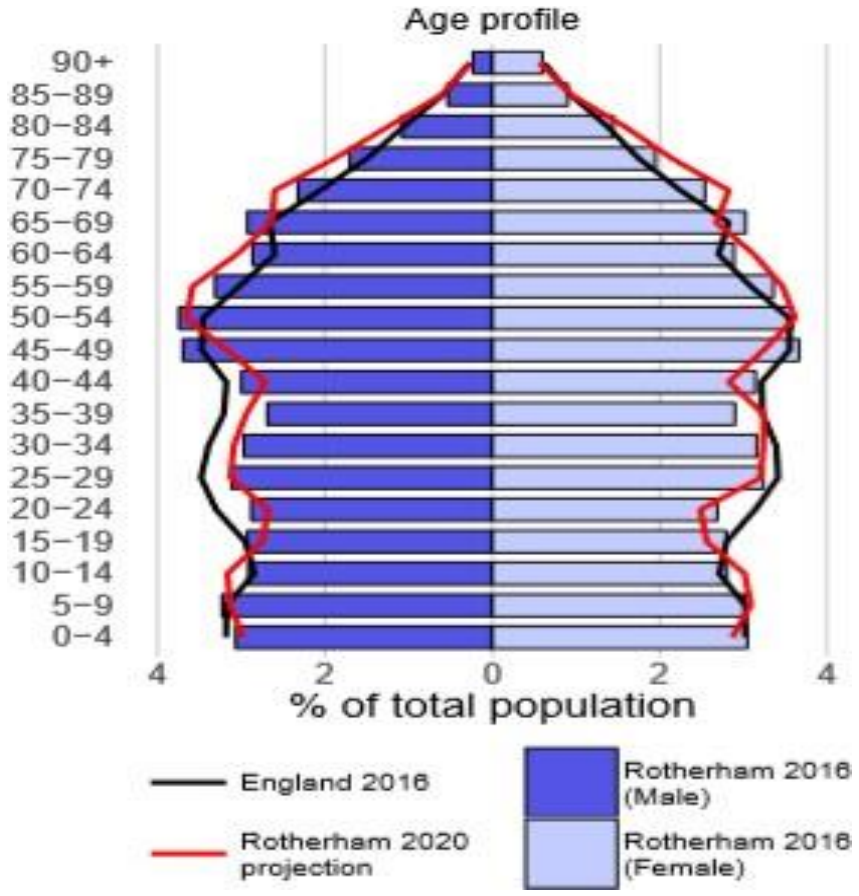
Amount of employment land to be provided in or near each community from 2013 to 2028 and percentage of Borough total

Total 235 hectares



4.1.3 DEMOGRAPHIIC PROFILE

The population of Rotherham continues to grow. It was estimated at 262,000 in 2016 and is projected to reach 266,900 by 2020.



The profile pyramid shows Rotherham's age profile for males and females alongside the England projections.

The changing age profile of Rotherham is revealed by population estimates over the last ten years. The total number of children has been falling although those aged 0-4 is projected to stabilise over the next ten years. The number of young people aged 16-19 is projected to fall to 2019 before rising again. The working age population 16-44 years is lower and the 45-64 years higher than regional and national level, the most significant long-term demographic change taking place in Rotherham is the growth in the number of older people. Figures identify an increase in the population of 38.6% aged 50 or over, 22% aged 65, and the oldest age groups 85+ which have increased by 41% between 2001 and 2015 compared to a 5% overall rise.

Rotherham has as many people aged 63 or over as children under 18 and the next two decades will see the baby boomers coming of retirement age that is likely to create a bulge in need rather than a steady increase. Progressively more of these people will be living alone.

Based on the ONS Mid-2016 Population Estimates for Wards the

average for Rotherham is 19.3% of the population. Within this there are nine wards that will be over 20% with Anston/Woodsetts (26.3%), Sitwell (25.0%), Wales (23.3%), Swinton (22.8%), and Wickersley (22.3%).

Such a demographic change will be associated with an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. As a consequence, there will be a rising demand for health and adult social care services, informal care and all services heavily used by older people.

The 10 most deprived areas of Rotherham (the Super Output Areas, or SOAs are Ferham, East Herringthorpe North, Eastwood Village, Canklow North, Eastwood East, East Herringthorpe South, Eastwood South, Maltby Birks Holt, East Dene East and Masbrough. They have a combined population of 17,500, of which children aged 0-17 number 5,900 (33.6%), twice the proportion in the 10 least deprived areas. Of children in the most deprived areas, 43% are minority ethnic compared with just 4% in the least deprived.

As of the end March 2017 there were 2,612 Children in Need, 367 Children subject to a Child Protection Plan and 485 Looked after Children in Rotherham. The high Child Protection rate and increasing complexity in the social care cases demonstrate that the needs of local children and young people and their families are rising.

Nationally there is a direct correlation between social care needs and deprivation. Nationally 19.9% of children are affected by income deprivation, in Rotherham this is significantly higher at 24.3% and for children living in the ten most deprived communities, half of them are affected by income deprivation. At the neighbourhood level, the figures range from 3% to 62.5%, showing a polarisation in family income across the Borough.

In terms of migration, Rotherham has a relatively small black and minority ethnic (BME) community but one that is growing and becoming increasingly diverse. The single largest minority ethnic group is Pakistani (Kashmiri) and the second is White Other which includes EU migrants. The health of EU migrants from Eastern Europe is generally poorer because of the poor social conditions in their native country. High levels of smoking and alcohol use are likely to pose significant threats to the health of these communities.

Shifting social norms must be tackled not only by individuals but by wide ranging action by health and care services, local government, media, businesses, society at large, families and the voluntary and community sector. By working together and with prevention at the heart of our plans we should be seeing improvements in the short, medium and long term.

4.1.4 HEALTH NEEDS

The health of people in Rotherham is generally worse than the average for England, full details can be found in the Joint Strategic Needs Assessment (JSNA) http://www.rotherham.gov.uk/jsna/. Rotherham is one of the 20% most deprived districts in England and about 21% (12,300) of children live in low-income families There is significantly higher than average deprivation, unemployment and long-term unemployment.

Life expectancy at birth is 78 years for men and 82 years for women for 2014-16 which is lower than the England average. Healthy life expectancy at birth has increased for men to 59.8 years. However there has been a decrease for women to 55.7 years. Overall, Healthy Life Expectancy has increased by 1.7 years for males and decreased by 4.4 years for females over the period 2009-11 to 2014-16. This means that men in Rotherham will live 18 years of their lives with at least one long term health condition and women will live 26 years with at least one long term health condition.

Another striking health issue in Rotherham is the degree of inequality within the Borough. The difference between the most and least deprived parts of Rotherham it is 9.8 years for men and 7.6 years for women (based on 2013-15). This gap has increased in recent years.

Over the last decade (2006-2016), all-cause mortality rates have fallen by 6%. While early deaths from cancer, heart disease and stroke have fallen they remain worse than the England average. In contrast, premature deaths from liver disease have increased by 29%, particularly in females. Respiratory disease mortality rates have fluctuated over the last decade decreasing 14% overall by 2014-16. The overall small increase in recent years masks a large increase in rates for females and a large decrease in male rates.

Another impact of the changing demography of Rotherham is the increasing number of people living alone. Potential consequences of this include poverty, loneliness and mental ill health. Mental ill health is the biggest cause of morbidity and incapacity and the growing burden of dementia is an increasing concern.

In response to the growth in long term conditions and care needs, the number of informal carers has increased. The age profile of carers is following the same pattern as the general population and is believed to reflect the increasing number of spouse carers. The increase in the number of younger carers is more modest and this is likely to result in a widening of the "care gap" which could lead to greater demands on formal care services including acute care.

The consequences of sexual exploitation for the victims of abuse and their families will be significant and will be lifelong. Mental health support and understanding will require investment both in professional awareness and increased working in services for those who have been abused.

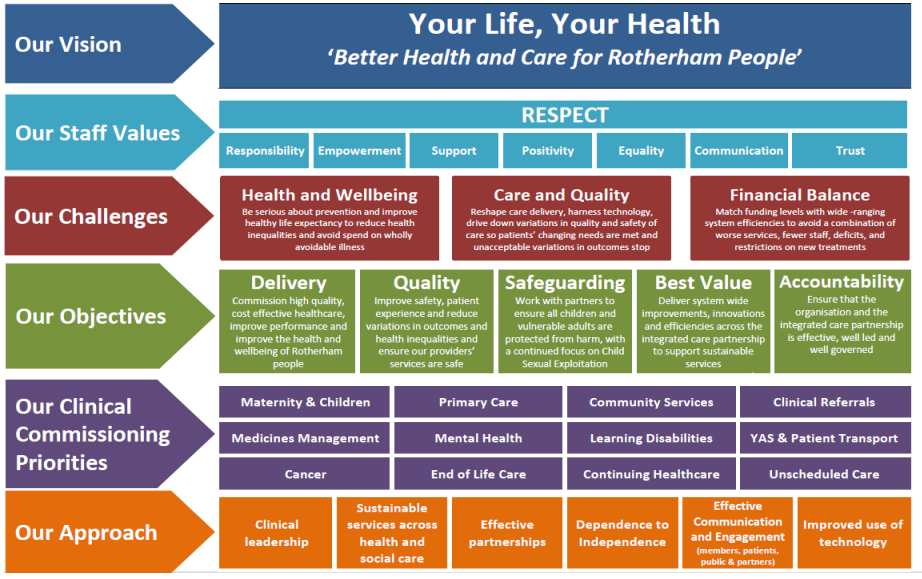
4.2 Clinical Commissioning Group (CCG)

Clinical Commissioning Groups (CCGs) are groups of General Practitioners (GPs) that, from April 2013, became responsible for planning and funding (commissioning) local health services across England. In Rotherham there is a single CCG that is co terminus with the LA boundary.

The role of the Clinical Commissioning Group is to lead in preventing people dying prematurely including action to improve early diagnosis and equitable access to services. The key health issues for Rotherham are:

- Long term conditions – Cardio Vascular Disease (CVD &CHD), Diabetes, Respiratory
- Drug and Alcohol related disorders
- Cancer
- Mental health including dementia

The CCG publishes a Commissioning Plan, Your Life, Your Health, setting out their approach for meeting the health needs of their registered population which is summarised as a plan on a page below.



This CCG Commissioning Plan 2016-20 is developed using a variety of sources from national and regional policy e.g. FYFV and the STP, local needs assessment, clinician involvement, patient and public feedback and is set to deliver the CCGs statutory duties and performance requirements.

This approach includes the Rotherham Integrated Health and Social Care Place Plan, and both are delivered through joint working with key local partners.

As part of delivering the Five Year Forward View, Rotherham CCG have a Five-Year Primary Care Strategy. It sets out how the CCG will work with GP Practices to transform services to improve consistency and equality in access to general practice, provide a seamless pathway for patients with GPs and the linchpin for care, and support

patients to manage their conditions by using technology to connect with healthcare professionals. Locally they use an Improvement & Assessment Framework (IAF).

4.3 Local Authorities

The area is a Unitary Authority and is overseen by Rotherham Metropolitan Borough Council. To meet housing and employment requirements identified for the wider Sheffield City Region the Borough Council works with neighbouring local authorities.

The Rotherham Clinical Commissioning Group has co-terminus boundaries with the Rotherham Metropolitan Borough Council.

4.4 Providers / Third Sector

A range of providers including the third sector organisations operate services from estate within the Rotherham area. This includes using their own premises, leasing from private landlords or other NHS and public funded bodies e.g. NHS Property Services, local authority etc.

The key NHS trusts/private sector providers of acute and community care who utilise NHS estate in the area are:

- Rotherham, Doncaster and South Humber NHS FT
- Rotherham NHS Foundation Trust
- Voluntary Action Rotherham

4.5 South Yorkshire & Bassetlaw Integrated Care System

Sustainability and transformation plans (STPs) were announced in NHS Planning guidance published in December 2015. NHS organisations and local authorities were asked to come together to develop 'place-based plans' for the future of health and care services in their area.

The next step was for NHS and local councils to form Sustainability and Transformation Partnerships (STPs) to continue to build on the collaborative work. There are 44 STPs covering all of England with the aim to improve health and care by looking at the needs of the whole population in the area - not just those of individual organisations. Rotherham is part of South Yorkshire and Bassetlaw.

An Integrated Care System is where NHS organisations (both commissioners and providers), in partnership with local authorities, choose to take on collective responsibility for resources and population health. In return they get far more control and freedom over their health system, such as delegated decision making and devolved budgets.

South Yorkshire and Bassetlaw has been chosen as one of the 9 areas to work towards becoming an ICS.

SY&B ICS has a goal for everyone in South Yorkshire and Bassetlaw through the following ambition: *"We want everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and live longer."*

Its plan is based on five 'places' within South Yorkshire and Bassetlaw – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. The five place plans are the foundation of what will be delivered in each area and set out how improvements from new ways of working and prevention will be made. The place plans focus on aligning primary and community care, putting the greatest emphasis on helping people in their neighbourhoods and managing demand on services. They also home in on improving health and wellbeing and the other factors that affect health, such as employment, housing, education and access to green spaces.

There are also eight priority areas of focus:

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities
- Urgent and emergency care
- Elective and diagnostic services
- Children's and maternity services
- Cancer
- Spreading best practice and collaborating on support office functions.

The plan focuses on people staying well in their own neighbourhoods, prioritising prevention, whilst introducing new services, improving co-ordination between those that exist and have staff working in the best way to meet people's needs.

Alongside reshaping and strengthening primary and community services, by working as a network of 25 partners, access to specialist hospital care will be improved so that no matter where people live, they have excellent, high quality care and experiences.

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

5.1 Rotherham Strategic Estates Plan

The Rotherham CCG has a Strategic Estates Plan which summarises the estates strategies of partners across the local health system and identifies actions to take forward agreed key priorities. The information on Primary Care is less developed than partner data and strategy development which was one of the drivers for the Primary Care Estates Strategy and the proposals within this document

The SEP was developed with an understanding that the commissioning environment is changing with FYFV. Providers of Primary, Community, Mental Health, Acute and Specialist will increasingly be required to compete for short term (3-5 year) contracts for services. This may include the need to include an estates solution within their proposal identifying where these services are to be delivered.

However, there is also a growing recognition within the 'System' that for service providers to provide estate for such short-term contracts, does not always offer the best value for money solution.

GP's are being encouraged to modify their traditional business model to become confederated or merged practices (super practices). This drive is to achieve the economies of scale needed, address workforce issues and put them in a position to compete for 'Primary Care Plus' services in line with the FYFV as Commissioners seek to transfer activity from acute to community settings.

The impact of this is an evolving 'System' approach of a relevant NHS Estate being managed and provided by NHS Property Services (NHSPS) and leased on behalf of Commissioners who can enter into the required long leases to underwrite any required long-term capital investment, and then sublet to Providers on leases which are coterminous with their service contracts. For General Practice and wider Primary Care NHSPS / CHP ownership, or leased from the Private Sector, on long leases are seen as the way forward.

A broader range of NHS estate in the commissioning control of CCG's and Transformation Board to ensure suitable facilities available within localities to meet the needs of outreach services will change the status quo.

Estates decisions made by individual NHS trusts may also have consequences for other providers e.g. services currently located in an acute setting will need to be relocated in the future as acute, community and mental health trusts rationalise their estate to focus

on core clinical delivery and divesting themselves of non-core estate which might impact on Primary Care.

A focal building within the Health Village and Central localities is the Rotherham Community Health Centre (Map no 51). This is a substantial purpose-built facility with a GIA of circa 5,400m² comprising three floors of primary and community type of accommodation plus diagnostics, theatres and dental suites. From local knowledge this building is significantly underutilised made more so by the GP 'walk in' services having moved from this building to the Rotherham Urgent Care Centre in line national policy. Other services have sought to vacate space due to the costs associated with occupying this building.

