Recommendations for: Primary Care	
Recommendation/area for improvement	**Response/actions to be taken**
Ensure that GPs have all the information they need on the service offer and referral process to the Long Covid Rehabilitation Hub and illustrate this through the use of patient stories. This could be shared during protected learning initiatives, rather than through bulletins.	Information on the service offer and referral process have been made available to GPs. These messages will be re-shared to all GP practices with additional sessions offered to share more detail and discuss. The report highlights the strain on relationships and family dynamics. We will look to highlight with GPs the need to make a connection with the patients' role as a parent i.e. is their condition having an adverse impact on their role in parenting or supporting a child with additional needs for example. GPs can refer into Early Help for wider support as part of a package of care.
Provide training for healthcare professionals on how to recognise and manage cases of Long Covid – with updated and easily accessible information, particularly around diagnostic criteria and the relapsing and remitting nature of the condition.	We will discuss with the Long COVID hub team to identify any specific learning needs/support offer.
Building on the work of some existing Primary Care Networks, to develop the role of a dedicated care-coordinator within the healthcare setting who understands the patient's story and coordinates referrals and treatments accordingly. This would streamline the process and improve patient outcomes.	PCN care co-ordinators are one of the additional roles available to Primary Care Networks (PCNs) funded through the Network Contract Directed Enhanced Service ARRS funding. Within the provisions of the DES, each PCN is able to determine and recruit their own ARRS workforce based on their assessment of the population health need in their network, existing practice workforce and priorities. A number of Sheffield PCNs have chosen to recruit care co-ordinators and have found these staff to add value to their patients and their own ways of working. The decision to recruit care co-ordinators sits with individual PCNs however, the Place Team, and Primary Care Sheffield who are commissioned by the Sheffield Place to provide development support to PCNs have taken steps to share good practice information about workforce and skill mix through a range of events and approaches.

	The Place Team recently commissioned an evaluation of ARRS roles and benefits which has been circulated to and discussed with PCNs.
Trialling new systems to manage booking appointments with the GP - to better suit people with chronic conditions for whom early mornings are often more difficult.	During recent years demand for GP appointments has considerable outstripped capacity. Great efforts have been made by many GP practices to improve access and ensure that approaches meet the needs, as far as possible, of all their patient groups. This work has been supported through NHS England's Delivery Plan for Recovering Access to Primary Care. In the last 18 months practices have been supported to transition from analogue to cloud based telephony and to implement call queuing making it easier for patients to contact their GP by phone, to increase use of online consultation to allow patients to contact their GP online, during the entire working day, and to implement the Modern Model of GP Access which supports the effective triage of patients to improve access and reduce hand-offs between clinicians. Sheffield Place has also invested in additional primary care capacity through the year-round urgent same day service and the winter Acute Respiratory hubs, and has continued to support additional capacity in general practices over the winter period. In addition, the ICB, STH and One Medical are currently trialling GP bookable appointments in the Walk in Centre. This additional capacity, together with PCN Enhanced Access services is designed to increase availability of appointments and support care for patients with long term conditions. Our PCNs and practices are supported to develop and engage with patient participation groups to understand the concerns and preferences of their patients and respond accordingly. We have run several development sessions for practices that have included information and advice on effective patient engagement. A number of our practices are also undertaking the General Practice Improvement Programme, designed to look in depth at patient access and develop plans to improve this. We are committed to sharing the leaning and good practice form this work with practices across the city.

Recommendations for: NHS South Yorkshire Integrated Care Board

Recommendation/area for improvement	Response/actions to be taken
Strategic commissioning decisions should actively involve individuals with Long Covid in the planning process and explore innovative approaches to meet their needs (see North Central London case study on page 21)	This project and report were commissioned by Sheffield Teaching Hospitals NHS Foundation Trust and NHS South Yorkshire Integrated Care Board to understand the experiences of people living with, and accessing care and support for, Long Covid; the barriers to accessing support and gaps in support; and to ask what would lead to better outcomes for people. Additionally, we wanted to understand how the role of the Voluntary and Community Sector (VCS) could be developed to connect and support individuals with Long Covid. This was to help ensure that the voice of people living with Long Covid could influence the current support and future strategic commissioning decisions. In line with our Start with People strategy, we will ensure individuals with Long Covid continue to be heard and involved throughout the planning process.