The health system has a plan to progress a resolution to this issue. This is key as the CCG may not be able to justify further investment into primary care estate within central Rotherham until the issues with this facility are resolved.

5.2 Identifying Priorities for the Rotherham Primary Care Estates Strategy

The box across identifies the processes undertaken to review the Rotherham primary care estate and determine priorities for action.

Knowledge Review and Mapping CCGs/Localities

- Undertake a desk top review of the existing estate data breaking these up into the CCGs and agreed localities.
- Create Asset maps for CCG/Locality areas that will give a visual picture supported by action plans.

Analysis of Six Facet Surveys

- Review available survey information by CCG and cross reference with current knowledge and data to see if significant changes to any of the six facets influence estate priorities or actions.

Understanding / linking Commissioning Strategies

- Working with CHP/NHS England / CCGs consider the impact of any Service review and commissioning plans and their impact on current Asset base.
- Review STP/SEP priorities to ensure best fit with the SEP priorities to use existing core estate and improvement proposals

CCG Action Planning

- Identify key issues arising from mapping.
- Create draft action plans for discussion/consideration and sense check by CCG.

Primary Care Estate Strategy Document

Produce a Primary Care Estate Strategy Report for the CCG that provides a visual plan CCG wide and broken down by localities which is underpinned with recommendations and actions across a 5year period.


Library

6. ROTHERHAM CCG REVIEW

GP Practices

Main premises

Branch premises

Health Village/Central

Central North

Maltby & Wickersley

Rother Valley North

Rother Valley South

Wath/Swinton

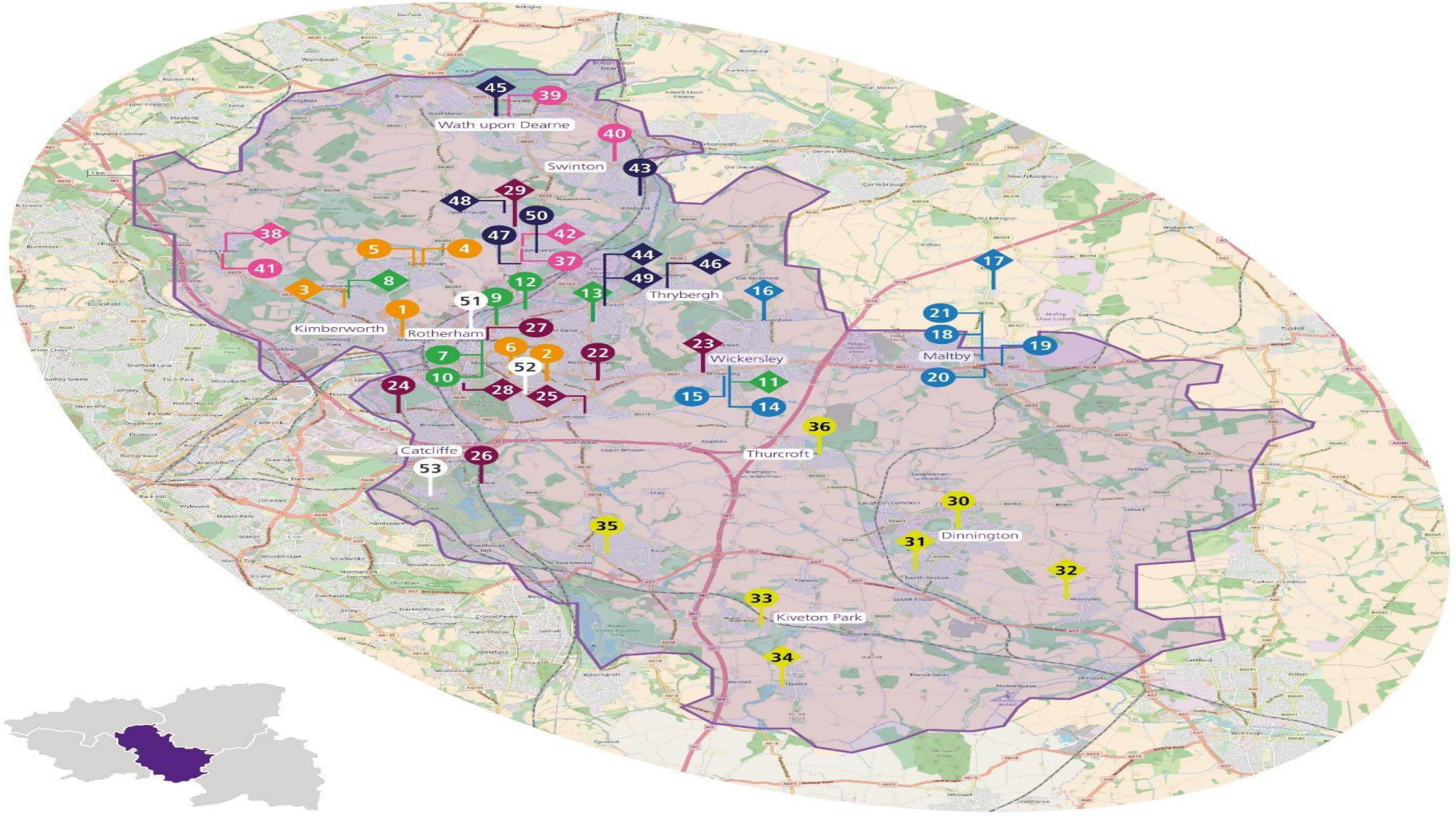
Wentworth South

Other

No	Code	Practice
1	C87003	Woodstock Bower Group Practice – Rotherham
2	C87012	Broom Lane Medical Centre – Rotherham
3	C87012	Broom Lane Medical Centre – Kimberworth Park
4	C87020	Greenside Surgery – Greasbrough
5	C87603	Greasbrough Medical Centre – Greasbrough
6	C87621	Broom Valley Road Surgery – Rotherham
7	C87005	St Ann's Medical Centre – Rotherham Health Village
8	C87005	St Ann's Medical Centre – Kimberworth Park
9	C87010	York Road Surgery – Rotherham
10	C87017	Clifton Medical Centre – Rotherham Health Village
11	C87017	Clifton Medical Centre – Wickersley Health Centre
12	C87608	Shakespeare Road Surgery – Eastwood
13	C87608	Shakespeare Road Surgery – Ridegway Medical Centre
14	C87015	Wickersley Health Centre – Wickersley
15	C87016	Morthen Road Group Practice – Wickersley
16	C87016	Morthen Road Group Practice – Ravenfield
17	C87016	Morthen Road Group Practice – Braithwell
18	C87031	Maltby Services Centre – Maltby
19	C87606	Queens Medical Centre – Maltby
20	C87616	Blyth Road Medical Centre – Maltby
21	C87620	Manor Field Surgery – Maltby
22	C87007	Stag Medical Centre – Rotherham
23	C87007	Stag Medical Centre – Wickersley
24	C87009	Brinsworth Medical Centre – Brinsworth
25	C87009	Brinsworth Medical Centre – Whiston
26	C87014	Treeton Medical Centre – Treeton
27	C87622	Gateway Primary Care – Rotherham
28	C87622	Gateway Primary Care – Canklow
29	C87622	Gateway Primary Care – Rawmarsh

No	Code	Practice
30	C87002	Dinnington Group Practice – Dinnington
31	C87002	Dinnington Group Practice – North Anston
32	C87002	Dinnington Group Practice – Woodsetts
33	C87004	Kiveton Park Medical Practice – Kiveton Park
34	C87004	Kiveton Park Medical Practice – Harthill
35	C87008	Swallownest Health Centre – Swallownest
36	C87022	Village Surgery – Thurcroft
37	C87018	High Street Surgery – Rawmarsh
38	C87018	High Street Surgery – Thorpe Hesley
39	C87029	Market Surgery – Wath upon Dearne
40	C87030	Crown Street Surgery – Swinton
41	C87604	Thorpe Hesley Surgery – Thorpe Hesley
42	C87604	Thorpe Hesley Surgery – Rawmarsh
43	C87006	Magna Group Practice – Kilnhurst
44	C87006	Magna Group Practice – Dalton
45	C87006	Magna Group Practice – Wath upon Dearne
46	C87006	Magna Group Practice – Thrybergh
47	C87013	Parkgate Medical Centre – Parkgate
48	C87013	Parkgate Medical Centre – Rawmarsh
49	C87006	Magna Group Practice – Brookfield Surgery, Dalton
50	C87024	Rawmarsh Health Centre – Rawmarsh
51		Rotherham Community Health Centre – Rotherham
52		Urgent & Emergency Care Centre – Rotherham
53		New practice – Waverley

6. ROTHERHAM CCG REVIEW



6.1 Review of Primary Care Estate

6.1.1 Rotherham Primary Care Asset Mapping

Across Rotherham the primary care estate is in a mixed condition with an active history of decision making and investment. This has resulted in the estate being generally well developed and in the right locations with many owned by NHS Property Services. Improvements have been achieved in the existing primary care estate and some additional new builds for individual GP practices or within service centres where multiple services have been co located.

The NHS standard for acceptable buildings is 'Condition B' or better (Condition A, which is 'as new').

Many Rotherham primary care buildings are at the lower end of the risk scale in terms of fitness for purpose. The table which follows shows the overall condition of the GP premises across Rotherham CCG based on the 6-facet information.

CCG Wide Facets	Condition A/B (%)	Condition B/C (%)	Condition C/D or less (%)
	Low risk	Medium risk	High risk
Physical condition	44%	54%	2%
Functional Suitability / Space Utilisation	80%	12%	8%
Statutory Compliance Status	46%	46%	6%

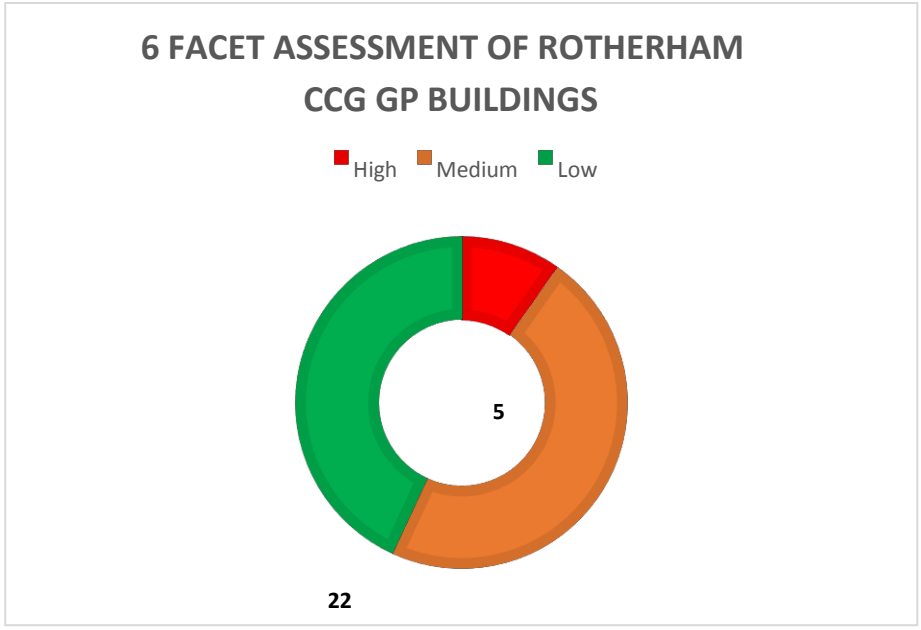
This assessment covers both the condition of the fabric of the buildings and the operational aspects including the full range of statutory compliance and how the accommodation is managed.

Some aspects of the physical condition may require estates solutions to make premises suitable for new models of care whereas operational elements of statutory compliance should be addressed through operational management and performance managed through standard PMS/GMS contract processes.

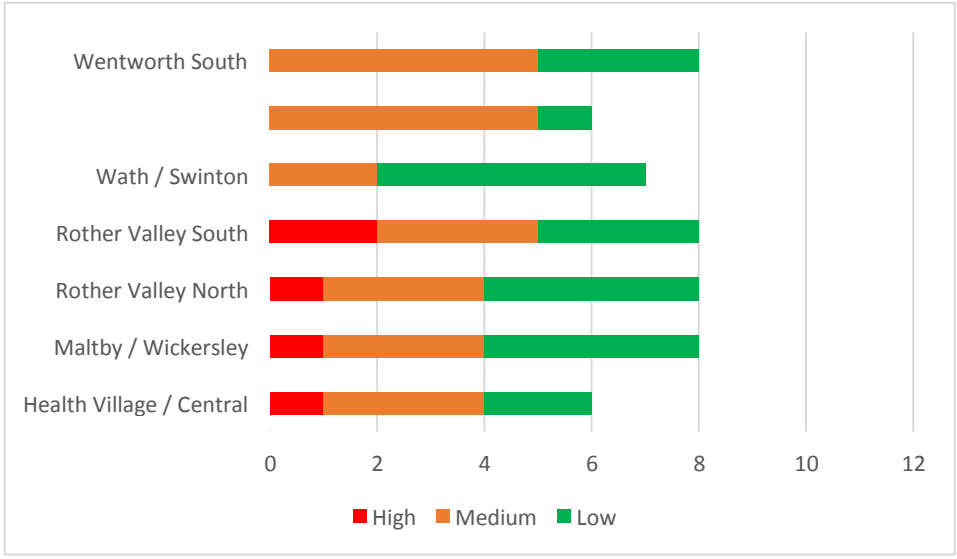
Functional suitability and space issues, 80% Condition A/B and 12% at B/C or below shows potential to consider modifying utilisation and repurposing of the existing estate. This could assist in both accommodating service transformation, the significant changes in service delivery outlined in the FYFV advanced primary care model

and, depending on the location, increases in registered patients due housing development.

Following analysis of estate and commissioning data the assessed priority rating for the CCG is set out in the following pie diagram with 5 properties identified as high priorities for action.



This is split into individual practices and localities to inform priorities and opportunities for strategic estate improvement/development in support of new planned models of care and may incorporate premises with a lower individual priority rating. However, they may be part of wider estate efficiencies between practices and/or other health/public sector facilities a local area to maximise estate funded through the public pound (£).



The 5-year financial plan for the CCG includes costs for the existing estate and estimates for improvement and development projects. The overall known risk cost of the existing properties is estimated at £1,882,377. This includes addressing current compliance but does not include project delivery costs or any additional sums which might ensue following the 2016 surveys or any improvements undertaken since they were last assessed. The figures have been updated to 2018 index costs to give a more current picture of liability.

The Improvement, Investment and Development element is estimated at £10,354,000 and would be subject to more detailed service commissioning intentions of the CCGs. (See financial summary in Section 7).


PENNYHILL PRIMARY SCHOOL

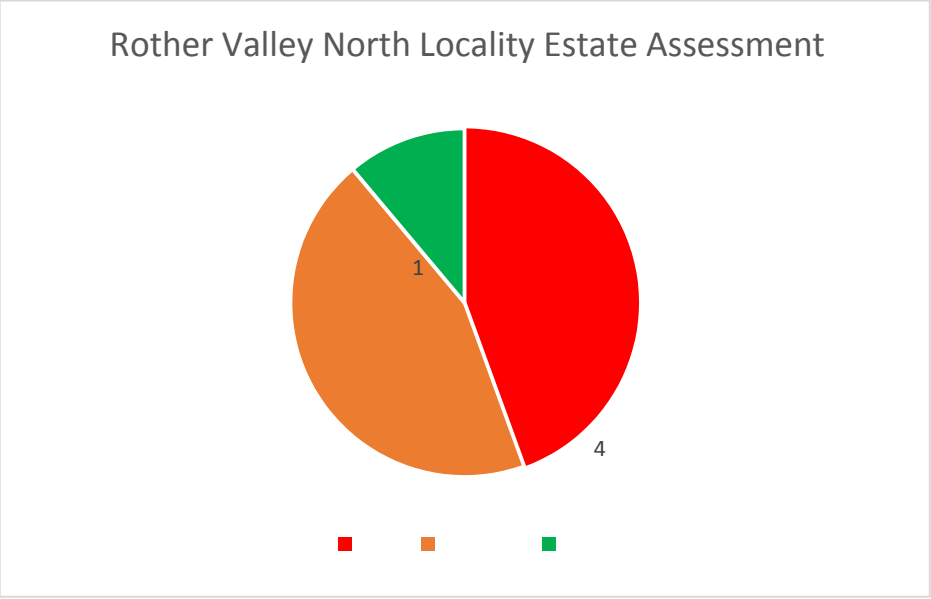
6.2 Rother Valley North Locality

The estate across the Rother Valley North locality is in a very mixed condition. Four practices occupy 8 buildings, providing services for circa 36,000 registered patients (April 2018). The total risk cost identified for the GP premises in this locality is £265,167.

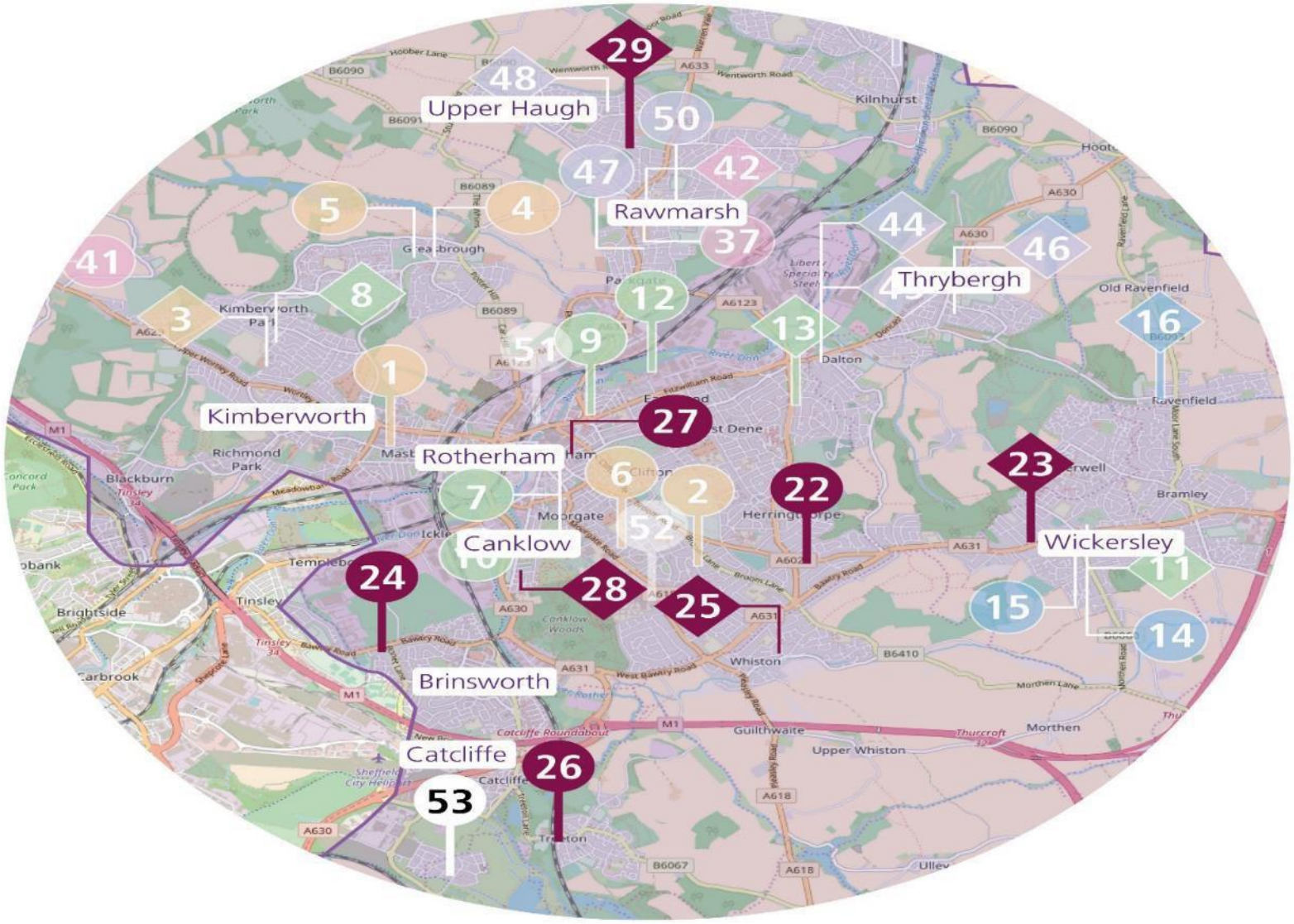
Facets	Condition A/B (%)	Condition B/C (%)	Condition C/D or less (%)
	Low risk	Medium risk	High Risk
Physical condition	38%	62%	0%
Functional Suitability / Space utilisation	56%	19%	25%
Statutory Compliance Status	50%	50%	0%

The 6F assessment in this locality shows the key issues going forward are likely to relate to physical condition, functional suitability and space. These
will need to be considered carefully when looking at opportunities to improve or rationalise the estate.

The premises assessment identifies high priorities as 'red' sites. These relate to those with either the potential (to maximise existing buildings/sites in strategically appropriate places) or of those of poor quality as the key areas that offer opportunities for improvement or rationalisation.



The high priorities identified for Rother Valley North Locality are the existing premises at Wickersley and Treeton and the development of premises at Waverley to address the housing impact.



Rotherham Prim a

6.2.1 Property Assessment of Rother Valley North Locality

The premises assessment is based on local CCG estates knowledge including reviewed 6 Facet survey data 2016 where this was available and our team's assessment of the potential to develop, extend or rationalise to support the proposed new service and the CCGs commissioning objectives.

Map No	Code	Name	Address 1	Address 2	Post Code	Assessment	Total	GIA m²	List Size (Apr 18)	Multi site
22	C87007	Stag Medical Centre	162 Wickersley Road	Rotherham	S60 4JW		8.0	640	11,697	M
23			Rose Court Surgery 121 Bawtry Road	Wickersley	S66 2BL		14.0	185	incl	B
24	C87009	Brinsworth Medical Centre	171 Bawtry Road	Brinsworth	S60 5ND		10.5	389	9,994	M
25			Surgery of Light Hunger Hill Lane	Whiston	S60 4BD		11.0	191	incl	B
26	C87014	Treeton Medical Centre	10 Arundel Street	Treeton	S60 5PW		13.5	452	6,615	S
27	C87622	Gateway Primary Care	Chatham House	Doncaster Gate	S65 1DA		9.5	720	7,661	M
28			Canklow Road Surgery Henderson Place	Canklow	S60 2JH		9.0	220	incl	B
29			Rosehill Medical Centre 52 Rosehill Road	Rawmarsh	S62 7BT		12.0	115	incl.	B
53			New Build to be undertaken	Waverley			n/a	590	6,000	B

6.2.2 Key Issues from Appraisal and Mapping

Following the review and assessment the following are key issues for consideration across the Rother Valley North locality:

- There are noticeable differences in condition and functionality which reflects historical decision making, investment in premises and the standard of operational estate management of each building and two buildings are identified as high risk based on 6 facet assessment.
- Three properties in this locality are owned or leased by NHSPS. All GP premises in the locality are reported to be running full or over crowded regarding space utilisation.
- Rother Valley North is the locality reporting the greatest pressure on space across the CCG.
- Lack of space appears to be a particular issue at Rose Court Surgery, Treeton Medical Centre, Rosehill Medical Centre and the Brinsworth practice (both main and branch premises). These appear undersized for their registered population where they only operate from a single site however further space utilisation work may be required to quantify the significance of this finding.
- For its identified GIA, Rosehill Medical Centre, Rawmarsh (Map no 29) appears to have a significant risk cost associated with backlog maintenance. Rawmarsh is an area where consolidation and co-location across the current six premises (which fall across three CCG localities) may be achievable.
- NHS PS have the head lease for Rawmarsh Multi Service Centre and consideration of moving e.g. Gateway Primary Care, Rosehill Medical Centre branches and Parkgate Medical Centre (Map nos 29 and 48) is advised.
- The longer-term premises requirement for the branch practice of Rose Court at Wickersley (Map no 23) could be considered with other buildings in the area e.g. Wickersley Health Centre (Map no 11 &14) and Morthen Group Practice (Map no 15).
- Planning and development of the new surgery at Waverley of 590m² GIA for 6,000 additional patients' needs to be progressed to its construction and commissioning to cater for the new housing.
- All buildings need ongoing effective estate management particularly for compliance with Fire, Health and Safety and Access in line with the Disability Discrimination Act (DDA) and backlog maintenance to achieve or maintain the Condition B standard.

6.2.3 Rother Valley North Locality Prioritisation

The CCG aim of rationalisation/development of the estate for GMS and FYFV considers strategic locations or sites for development/maximising existing buildings including other NHS premises.

The housing impact in this locality will be significant with permission granted for 4,000 new homes of which 2,500 will be built be 2028 in Waverley as part of the significant development of a new community of housing and employment with its own social and community infrastructure. This would put pressure on the practices at Brinsworth Medical Centre and Treeton Medical Centre.

However, the CCG has awarded a new PMS contract to Gateway Primary Care to establish a practice in Waverley which will include new premises to address the additional number of patients expected from this housing development.

In addition, the impact of a higher than CCG average growth in the over 65's (CCG average is 19.8%) will impact on Wickersley ward (22.5%) and the Sitwell ward (25%) situated to the west of Wickersley.

This will also impact on the Wickersley buildings in Maltby and Wickersley Locality.

The key priorities for Rother Valley North locality are listed in the table below with an estimated cost for improvement/investment where identified:

Premises / Issue	Priority S=1-year M=2-4 L=5	Action	Improvement Cost Estimate (£)
Wickersley area	S	Consider undertaking a feasibility study to determine potential for developing a combined community hub which also addresses current GP premises issues and housing development to provide the information to complete a PID. (also includes Maltby/Wickesrley and HV Central practices)	Costed in Maltby/Wickersley locality
Waverley	M	New practice to be	£1,475,000

		established for 6,000 patients with GIA of circa 590m².	
Statutory Compliance	S	Review all practices scoring Cat C or below for Compliance through GMS contract management process	n/a

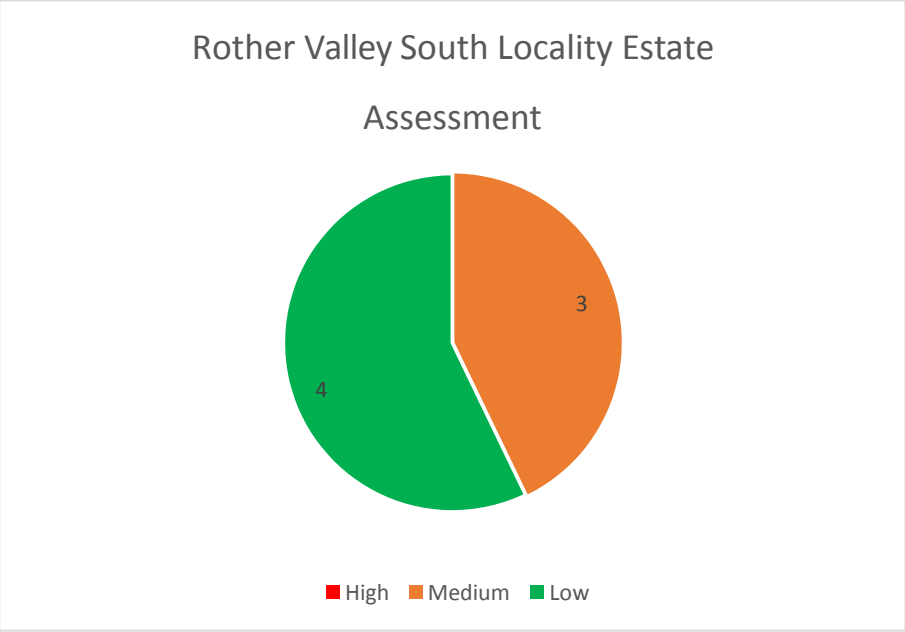
6.3 Rother Valley South Locality

The estate across Rother Valley South is in good condition overall and in appropriate parts of the locality. Four practices occupy 7 buildings, providing services for circa 57,000 registered patients (April 2018). The total risk cost identified for the GP premises in this locality is estimated at £203,752.

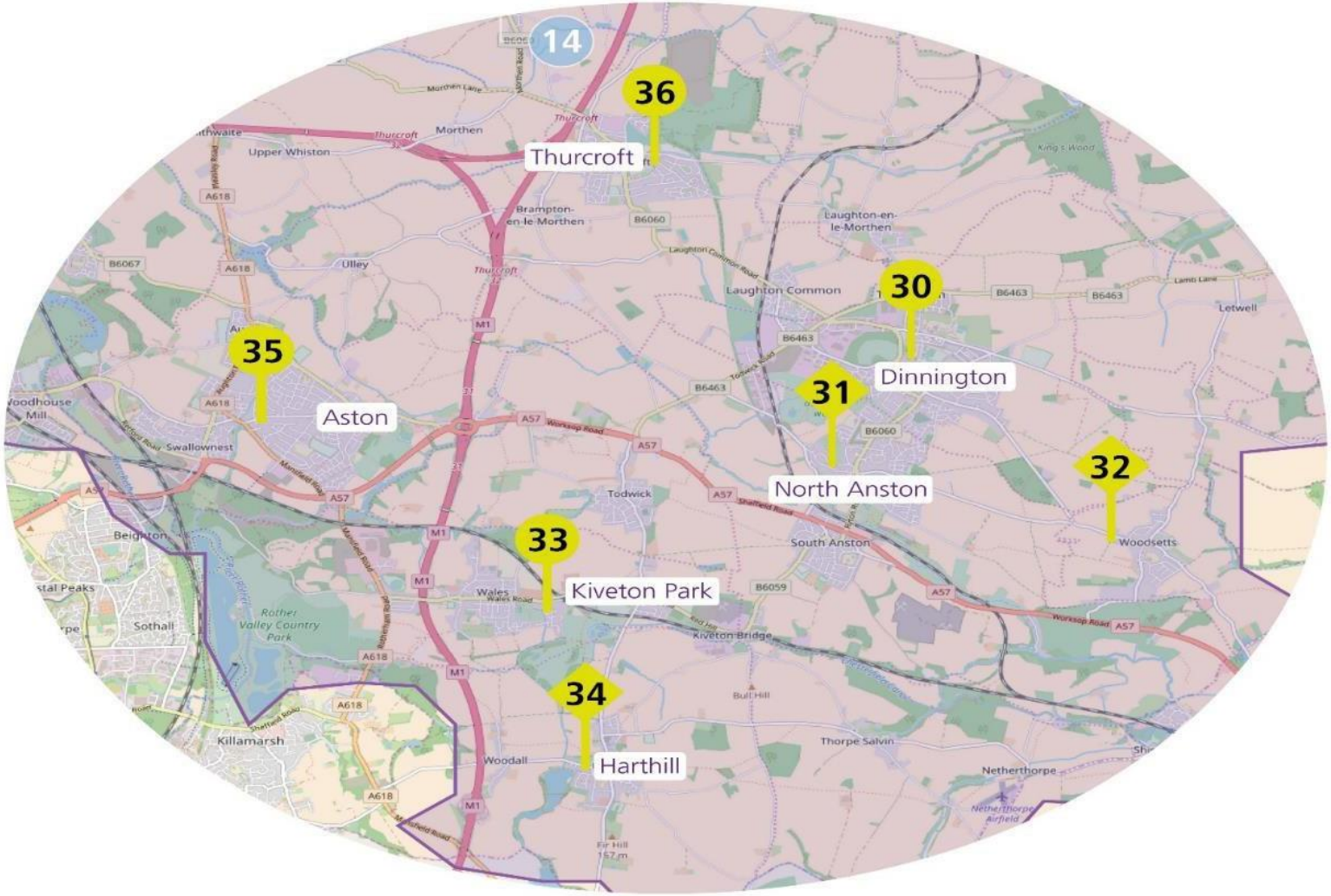
Facets	Condition A/B (%)	Condition B/C (%)	Condition C/D or less (%)
	Low risk	Medium risk	High risk
Physical Condition Status	43%	57%	0%
Functional Suitability /Space Utilisation Status	100%	0%	0%
Statutory Compliance Status	57%	43%	0%

The issues in this locality are around physical condition of some of the buildings which will need to be considered carefully when looking at opportunities to improve or rationalise the estate. However, three of the branch surgeries did not have a 6F survey and the condition of the premises is based on practice reporting.

The premises assessment identifies as high priorities as 'red' sites. These relate to those with either the potential (to maximise existing buildings/sites in strategically appropriate places) or of those of poor quality as the key areas that offer opportunities for improvement or rationalisation.



There are no high priority premises identified for the Rother Valley South Locality as much of the estate is in good condition and in appropriate parts of the locality.


14
36
Thurcroft
30
Dinnington
35
Aston
31
North Anston
32
Woodsetts
33
Kiveton Park
34
Harthill
Morthen
Upper Whiston
Brampton-en-le-Morthen
Ulley
Laughton-en-le-Morthen
Laughton Common
Letwell
Swallownest
Todwick
South Anston
Beighton
Sothall
Rother Valley Country Park
Wales
Kiveton Bridge
Killamarsh
Woodall
Thorpe Salvin
Netherthorpe
Bull Hill
A57
M1
A618
B6463
B6060
B6059

6.3.1 Property Assessment of Rother Valley South Locality

The premises assessment is based on local estates knowledge from the CCG including reviewed 6 Facet survey data 2016 where this was available and our team's assessment of the potential to develop, extend or rationalise to support the proposed new service and the CCGs commissioning objectives.

Map No	Code	Name	Address 1	Address 2	Town/City	Post Code	Assessment	Total	GIA m²	List Size (Apr 18)	Multi site
30	C87002	Dinnington Group Practice	New Street	Dinnington	Sheffield	S25 2EZ		9.0	795	20,819	M
31			15 Quarry Lane	North Anston	Sheffield	S25 4DB		10.0	520		B
32			2a Berne Square	Woodsetts	Worksop	S81 8RJ		9.5	131		B
33	C87004	Kiveton Park Medical Practice	Chapel Way	Kiveton Park	Sheffield	S26 6QU		10.0	1,199	11,466	M
34			Woodall Lane	Harthill	Sheffield	S26 7YQ		6.0	115		B
35	C87008	Swallownest Health Centre	Worksop Road	Swallownest	Sheffield	S26 4WD		7.5	452	16,564	S
36	C87022	Village Surgery	24-28 Laughton Road	Thurcroft	Rotherham	S66 9LP		9.0	419	7,703	S

6.3.2 Key Issues from Appraisal and Mapping

Following the review and assessment the following are key issues for consideration across the Rother Valley South locality;

- There are differences in condition and functionality which reflects historical decision making, investment in premises and the standard of operational estate management of each building.
- No buildings are identified as high risk based on 6 facet assessment.
- Due to geographic spread of this locality there appears few opportunities to consider further co location across the practices.
- Village Surgery in Thurcroft (Map no 36) is below the recommended GIA allocation for the number of registered patients and appears to have a significant risk cost associated with backlog maintenance.
- Swallownest practice, with a reported GIA of 452m², is significantly below the advised space maxima which is circa 1,100m².
- All GP premises in the locality are reported to be running full or over crowded regarding space utilisation.
- Kiveton Park Practice (Chapel Way) although identified as 'Full' in the 6F survey, appear to have a generous GIA allocation for the number of registered patients than recommended and should be able to absorb additional activity.
- The Dinnington Group Practice operates from three sites in Dinnington, North Anston and Woodsetts and appears to have adequate space within the multiple sites for current activities.
- If premises appear to be coming under a space pressure, the CCG may want to consider formal space utilisation surveys in the future to determine the difference between space allocation and actual usage.
- All buildings need ongoing effective estate management particularly for compliance with Fire, Health and Safety and Access in line with the Disability Discrimination Act (DDA) and backlog maintenance to achieve or maintain the Condition B standard.

6.3.3 Rother Valley South Locality Prioritisation

The CCG aim of rationalisation/development of the estate for GMS and FYFV considers strategic locations or sites for development/maximising

existing buildings including other NHS premises. No additional new buildings or significant consolidations are identified for this locality.

The main housing impact will come in both the east and the west of the locality. 1,300 planned additional properties in the Dinnington, Anston and Laughton Common area which is likely to impact most on the Dinningtom group practice in the east. This could bring an additional 2,990 patients into the west of the area. Consideration of the number and position of premises within this group practice could be undertaken opportunistically with the new housing and additional patients it may bring to this area. This could be done in a multiagency partnership to create a community hub for the wider area.

In the west of the locality housing development of circa 1,100 units in Wales, Kiveton Park, Aston, Aughton and Swallownest may bring in an additional 2,500 patients. In addition, a higher than CCG average growth in the over 65's (CCG average is 19.8%) will impact on Anston/Woodsetts ward (26.3%) south of Dinnington and the Wales ward (23.3%) situated near to Kiveton Park.

Based on the stated GIAs, Kiveton Park have an allocation which should allow them to absorb this element of the housing development and the older demographic from an estate's perspective, but this is not the case regarding

The key priorities for Rother Valley South locality are listed in the table below with an estimated cost for improvement/investment where identified:

Premises / Issue	Priority S=1-year M=2-4 LI=5	Action	Improvement Cost Estimate (£)
Capacity and Utilisation	S	Consider undertaking a space utilisation survey of Swallownest to assess operational capacity of premises.	£3-4,000 (depending on the size & no of rooms)
	M	Consider undertaking space utilisation surveys of Kiveton, Chapel Way and others if premises come under pressure.	£3-4,000 per survey (depending on the size & no of rooms)
Statutory Compliance	S	Review all practices scoring Cat C or below for Compliance through GMS contract management process	n/a

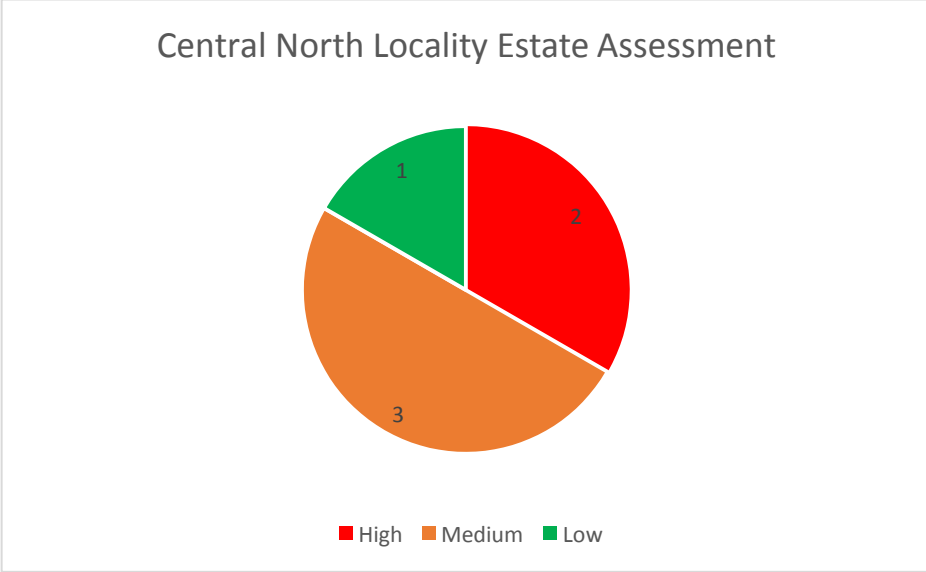
6.4 Central North Locality

The estate across Central North is in good condition overall. Five practices occupy 6 buildings providing services for circa 36,000 registered patients (April 2018). The total risk cost identified for the GP premises in this locality is £234,990.

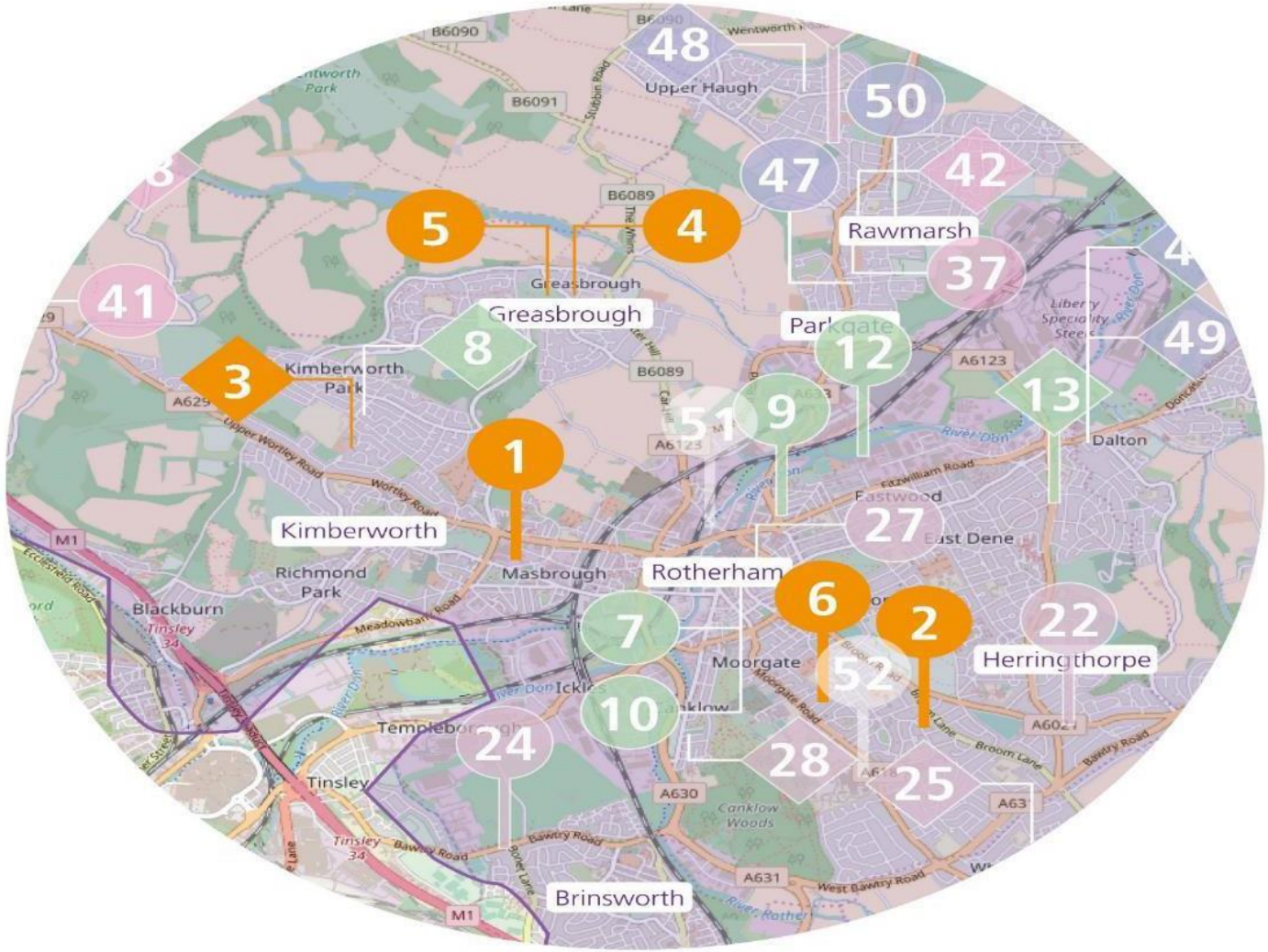
Facets	Condition A/B (%)	Condition B/C (%)	Condition C/D or less (%)
	Low risk	Medium risk	High risk
Physical Condition Status	33%	67%	0%
Functional Suitability /Space Utilisation Status	42%	25%	33%
Statutory Compliance Status	83%	0%	17%

The 6F assessments in this locality are showing some risks around physical condition and for functional suitability and space. Statutory compliance is high overall. These factors will need to be considered carefully when looking at opportunities to improve or rationalise the estate.

The premises assessment identifies high priorities as 'red' sites. These relate to those with either the potential (to maximise existing buildings/sites in strategically appropriate places) or of those of poor quality as the key areas that offer opportunities for improvement or rationalisation. The key issue for this locality is the impact of housing development which is a factor in the assessment of priorities.



The high priorities identified for Central North Locality are the Greasbrough and Kimberworth Park premises in terms of the expected housing impact.


48
Upper Haugh
50
47
42
Rawmarsh
37
5
4
Greasbrough
41
Greasbrough
8
12
49
3
Kimberworth
Park
A6123
13
9
51
1
Dalton
Kimberworth
27
Rotherham
Masbrough
Richmond
Park
Blackburn
6
2
22
Herringthorpe
7
Moorgate
52
10
24
28
25
Tinsley
A630
Canklow
Woods
A631
Brinsworth
M1
B6090
B6091
B6089
A629
A6123
Upper Wortley Road
Wortley Road
Fitzwilliam Road
Eastwood
Meadowbank Road
Moorgate Road
Broom Lane
Bawtry Road
West Bawtry Road
Tinsley
34

6.4.1 Property Assessment for Central North Locality

The premises assessment is based on local CCG estates knowledge including reviewed 6 Facet survey data 2016 where this was available and our team's assessment of the potential to develop, extend or rationalise to support the proposed new service and the CCGs commissioning objectives.

Map No	Code	Name	Address 1	Post Code	Assessment	Total	GIA m²	List Size (Apr 18)	Multi site
1	C87003	Woodstock Bower Group Practice	1 Kimberworth Road	S61 1AH		8.0	800	11,184	S
2	C87012	Broom Lane Medical Centre	70 Broom Lane	S60 3EW		13.0	395	13,080	M
3		Broom Lane Medical Centre	Langdon Road Kimberworth Park	S61 3QH		10.0	400	incl	B
4	C87020	Greenside Surgery	Greasbrough	S61 4PT		9.5	310	5,991	S
5	C87603	Greasbrough Medical Centre	Munsbrough Rise Greasbrough	S61 4RB		12.5	261	3,403	S
6	C87621	Broom Valley Road Surgery	102-104 Broom Valley Road	S60 2QY		11.5	260	1,787	S

6.4.2 Key issues from Appraisal and Mapping

Following the review and assessment the following are key issues for consideration across the Central North locality:

- There are noticeable differences in condition and functionality which reflects historical decision making, investment in premises and the standard of operational estate management of each building and one building is identified as high risk based on 6 facet assessment.
- All buildings need ongoing effective estate management particularly for compliance with Fire, Health and Safety and Access in line with the Disability Discrimination Act (DDA) and backlog maintenance to achieve or maintain the Condition B standard.
- All GP premises in the locality are reported to be running full or over crowded regarding space utilisation.
- Based on the given GIAs space in all single site practices are within the expected size based on the space maxima allowance for their registered patient numbers, with the exception of Greenside Surgery, Greasbrough and Woodstock Bower (Map no 1 and 4) which appear undersized for their registered patient numbers.
- Greenside Surgery site appears to have no further option to extend as it is fully occupying its current land footprint.
- Broom Lane main and branch practice (Map no 2 and 3) is the Access Centre for this locality.
- The current estate is unlikely to be able to accommodate the projected rise in patient numbers in the area.
- Woodstock Bower Surgery (Map no 1) is the most recently built practice in the locality (2009) and is in good condition. It is tight in its space maxima allowance for their current patient list size and reported to be fully utilised. It is therefore unlikely to be able to expand its offering without extended opening.
- Broom Lane Medical Centre (Map no 2), is identified as high risk based on 6 facet assessment across all aspects of physical condition, functional suitability and quality.
- Broom Valley Surgery (Map no 6) is a small practice and co- location options with other practices/services into one site with a GIA 1,100 m². could be considered for the long term with Broom Lane Medical Centre (Map no 2). A new assisted living development is being built at Broom Valley which might offer site options for a new health facility.

- Co-locating the two Greasborough premises (Map nos 4 and 5) by re-providing/extending one could be considered. However, the current Greenside premises site is assessed as not suitable for expansion as this site does appear to have space for an extension.
- Alternatively, considering the building of new practice premises for one or both of the Greasbrough practices either by extending the health centre or a new build within the footprint of Bassingthorpe Farm might assist in developing the additional primary care capacity for this new housing.
- The CCG should pursue discussions with the Local Authority for a financial contribution from the Community Infrastructure Levy (CIL) for the additional health infrastructure required for the housing development on Bassingthorpe Farm.
- The future requirements of Broom Lane at Kimberworth Park (Map no 3) where the practice report that space is over utilised and current opening times are comprehensive needs to be further assessed.

6.4.3 Central North Locality Prioritisation

The CCG aim of rationalisation/development of the estate for GMS/PMS and FYFV considers strategic locations or sites for development/maximising existing buildings including other NHS or LA premises.

The list sizes of the practices in this locality, possibly shared with Health Village/Central are likely to grow by circa 11,500 patients. This is due to the development of Bassingthorpe Farm with circa 5,000 houses being built. The premises of three of the practices – Greasborough Medical Centre, Greenside Surgery and Kimberworth (Map nos 1, 4 and 5), are likely to come under significant pressure from additional patients generated by this development. There is little impact projected for this area in terms of a significant rise in the 65+ population.

The key priorities for Central North locality are listed in the table below with an estimated cost for improvement/investment where identified:

Premises / Issue	Priority S=1-year M=2-4 L=5	Action	Improvement Cost Estimate (£)
Greasborough (Bassingthorpe Farm)	S	Consider undertaking a feasibility study to identify local configuration of premises including a potential for extending on the Greasborough Health Centre site or a new build within Bassingthorpe Farm for one of the practices and provide information to complete a PID.	£15,000
Greasborough (Bassingthorpe Farm)	L	Consider a new build of circa 916m² GIA for 12,000 patients to include one of the existing Greasborough premises plus elements of housing growth.	£2,290,000
Broom Lane/Valley area	M	Consider undertaking a feasibility study to consolidate/ collocate Broom Lane Medical Centre (not including KP branch) and Broom Valley Rd Surgery into a larger hub and provide information to complete a PID	£15,000
Broom Lane/Valley area	L	Develop a long-term option of co locating the practices into a new build with a GIA of circa 1100m².	£2,750,000
Woodstock Bower	S	Consider a space utilisation survey of this relatively new building as already under space pressure.	£3,000-£4,000 depending on the number of sensors required
Statutory Compliance	S	Review all practices scoring Cat C or below for Compliance through GMS contract management process	n/a

6.5 Health Village / Central Locality

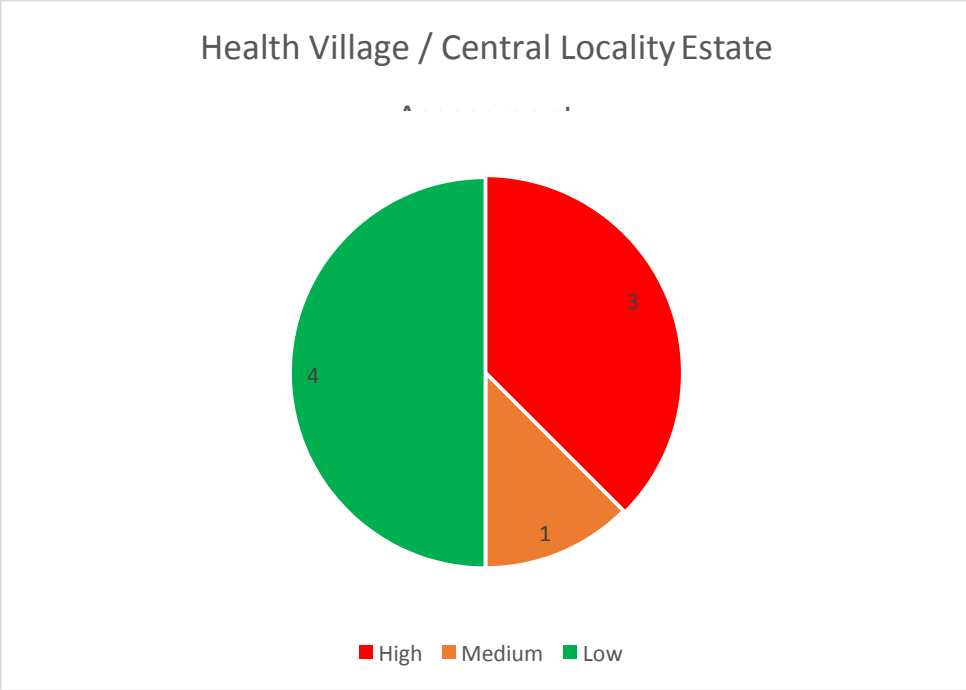
The estate across Health Village / Central overall is in a fair condition overall and spread across the locality. Five practices operate from 6 buildings, providing services for circa 57,000 registered patients (April 2018). The total risk cost identified for the GP premises in this locality is £316,666.

Facets	Condition A/B (%)	Condition B/C (%)	Condition C/D or less (%)
	Low risk	Medium risk	High risk
Physical Condition Status	14%	71%	14%
Functional Suitability /Space Utilisation Status	86%	14%	0%
Statutory Compliance Status	43%	57%	0%

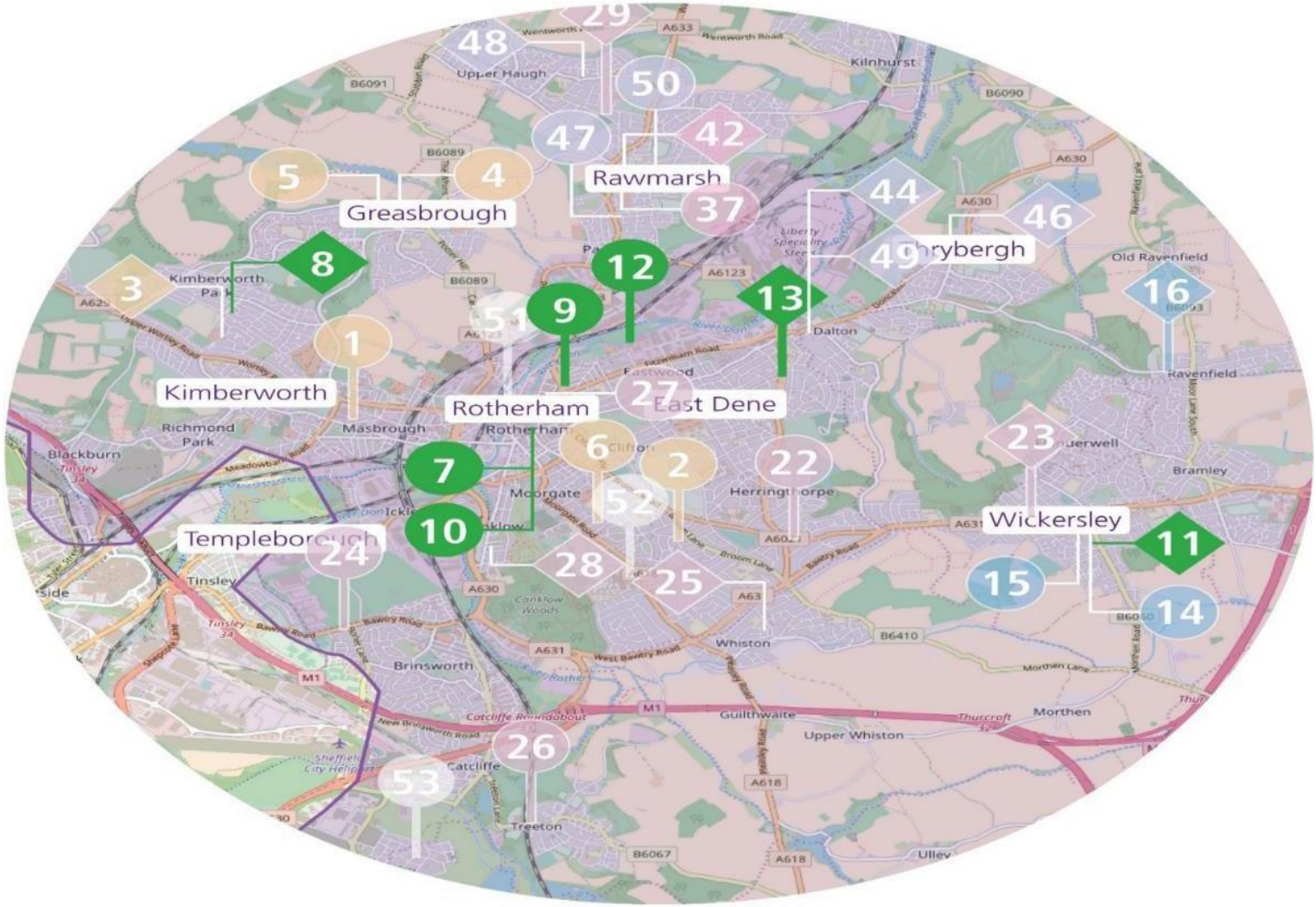
The 6F assessment in this locality shows that physical condition is the most noticeable issue for this locality in addition to statutory compliance.

These will need to be considered carefully when looking at opportunities to improve or rationalise the estate.

The premises assessment identifies high priorities as 'red' sites. These relate to those with either the potential (to maximise existing buildings/sites in strategically appropriate places) or of those of poor quality as the key areas that offer opportunities for improvement or rationalisation.



The high priority identified for Health Village / Central is the Clifton Medical Centre Branch premises at Wickersley.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29
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Rawmarsh
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Greasbrough
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Kimberworth
Rotherham
27
East Dene
Dalton
Old Ravenfield
16
Ravenfield
Richmond Park
Masbrough
Blackburn
7
6
2
22
23
Bramley
Moorgate
52
10
Templeborough
24
28
25
Wickersley
11
15
14
Tinsley
Brinsworth
Whiston
Guilthwaite
Upper Whiston
Morthen
26
53
Catcliffe
Treeton
Ulley
Kilnhurst
Upper Haugh
Old Ravenfield
Ravenfield
Dalton
Bramley
Wickersley
Whiston
Morthen
Upper Whiston
Guilthwaite
Catcliffe
Treeton
Ulley
Tinsley
Brinsworth
Templeborough
Kimberworth
Greasbrough
Rawmarsh
East Dene
Rotherham
Masbrough
Moorgate
Herringthorpe
Richmond Park
Blackburn
Kimberworth Park
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A631
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A6123
B6089
B6090
B6091
M1
A618
A63
B6410
B6067

6.5.1 Property Assessment for Health Village/Central Locality

The premises assessment is based on local estates knowledge including reviewed 6 Facet survey data 2016 where this was available and our team's assessment of the potential to develop, extend or rationalise to support the proposed new service and the CCGs commissioning objectives.

Map No	Code	Name	Address 1	Address 2	Post Code	Assessment	Total	GIA m²	List Size (Apr 18)	Multi site
7	C87005	St Ann's Medical Centre	Rotherham Health Village	Doncaster Gate	S65 1DA		10.5	591	17,508	M
13*		St Ann's Medical Centre	14 Ridgeway	Ridgeway	S65 3PG		8.0	108	incl	B
8		St Ann's Medical Centre	240 Kimberworth Park Road	Kimberworth	S61 3JN		9.0		incl	B
9	C87010	York Road Surgery	York Road		S65 1PW		12.5	260	4,612	S
10	C87017	Clifton Medical Centre	Rotherham Health Village	Doncaster Gate	S65 1DA		10.0	2,100*	13,318	M
11		Clifton Medical Centre	Wickersley Health Centre Poplar Glade	Wickersley	S66 2JQ		6.5	197	incl	B
12	C87608	Shakespeare Road Surgery	50 Shakespeare Road	Eastwood	S65 1QY		9.0	290	5,440	M
13*		Shakespeare Road Surgery	14 Ridgeway	Ridgeway	S65 3PG		8.0	111	incl	B

6.5.2 Key Issues from Appraisal and Mapping

Following the review and assessment the following are key issues for consideration across the Health Village / Central locality.

- All buildings need ongoing effective estate management particularly for compliance with Fire, Health and Safety and Access in line with the Disability Discrimination Act (DDA) and backlog maintenance to achieve or maintain the Condition B standard.
- There are noticeable differences in condition and functionality which reflects historical decision making, investment in premises and the standard of operational estate management of each building and one building is are identified as high risk based on 6 facet assessment.
- All GP premises in the locality are reported to be running full regarding space utilisation.
- Without further investigation to understand how many patients are seen routinely at each venue it is difficult to assess the space maxima for a multi-site practice such as St Ann's. This practice seems to have a relatively small area at the property designated as their main site (Map no 7) of 591m² which would equate to circa 7,000 patients unless 10,000 plus are seen through the two branch practices.
- York Rd Surgery (Map no 9) has a below the recommended GIA for its patient list size therefore it is unlikely that it is possible to add activity into this venue. These premises would benefit from some minor upgrading and improvement to improve Disabled access if this has not already been undertaken since the time of the last survey.
- The shared branch premises of both St Ann's and Shakespeare Road Surgeries (Map no 13) should be considered against CCG commissioning intentions and their longer-term future considered.
- Rotherham Health Village (Map no 7 and 10) share a building with Rotherham Foundation NHS Trust. A Space Utilisation survey undertaken in May 2016 shows that the whole of this property has a low average utilisation rate at 40.8%. The Clifton Practice has the highest rate at 44.9% and St. Ann's Practice at 40.1%. Bookable rooms within this building have the lowest utilisation rate at 36.4%. Based on this information there is scope to improve the utilisation of this building, bringing additional services to meet commissioning requirements.
- The GIAs in Rotherham Health Village for the two GP practices housed there (Clifton Medical Centre St Ann's Medical Centre, Map nos 7 and 10) are out of line with expectations.

- Rotherham Health Village has 71m² available expansion space within the building that could be considered for additional primary care service pressures in the future.

6.6.3 Health Village / Central Locality Estates Prioritisation

The CCG aim of rationalisation/development of the estate for GMS and FYFV considers strategic locations or sites for development/maximising existing buildings including other NHS or LA premises. There appears to be little impact anticipated from housing development. Other than small 'infill' development, the significant site of Bassingthorpe Farm, although not far away geographically, is west of the main railway lines through the city therefore patient flows to Health Village/Central are less likely. In addition, there is little impact projected for this area in terms of a significant rise in the 65+ population above the CCG average of 19.8%.

The key priorities for Health Village / Central locality are listed in the table below with an estimated cost for improvement/investment where identified:

Premises / Issue	Priority S=1-year M=2-4 L=5	Action	Improvement Cost Estimate (£)
Accuracy of GIA	S	Confirm the accurate GIAs for each practice within Rotherham Health Village with owner or leaseholder.	n/a
Utilisation and capacity for extending services	S	Consider the potential to commission additional locality and Hub services from Rotherham Health Village building	n/a
Wickersley area (for Clifton Medical Centre, Wickersley branch	S	Consider undertaking a feasibility study to determine potential for developing a combined community hub which also addresses current GP premises issues and housing development to provide the information to complete a PID. (also includes RV North and Maltby / Wickersley practices)	Costed in Maltby / Wickersley section
Statutory Compliance	S	Review all practices scoring Cat C or below for Compliance through	n/a

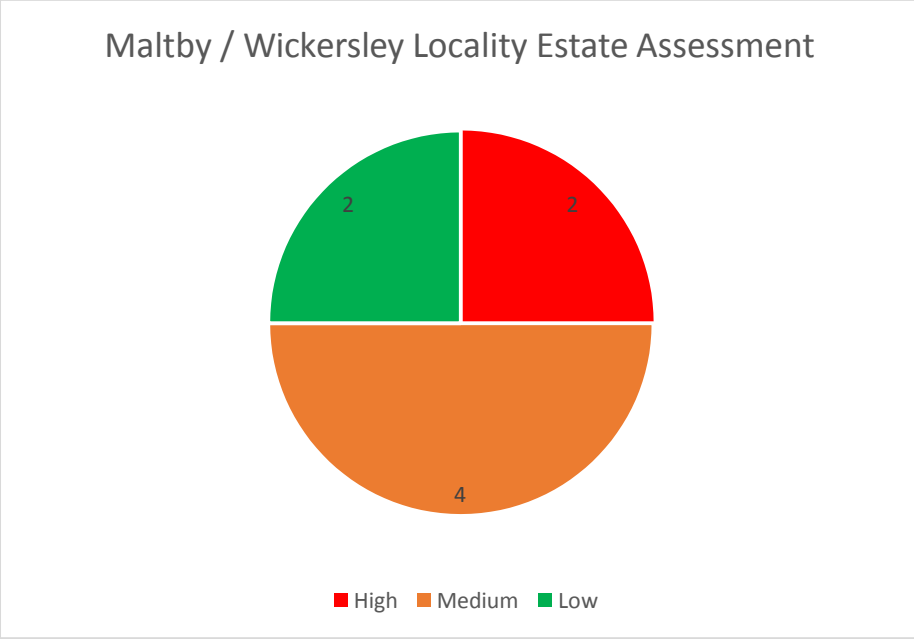
		GMS contract management process	

6.6 Maltby and Wickersley Locality

The estate across Maltby and Wickersley is in a mixed condition overall with six practices occupying 8 buildings, providing services for circa 36,000 registered patients (April 2018). The total risk cost identified for the GP premises in this locality is £479,786. This is the largest in the CCG area and primarily is associated with three of the eight buildings.

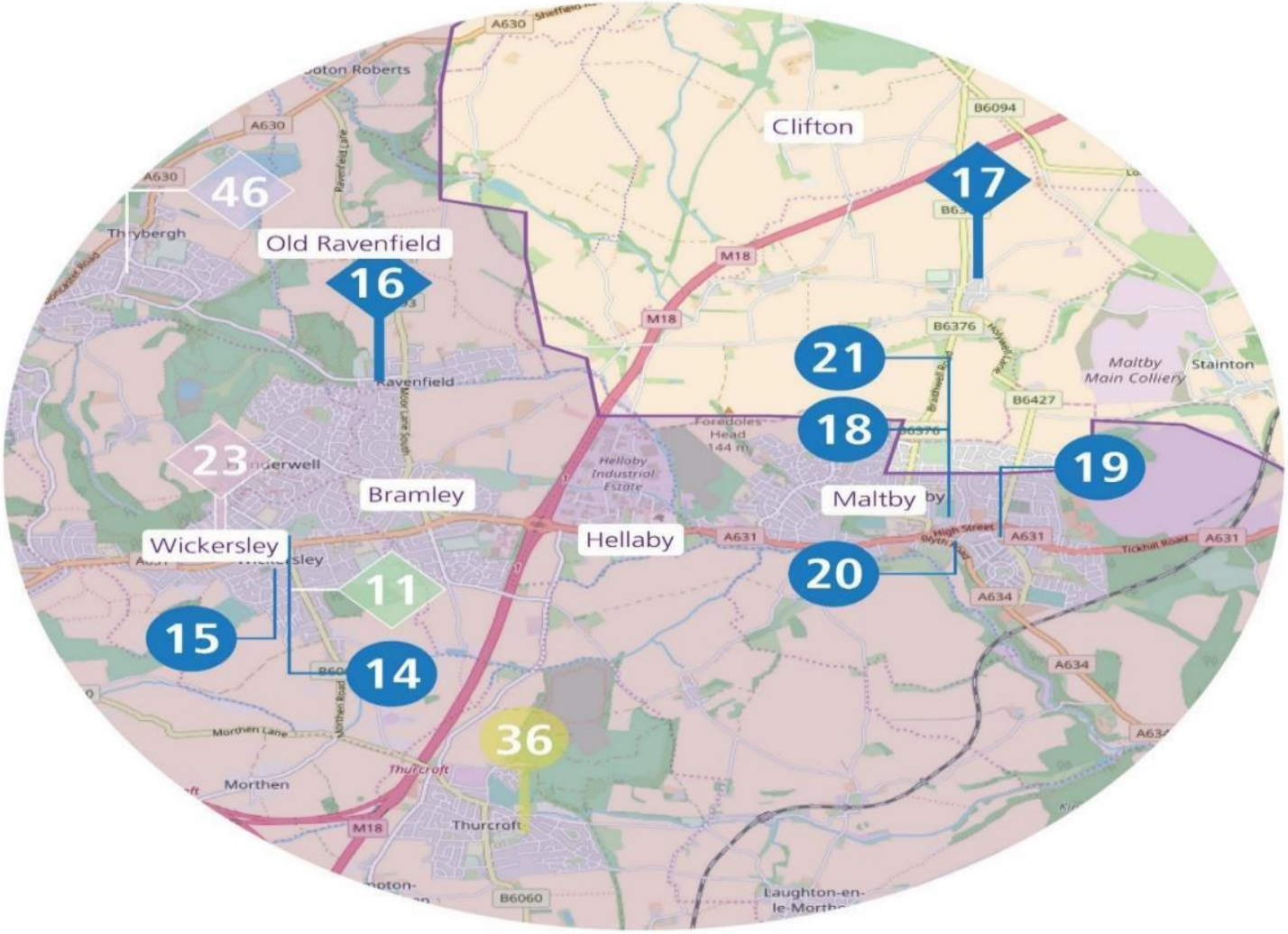
Facets	Condition A/B (%)	Condition B/C (%)	Condition C/D or less (%)
	Low risk	Medium risk	High risk
Physical Condition Status	88%	12%	0%
Functional Suitability /Space Utilisation Status	92%	8%	0%
Statutory Compliance Status	63%	37%	0%

The 6F assessment shows a positive result for many buildings across all elements of physical condition, functional suitability, statutory compliance and space in this locality. These issues will need to be considered carefully when looking at opportunities to improve or rationalise the estate.



The premises assessment identifies high priorities as 'red' sites. These relate to those with the potential to maximise existing buildings/sites in strategically appropriate places as the key areas that offer opportunities for improvement or rationalisation.

The high priorities identified for Maltby and Wickersley Locality are Wickersley Health Centre and 2 Morthen Road.


Clifton
46
Old Ravenfield
16
17
21
18
19
20
23
Bramley
Wickersley
Hellaby
Maltby
11
15
14
36
Ravenfield
Thorpe Hesley
Morthen
Thurcroft
Maltby Main Colliery
Stainton
Hellaby Industrial Estate
Foredoles Head 144 m
A630
A631
A634
M18
B6094
B6376
B6427
B6060

6.6.1 Maltby and Wickersley Premises Assessment

The premises assessment is based on local estates knowledge including reviewed 6 Facet survey data 2016 where this was available and our team's assessment of the potential to develop, extend or rationalise to support the proposed new service and the CCGs commissioning objectives.

Map No	Code	Name	Address 1	Address 2	Post Code	Assessment	Total	GIA m²	List Size (Apr 18)	Multi site
14	C87015	Wickersley Health Centre	Poplar Glade	Wickersley	S66 2JQ		13.0	550	7,018	S
15	C87016	Morthen Road Group Practice	2 Morthen Road	Wickersley	S66 1EU		9.5	591	11,567	M
16		Morthen Road Group Practice	8 Hollings Lane	Ravenfield	S65 4PU		7.5	204	Incl	B
17		Morthen Road Group Practice	High Street	Braithwell	S66 7AU		10.0	68	incl	B
18	C87031	Maltby Services Centre	Braithwell Road	Maltby	S66 8JE		10.5	244	3,261	S
19	C87606	Queens Medical Centre	Muglet Lane	Maltby	S66 7NA		9.0	177	1,585	S
20	C87616	Blyth Road Medical Centre	8 Blyth Road	Maltby	S66 8JD		11.5	280	5,941	S
21	C87620	Manor Field Surgery	Braithwell Road	Maltby	S66 8JE		8.5	331	6,408	S

6.6.2 Key Issues from Appraisal and Mapping

Following the review and assessment the following are key issues for consideration across the Maltby & Wickersley locality:

- There is a relatively positive commonality in condition and functional suitability premises and the standard of operational estate management of each building. One of the buildings is identified as high risk based on 6 facet assessment.
- All GP premises in the locality are reported to be at fully utilised regarding space.
- Wickersley Health Centre (Map nos 11, 14) housing the practice of the same name and the branch surgery of Clifton Medical Centre have been scored as Dx for quality. An 'x' after a grading for 6 facet assessment indicates that nothing other than a total rebuild or relocation will suffice (improvements are either impractical or too expensive) to improve the environment for patients and staff.
- The 2 Morthen Road premises at Wickersley (Map no 15) is carrying one of the largest risk costs in the CCG of £252,580. It is a 1960's building which would require large scale refurbishment, and improvement by the GPs to provide a quality patient and staff. In estates terms; its design, method of construction and size does not meet the identified needs of the area going forward.
- Based on the condition of buildings in Wickersley the CCG are advised to consider consolidation of practices into a more appropriate new build solution on a single site.
- The longer term clinical, premises and financial viability of the Queens Medical Centre practice with its small patient list may be better served from co-location with other local health or public sector services.
- Blyth Road, Maltby (Map no 20) a converted car showroom/garage has a number of premises issues that need addressing and a notable risk for its 280m² size.
- From a space utilisation survey from May 2016, we would estimate that Blyth Rd is running at between 60-70% utilisation, Monday to Friday, which includes extended opening on Thursday and Fridays. There are fewer rooms for the GIA as the size of some are greater than HBN recommendations which results in a less efficient building foot plate and contributes to the room pressures in this building.
- Manor Field Surgery and Dr Shrivastava (Map nos 18, 21) are both within a local authority multi service centre offering a range of facilities within a hub in Maltby.

- There may be potential to maximise space in Maltby Services Centre as a single locality hub to incorporate practices currently operating in Blyth Road, Queens Medical Centre and Braithwell (Map nos 17, 19 and 20)
- The future configuration of the branch premises and potential co location opportunities with other public sector services may be worth considering for Ravenfield (Map no 16) in the longer term if this service is required going forward as it appears to serve a discreet community.
- All buildings need ongoing effective estate management particularly for compliance with Fire, Health and Safety and Access in line with the Disability Discrimination Act (DDA) and backlog maintenance to achieve or maintain the Condition B standard.

6.6.3 Maltby & Wickersley Locality Estates Prioritisation

The CCG aim of rationalisation/development of the estate for GMS and FYFV considers strategic locations or sites for development/maximising existing buildings including other NHS or LA premises.

The list sizes of the practices in this locality, are likely to grow by circa 2,400 patients. This is due to planned housing development of 800 units in Bramley, Wickersley and Ravenfield Common and 700 units in Maltby and Hellaby. There is no indication that any one practice will come under significant pressure from additional patients generated by these developments. However, the impact of a higher than CCG average growth in the over 65's (CCG average is 19.8%) will impact on Wickersley ward (22.5%) This will also impact on the Wickersley premises in Rother Valley North.

The priorities identified for this locality are to take a longer-term view about premises configuration and how that could both improve clinical and staff environments and offer options to develop a wider range of locally based services.

The key priorities for Maltby & Wickersley locality are listed in the table below with an estimated cost for improvement/investment where identified.

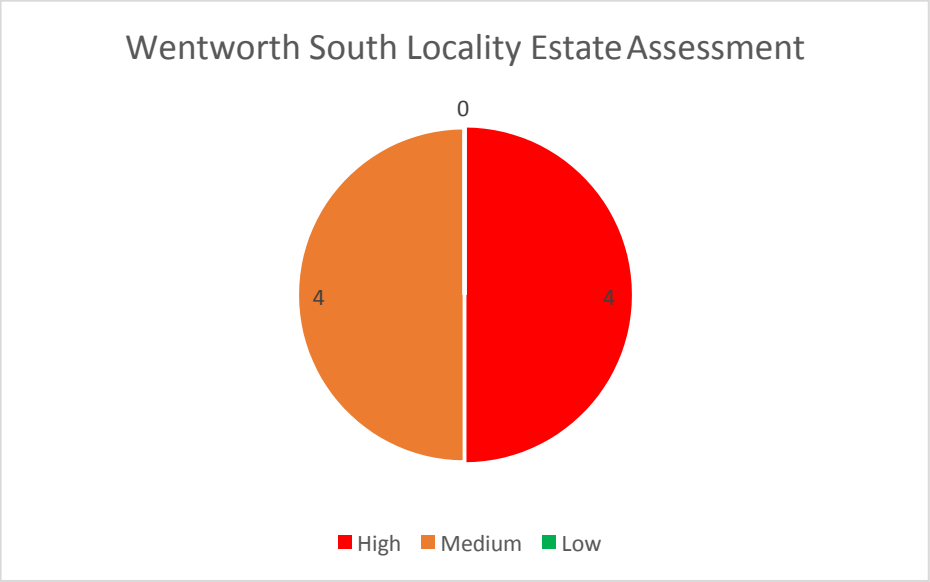
Premises / Issue	Priority S=1-year M=2-4 L=5	Action	Improvement Cost Estimate (£)
Maltby area	S	Consider undertaking a locality study to develop the investment case and determine the potential for delivering a single community hub based on Maltby Services Centre.	£5,000
Wickersley area	S	Consider undertaking a feasibility study to determine potential for developing a combined community hub which also addresses current GP premises issues and housing development to provide the information to complete a PID. (also includes RV North and HV Central practices)	£15,000
Wickersley	L	Potential new build of circa 1,500 m² in Wickersley to replace Health Centre, 2 Morthen Road and Stag medical Centre to reduce from 3 buildings to a single hub for the area	£3,750,000
Statutory Compliance	S	Review all practices scoring Cat C or below for Compliance through GMS contract management process	n/a

6.7 Wentworth South Locality

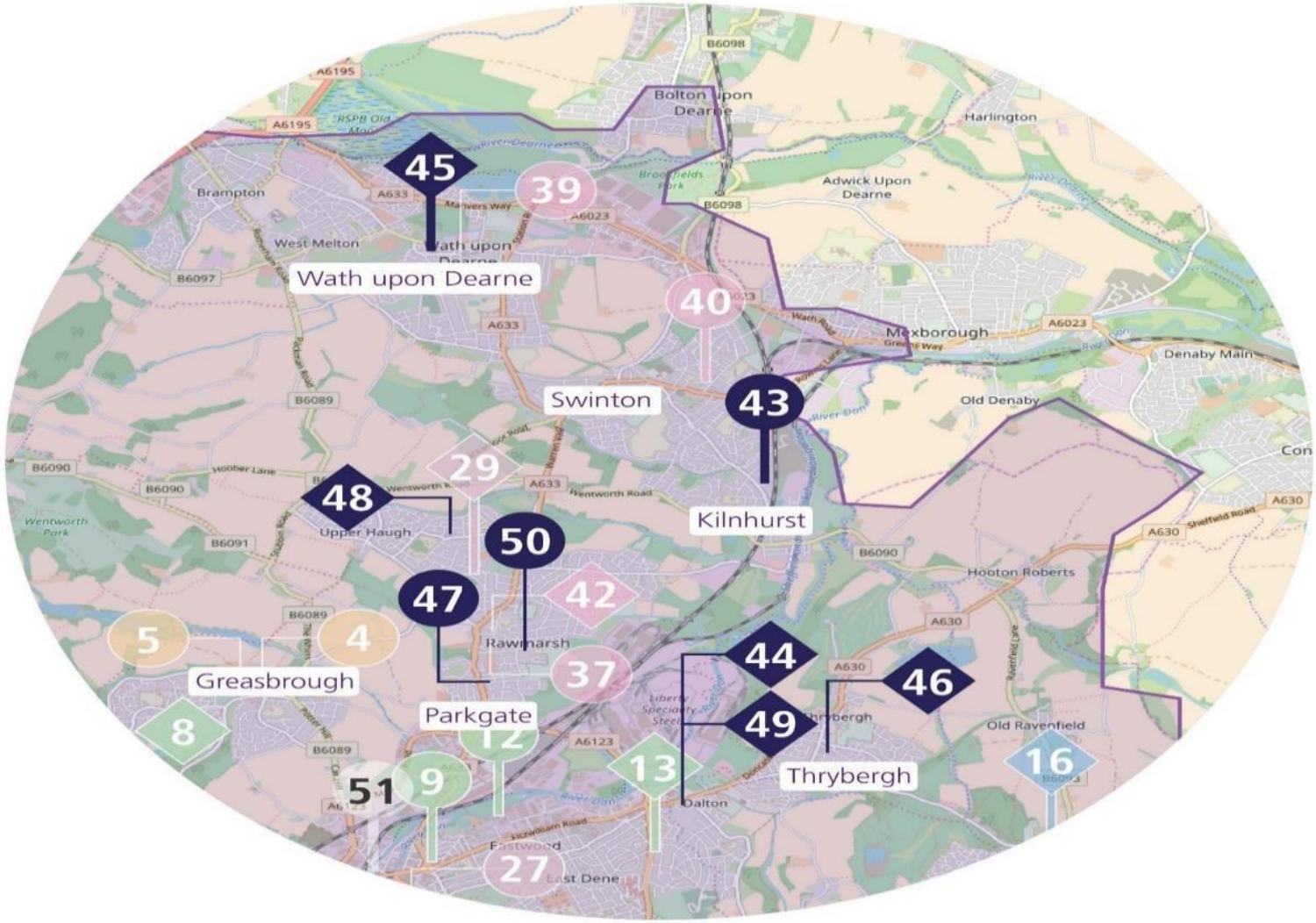
The estate across Wentworth South is in a variable condition some are newly built or in good condition however others are in need of modernisation/replacement. Three practices occupy 7 buildings following the merger of Brookfield Surgery into the Magna Group Practice. The locality practices provide services for circa 42,000 registered patients (April 2018). The total risk cost identified for the GP premises in this locality is £173,600.

Facets	Condition A/B (%)	Condition B/C (%)	Condition C/D or less (%)
	Low risk	Medium risk	High risk
Physical Condition Status	38%	62%	0%
Functional Suitability /Space Utilisation Status	88%	12%	0%
Statutory Compliance Status	25%	50%	25%

The 6F assessment shows issues around statutory compliance. Although the space utilisation appears to be low risk for current activity, all premises are identified as fully utilised and therefore this may restrict service development potential going forward. These issues will need to be considered carefully when looking at opportunities to improve or rationalise the estate.



The premises assessment identifies high priorities as 'red' sites. These relate to those with either the potential (to maximise existing buildings/sites in strategically appropriate places) or of those of poor quality as the key areas that offer opportunities for improvement or rationalisation. The high priority premises identified for Wentworth South locality are Valley Health Centre, Rawmarsh Multi Service Centre and Wath Health Centre.


45
39
40
43
29
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37
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13
16
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51
27
Wath upon Dearne
Swinton
Kilnhurst
Greasbrough
Parkgate
Thrybergh
Rawmarsh
Upper Haugh
Dalton
Bolton upon Dearne
Harlington
Adwick Upon Dearne
Brampton
West Melton
Mexborough
Denaby Main
Old Denaby
Hooton Roberts
Old Ravenfield
Wentworth Park
Eastwood
East Dene
B6098
A6195
A633
A6023
B6097
B6089
B6090
B6091
A630
A6123

6.7.1 Premises Assessment of Wentworth South Locality

The premises assessment is based on local estates knowledge including review of 6 Facet survey data 2016 where this was available and our team's assessment of the potential to develop, extend or rationalise to support the new service models and the CCGs commissioning objectives.

Map No	Code	Name	Address 1	Address 2	Post Code	Assessment	Total	GIA m²	List Size (Apr 18)	Multi-site
43	C87006	Magna Group Practice	Highthorn Road	Kilnhurst	S64 5UP		11.0	581	11,397	M
44		Magna Group Practice	Valley Health Centre Saville Street	Dalton	S65 3HD		8.0	484	incl	B
45		Magna Group Practice	Church Street	Wath-on-Dearne	S63 7RF		11.0	170	incl	B
46		Magna Group Practice	21 Park Lane	Thrybergh	S65 4BT		9.0	140	incl	B
49		Brookfield Surgery	Valley Health Centre Saville Street	Dalton	S65 3HD		6.0	372	2,030	B
47	C87013	Parkgate Medical Centre	Netherfield Lane	Parkgate	S62 6AW		11.5	470	6,248	M
48		Parkgate Medical Centre	Thorogate	Rawmarsh	S62 7HU		11.5	215	incl	B
50	C87024	Rawmarsh Health Centre	Barbers Avenue	Rawmarsh	S62 6AE		7.0	420	4,079	S

6.7.2 Key Issues from Appraisal and Mapping

Following the review and assessment the following are key issues for consideration in the Wentworth South locality:

- There are noticeable differences in condition and functionality which reflects historical decision making, investment in premises and the standard of operational estate management of each building but none are identified as high risk based on 6 facet assessment.
- All buildings need ongoing effective estate management particularly for compliance with Fire, Health and Safety and Access in line with the Disability Discrimination Act (DDA) and backlog maintenance to achieve or maintain the Condition B standard.
- The prioritisation assessment ascribed to this locality as medium and high is made based on both existing condition and the potential to consolidate premises and maximise existing estate.
- Further determination of the potential impact of the planned housing expansion may be required and it is multiple developments though it may impact on the west side of this locality in Wath (Map nos 45, 39).
- All GP premises in the locality are reported to be running full regarding space utilisation.
- The disparity between practices identifying their premises as 'full' and the stated GIA and opening hours in certain properties is likely to be a difference between occupancy and utilisation.
- Within this locality Rawmarsh Service Centre and Valley Health Centre (Map nos 44/49, 50) are strategic buildings in good condition but may not utilised to their optimum by both the GP practices and other community services.
- Rawmarsh is an area where consolidation and co-location across the current six premises may be achievable.
- NHS PS hold a lease for Rawmarsh Multi Service Centre (Map no 50) and exploration of moving e.g. Parkgate Medical Centre and Gateway Primary Care, Rawmarsh branches (Map nos 29 and 48) may provide a solution for this area.
- Premises, map numbers 37 and 42 are across the road from each other and a short distance from Rawmarsh Multi Service Centre (Map no 50).
- Assessing the given GIAs space the Valley Health Centre based GPs and The Magna Group Practice (including Brookfield

Surgery) across their four premises are well above the space maxima allowance for their registered patient numbers.

- Bringing the Thrybergh branch activities into the Valley Health centre is recommended. This would consolidate clinical skills, the range of service and quality of the environment for patients and workforce management and remove an aging estates asset from the portfolio.
- Valley Health Centre has expansion space available that could offer scope for additional patients in the Dalton/Thrybergh area for additional housing or as the primary care access centre for the locality or to bring out FYFV services from the acute settings.

6.7.3 Wentworth South Locality Estates Prioritisation

The CCG aim of rationalisation/development of the estate for GMS and FYFV considers strategic locations or sites for development/maximising existing buildings including other NHS premises.

The list sizes of the practices in this locality, are likely to grow depending on the patient flows from planned housing development. It would mostly impact on premises close to Swinton, Kilnhurst, Wath and possibly the Bassingthorpe Farm development south of Rawmarsh and Parkgate (Map nos 45,47, 48 and 50) In addition, the projection of a higher than CCG average growth (CCG average is 19.8%) in the over 65's will impact on Swinton ward (22.8%).

The key priorities for Wentworth South locality are listed in the table below with an estimated cost for improvement / investment where identified:

Premises / Issue	Priority S=1-year M=2 I=5	Action	Improvement Cost Estimate (£)
Utilisation and capacity for extending services	M	Undertake a utilisation survey to consider the capacity to commission additional locality and Hub services from Valley Health Centre.	£3-4,000 per survey (depending on the size & no of rooms)
Capacity	S	Further explore capacity and condition of Wath Health Centre and Market Surgery to be able to absorb additional housing.	Costed in Wath and Swinton locality*
Consolidation of premises in Rawmarsh	S	Work with NHSPS to assess the possibilities of taking additional space in Rawmarsh	n/a

		Multi Service Centre	
Statutory Compliance	S	Review all practices scoring Cat C or below for Compliance through GMS contract management process	n/a

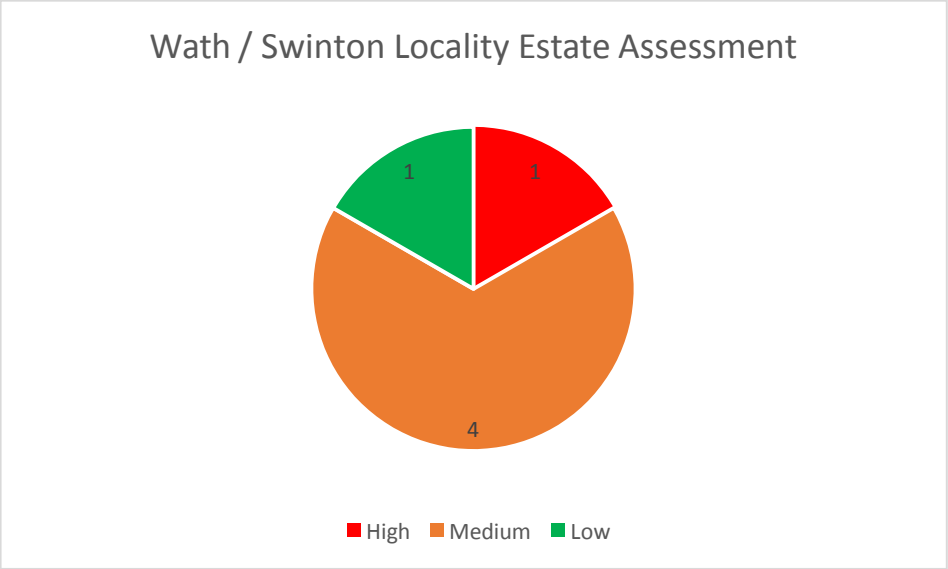
*A Barnsley CCG GP surgery (Woodgrove Practice, Doncaster Road) is situated in Wath close to two Rotherham practices (Map Nos 39 and 45). Joint working with Barnsley CCG on the locality feasibility study may offer a more cost-effective premises solution in this area.

6.8 Wath / Swinton Locality

The estate across Wath / Swinton is in a fair condition overall. The practices overlap other localities in terms of their geographical position with some buildings of Wentworth South, Central North and branch premises of Health Village/Central and Rother Valley North. Five practices occupy 7 buildings, providing services for circa 35,000 registered patients (April 2018). The total risk cost identified for the GP premises in this locality is £195,352.

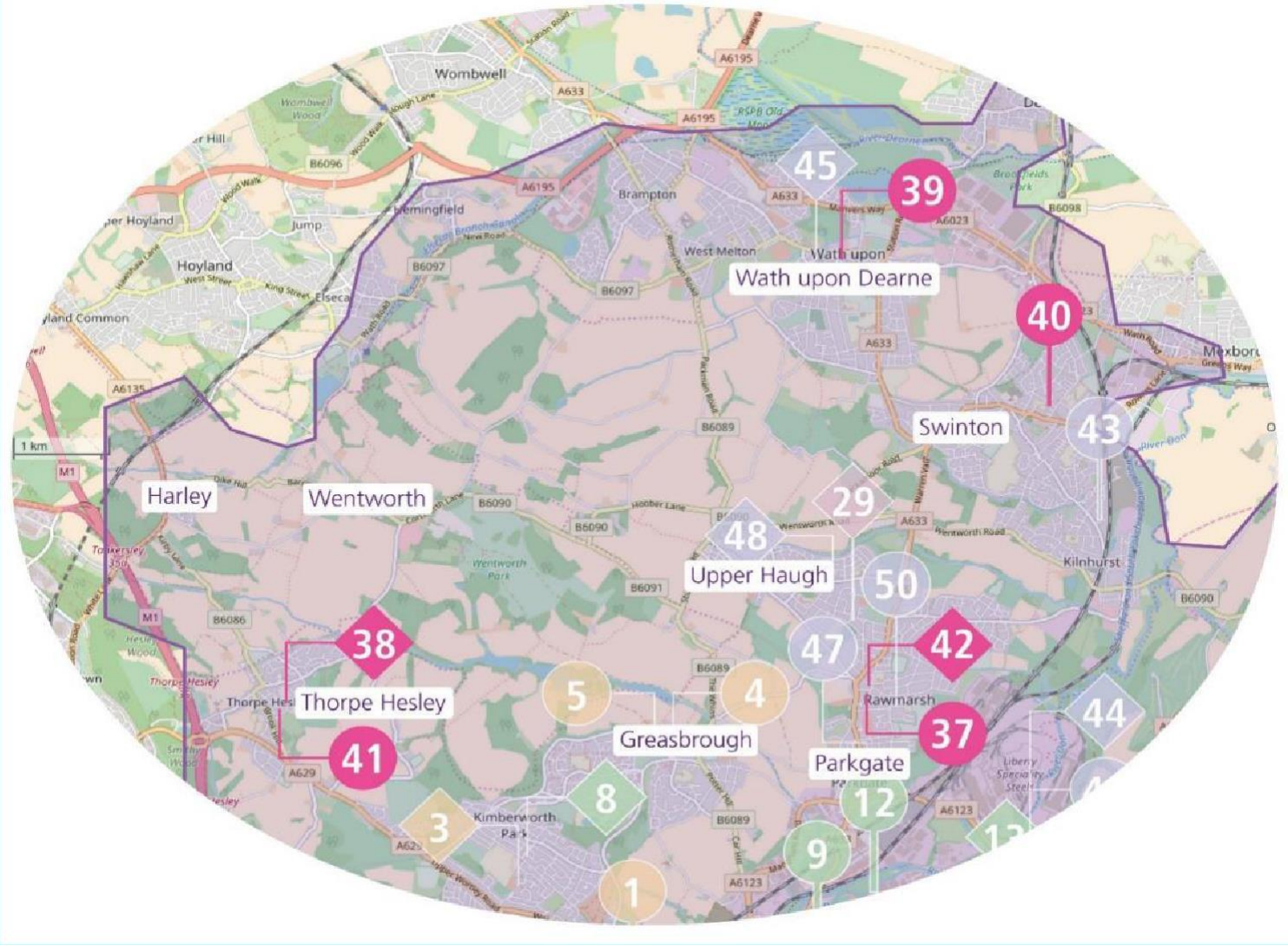
Facets	Condition A/B (%)	Condition B/C (%)	Condition C/D or less (%)
	Low risk	Medium risk	High risk
Physical Condition Status	50%	50%	0%
Functional Suitability /Space Utilisation Status	92%	8%	0%
Statutory Compliance Status	0%	100%	0%

The 6F assessment shows some issues around statutory compliance, functional suitability and space is challenged in two thirds of the buildings in this locality. These issues will need to be considered carefully when looking at opportunities to improve or rationalise the estate.



The premises assessment identifies high priorities as 'red' sites. These relate to those with either the potential (to maximise existing buildings/sites in strategically appropriate places) or of those of poor quality as the key areas that offer opportunities for improvement or rationalisation.

The high priority premises identified for Wath and Swinton locality is Market Surgery in the context of the housing development.


Wombwell
Brampton
West Melton
Wath upon Dearne
Swinton
Harley
Wentworth
Upper Haugh
Thorpe Hesley
Greasbrough
Rawmarsh
Parkgate
Kilnhurst
Kimberworth
Hoyland
Jump
Elsecar
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6.8.1 Premises Assessment of Wath / Swinton Locality

The premises assessment is based on local estates knowledge including review of 6 Facet survey data 2016 where this was available and our team's assessment of the potential to develop, extend or rationalise to support the new service models and the CCGs commissioning objectives.

Map No	Code	Name	Address 1	Address 2	Post Code	Assessment	Total	GIA m²	List Size (Apr 18)	Multi site
37	C87018	High Street Surgery	High Street	Rawmarsh	S62 6LW		11.0	299	7,991	M
38			Sough Hall Avenue	Thorpe Hesley	S61 2QP		11.0	59	Incl	B
39	C87029	Market Surgery	Warehouse Lane	Wath-on-Dearne	S63 7RA		9.5	751	11,630	S
40	C87030	Crown Street Surgery	17 Crown Street	Swinton	S64 8NB		10.0	504	9,127	S
41	C87604	Thorpe Hesley Surgery	Sough Hall Avenue	Thorpe Hesley	S61 2QP		11.0	287	5,785	M
42			Bellows Road	Rawmarsh	S62 6NF		8.0	Not known	incl	B

6.8.2 Key Issues from Appraisal and Mapping

Following the review and assessment the following are key issues for consideration in the Wath / Swinton locality:

- There are noticeable differences in condition and functionality which reflects historical decision making, investment in premises and the standard of operational estate management of each building and one building is are identified as high risk based on 6 facet assessment.
- All buildings need ongoing effective estate management particularly for compliance with Fire, Health and Safety and Access in line with the Disability Discrimination Act (DDA) and backlog maintenance to achieve or maintain the Condition B standard.
- All GP premises in the locality are reported to be running full regarding space utilisation, two are co located in Thorpe Hesley and two opposite each other in Rawmarsh.
- Rawmarsh is an area where consolidation and co-location across the current six premises may be achievable where Rawmarsh Service Centre (Map no 50) is a strategic building in good condition.
- NHS PS have the head lease for Rawmarsh Multi Service Centre (Map no 50) and with premises, (Map nos 37 and 42) across the road from each other and a short distance from Rawmarsh Multi Service Centre (Map no 50).
- Thorpe Hesley Health Centre is an NHS PS building housing Thorpe Hesley Surgery and High Street Surgery is immediately next door (Map no 41 and 38). Due to their condition and location these are likely to be strategically important in the long term.
- Further determination may be required of the planned housing development which may impact on the west side of this locality in Wath (Map nos 45, 39) as the current GP demises appear tight.
- Thorpe Hesley Health Centre and High Street Surgery would benefit from ongoing estates monitoring to inform any actions required for these strategically placed buildings serving a discreet geographical community for the longer term.
- The geographical overlap of this locality requires longer term premises development to be considered alongside those grouped in neighbouring localities.

6.8.3 Wath / Swinton Locality Estates Prioritisation

The CCG aim of rationalisation/development of the estate for GMS and FYFV considers strategic locations or sites for development/maximising existing buildings including other NHS and local authority premises.

The list sizes of the practices in this locality, are likely to grow by circa 4,280 patients. This is due to planned housing development of 1,300 units in Wath, Brampton Bierlow and West Melton and 560 in Swinton and Kilnhurst. It is likely to impact on the GPs in the north of the locality by circa 2,990 patients and those in north east by circa 1,290 patients. Some of this activity may be taken up by practices in Wentworth South locality.

In addition, practices north of the Bassingthorpe Farm development (Map nos 37, 42, 47 and 50) may experience some impact depending on how the patient flows materialise.

The key priorities for Wath / Swinton locality are listed in the table which follows with an estimated cost for improvement / investment where identified:

Premises / Issue	Priority S=1-year M=2 I=5	Action	Improvement Cost Estimate (£)
Confirmation of GIA	S	Confirm the accurate GIAs for the premises in this locality.	n/a
Capacity at Wath	S	Through a feasibility study, further explore capacity and condition of Wath Health Centre and Market Surgery to be able to absorb additional housing. *	£15,000
Capacity at Thorpe Hesley	L	Routine monitoring of building and utilisation assessment of capacity should commissioning plan or demographic changes radically.	£3-4,000 per survey (depending on the size & no of rooms)
Consolidation of premises in Rawmarsh	S	Work with NHSPS to assess the possibilities of taking additional space in Rawmarsh Multi Service Centre	n/a
Statutory Compliance	S	Review all practices scoring Cat C or below for Compliance	n/a

		through GMS contract management process	

*A Barnsley CCG GP surgery (Woodgrove Practice, Doncaster Road) is situated in Wath close to two Rotherham practices (Map Nos 39 and 45). Joint working with Barnsley CCG on the locality feasibility study may offer a more cost-effective premises solution in this area.

7 Financial Summary

Ref	Code	Name	Also Known As	6F Total	Condition Backlog incl H&S						Improvement/Development					
					Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Total Risk Cost	Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Imp/Dev Total Cost
22	C87007	Stag Medical Centre	162 Wickersley Road	8.0	0	0	0	18,497	0	£18,497						£0
23		Stag Medical Centre	Rose Court Surgery, 121 Bawtry Road, Wickersley	12.0	0	0	0	0	0	£28,666						£0
24	C87009	Brinsworth Medical Centre	171 Bawtry Road, Brinsworth	10.5	36935	0	0	0	383	£37,318						£0
25		Brinsworth Medical Centre	Surgery of Light, Hunger Hill Lane, Whiston	8.5	33050					£33,050						£0
26	C87014	Treeton Medical Centre	10 Arundel Street, Treeton	13.5	13985	5543	0	0	0	£19,528						£0
27	C87622	Gateway Primary Care	Chatham House, Doncaster Gate	9.5	0	0	0	0	0	£28,666						£0
28		Gateway Primary Care	Canklow Road Surgery, Henderson Place, Canklow	7.0	0	0	0	0	0	£28,666						£0
29		Gateway Primary Care	Rosehill Medical Centre, 52 Rosehill Road, Rawmarsh	12.0	39924	3118	3088	3083	21563	£70,776						£0
53		Gateway Primary Care	Waverley	n/a									1,475,000			£1,475,000
	Rother Valley North Locality				£123,894	£8,661	£3,088	£21,580	£21,946	£265,167	£0	£0	£1,475,000	£0	£0	£1,475,000

Ref	Code	Name	Also Known As	6F Total	Condition Backlog incl H&S						Improvement/Development					
					Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Total Risk Cost	Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Imp/Dev Total Cost
1	C87003	Woodstock Bower Group Practice	1 Kimberworth Road, Rotherham	8.0	14,661	9,816	0	0	0	£24,477	4,000					£4,000
6	C87621	Broom Valley Road Surgery	102-104 Broom Valley Road, Rotherham	11.5	43,364	693	594	0	0	£44,651		15,000			2,750,000	£2,765,000
2	C87012	Broom Lane Medical Centre	70 Broom Lane, Rotherham	13.0	41,729	11,548	5,938	0	0	£59,215						
3		Broom Lane Medical Centre	Langdon Road, Kimberworth Park, Rotherham	9.0	0	0	0	0	0	£28,666						£0
4	C87020	Greenside Surgery	Greasbrough, Rotherham	9.5	45,676	2,887	0	0	6,571	£55,134	15,000			2,290,000		£2,305,000
5	C87603	Greasbrough Medical Centre	Munsbrough Rise, Greasbrough	12.5	14,098	1,732	0	0	7,017	£22,847						
	Central North Locality				£159,528	£26,676	£6,532	£0	£13,588	£234,990	£19,000	£15,000	£0	£2,290,000	£2,750,000	£5,074,000

7. FINANCIAL SUMMARY

Ref	Code	Name	Also Known As	6F Total	Condition Backlog incl H&S						Improvement/Development					
					Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Total Risk Cost	Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Imp/Dev Total Cost
7	C87005	St Ann's Medical Centre	Rotherham Health Village, Doncaster Gate, Rotherham	10.5	26,954	22,403	16,031	14,674	3,190	**£83,252**						£0
13*		St Ann's Medical Centre	Ridegway Medical Centre, 14 Ridgeway, Rotherham	7.0	0	0	0	0	0	£28,666						£0
8		St Ann's Medical Centre	240 Kimberworth Park Road, Kimberworth	8.0	0	0	0	0	0	£28,666						£0
9	C87010	York Road Surgery	York Road, Rotherham	12.5	4906	693	1425	8015	1786	**£16,825**						£0
12	C87608	Shakespeare Road Surgery	50 Shakespeare Road, Eastwood	9.0	8177	0	5344	1850	638	**£16,009**						£0
13*		Shakespeare Road Surgery	Ridegway Medical Centre, 14 Ridgeway, Rotherham	7.0	0	0	0	0	0	£28,666						£0
10	C87017	Clifton Medical Centre	Rotherham Health Village, Doncaster Gate, Rotherham	10.0	27462	20151	21494	11961	4848	**£85,916**						£0
	Health Village / Central Locality				**£67,499**	**£43,247**	**£44,294**	**£36,500**	**£10,462**	**£288,000**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
11	C87017	Clifton Medical Centre	Wickersley Health Centre, Poplar Glade, Wickersley	11.5	0	0	0	0	0	£28,666						
14	C87015	Wickersley Health Centre	Poplar Glade, Wickersley	13.0	46,804	3,002	3,028	2,528	4,338	**£59,700**		15,000			£3,750,000	£3,765,000
15	C87016	Morthen Road Group Practice	2 Morthen Road, Wickersley	9.5	71,051	45,846	10,688	1,233	123,762	**£252,580**						
16		Morthen Road Group Practice	Ravenfield Medical Centre, 8 Hollings Lane, Ravenfield	7.5	0	0	0	0	0	£28,666						£0
17		Morthen Road Group Practice	Old School House Surgery, Braithwell	9.0	0	0	0	0	0	£28,666						£0
18	C87031	Maltby Services Centre	Dr Shirvastava, Braithwell Road, Maltby	10.5	0	0	4,750	7,399	0	**£12,149**						£0
19	C87606	Queens Medical Centre	Muglet Lane, Maltby	9.0	0	3,464	11,875	0	0	**£15,339**						£0
20	C87616	Blyth Road Medical Centre	8 Blyth Road, Maltby	11.5	23,120	15,012	21,375	12,331	8,931	**£80,769**						£0
21	C87620	Manor Field Surgery	Maltby Services Centre, Braithwell Road, Maltby	8.5	1,917	0	0	0	0	**£1,917**	5,000					£5,000
	Maltby & Wickersley Locality				**£142,892**	**£67,324**	**£51,716**	**£23,491**	**£137,031**	**£508,452**	**£5,000**	**£15,000**	**£0**	**£0**	**£3,750,000**	**£3,770,000**

7. FINANCIAL SUMMARY

Ref	Code	Name	Also Known As	6F Total	Condition Backlog incl H&S						Improvement/Development					
					Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Total Risk Cost	Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Imp/Dev Total Cost
30	C87002	Dinnington Group Practice	New Street, Dinnington, Sheffield	**9.0**	3947	0	0	0	0	**£3,947**						£0
31		Dinnington Group Practice	Anston Medical Centre, 15 Quarry Lane, North Anston, Sheffield	**8.0**	0	0	0	0	0	£28,666						£0
32		Dinnington Group Practice	Woodsetts Surgery, 2a Berne Square, Woodsetts, Worksop	7.5	0	0	0	0	0	£28,666						£0
33	C87004	Kiveton Park Medical Practice	Chapel Way, Kiverton Park, Sheffield	10.0	49792	0	0	0	3955	**£53,747**			4,000			£4,000
34		Kiveton Park Medical Practice	Woodall Lane, Harthill, Sheffield	6.0	0	0	0	0	0	**£0**						£0
35	C87008	Swallownest Health Centre	Worksop Road, Swallownest, Sheffield	7.5	0	0	0	0	0	£28,666	4,000					£4,000
36	C87022	Village Surgery	24-28 Laughton Road, Thurcroft, Rotherham	9.0	55488	0	4572	0	0	**£60,060**						£0
		Rother Valley South Locality			**£109,227**	**£0**	**£4,572**	**£0**	**£3,955**	**£203,752**	**£4,000**	**£0**	**£4,000**	**£0**	**£0**	**£8,000**

7. FINANCIAL SUMMARY

Ref	Code	Name	Also Known As	6F Total	Condition Backlog incl H&S						Improvement/Development					
					Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Total Risk Cost	Current/ Year 1	Year 2	Year 3	Year 4	Year 5	Imp/Dev Total Cost
37	C87018	High Street Surgery	High Street, Rawmarsh	11.0	15169	3291	3800	2343	8357	£32,960						£0
38		High Street Surgery	Thorpe Hesley Clinic, Sough Hall Avenue, Thorpe Hesley	8.0	0	0	0	0	0	£28,666				4,000		£4,000
39	C87029	Market Surgery	Warehouse Lane, Wath-on-Dearne	9.5	6147	6698	6056	6166	6507	£31,574	incl Wath practice from Barnsley CCG	15,000				£15,000
45	C87006	Magna Group Practice	Wath Health Centre, Church Street, Wath-on-Dearne,	8.5	52200					£52,200						
40	C87030	Crown Street Surgery	17 Crown Street, Swinton, Rotherham	10.0	21315	8315	4631	4747	128	£39,136						£0
41	C87604	Thorpe Hesley Surgery	Thorpe Hesley Clinic, Sough Hall Avenue, Thorpe Hesley	11.0	20921	5774	0	0	7655	£34,350				4,000		£4,000
42		Thorpe Hesley Surgery	Bellows Road Surgery, Bellows Road, Rawmarsh	8.5	0	0	0	0	0	£28,666						£0
Wath / Swinton Locality					£115,752	£24,078	£14,487	£13,256	£22,647	£247,552	£0	£15,000	£0	£8,000	£0	£23,000
43	C87006	Magna Group Practice	Highthorn Road, Kilnhurst, Rotherham	8.5	0	0	0	0	0	£28,666						£0
44		Magna Group Practice	Valley Health Centre, Saville Street, Dalton	8.0	733	289	1009	617	638	£3,286	4,000					£4,000
49		Magna Group Practice (formally Brookfield Surgey)	Valley Health Centre, Saville Street, Dalton	6.0	508	0	0	0	0	£508						
46		Magna Group Practice	Thrybergh Medical Centre, 21 Park Lane, Thrybergh, Rotherham	10.0	7128	346	0	0	6571	£14,045						£0
47	C87013	Parkgate Medical Centre	Netherfield Lane, Rotherham	11.5	51428	0	950	0	1276	£53,654						£0
48		Parkgate Medical Centre	Thorogate Medical Centre, Thorogate, Rawmarsh	11.5	0	0	0	0	0	£28,666						£0
50	C87024	Rawmarsh Health Centre	Barbers Avenue, Rawmarsh	7.0	5639	0	0	0	0	£5,639						£0
Wentworth South Locality					£65,436	£635	£1,959	£617	£8,485	£134,464	£4,000	£0	£0	£0	£0	£4,000

Notes on assumptions used in the numerical and financial figures throughout the strategy:

Six Facet Surveys	• The risk figures from 2016 surveys were revised using the 2018 industry index costs. • 6 Facet total scores were derived through an algorithm developed by Community Ventures and used in similar pieces of work. • Premises without a six-facet survey were given a condition score and risk cost of £28,666 – based on the CCG average.
Feasibility Studies	• Costs used are based on current benchmarked pieces of work across the sector including the ETTF process.
New Build costings	• Based on a planning figure of £2,500 per m² which excludes land cost, stamp duty and VAT.