Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 29th August, 2019
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor White (Vice-Chair)
Councillor Bell
Councillor Houghton
Councillor Professor Margetts
Councillor Noon
Councillor Payne

Contacts

Ed Grimshaw
Democratic Support Officer
Tel: 023 8083 2390
Email: ed.grimshaw@southampton.gov.uk

Mark Pirnie
Scrutiny Manager
Tel: 023 8083 3886
Email: mark.pirnie@southampton.gov.uk

PUBLIC INFORMATION

ROLE OF HEALTH OVERVIEW SCRUTINY PANEL (TERMS OF REFERENCE)

The Health Overview and Scrutiny Panel's responsibilities and terms of reference are set out within Part 3 of the Council's Constitution: Responsibility for Functions

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

MOBILE TELEPHONES: - Please switch your mobile telephones to silent whilst in the meeting.

USE OF SOCIAL MEDIA: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

SMOKING POLICY – the Council operates a no-smoking policy in all civic buildings.

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent lives
- Southampton is an attractive modern City, where people are proud to live and work

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

RULES OF PROCEDURE
The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship

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

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

(a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or

(b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

OTHER INTERESTS

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

- Any body to which they have been appointed or nominated by Southampton City Council
- Any public authority or body exercising functions of a public nature
- Any body directed to charitable purposes
- Any body whose principal purpose includes the influence of public opinion or policy

PRINCIPLES OF DECISION MAKING

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the “rationality” or “taking leave of your senses” principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, ‘live now, pay later’ and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

DATES OF MEETINGS: MUNICIPAL YEAR 2019/2020

2019	2020
27 June	27 February
29 August	23 April
24 October	
5 December	

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

(Pages 1 - 2)

To approve and sign as a correct record the minutes of the meeting held on 27 June 2019 and to deal with any matters arising, attached.

7 CONTINUING HEALTHCARE

(Pages 3 - 12)

Report of the Associate Director of Quality, NHS Southampton City CCG, providing the Panel with an overview of Continuing Healthcare in Southampton.

8 PRIMARY CARE IN SOUTHAMPTON

(Pages 13 - 36)

Report of the Director of System Delivery, NHS Southampton City CCG, providing the Panel with an update on developments relating to primary care in Southampton.

Tuesday, 20 August 2019 Director of Legal and Governance

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SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 27 JUNE 2019

Present: Councillors Bogle (Chair), Bell, Professor Margetts, Noon and Guthrie

Apologies: Councillors Houghton, Payne and White

1. **ELECTION OF VICE-CHAIR**

RESOLVED that the Panel, in his absence and with his consent, elected Councillor White as Vice Chair for the Municipal Year.

2. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

It was noted that following receipt of the temporary resignation of Councillor Houghton from the Panel, the Service Director Legal and Governance acting under delegated powers, had appointed Councillor Guthrie to replace them for the purposes of this meeting. The Panel also noted the apologies of Councillors Payne and White.

3. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panel meeting on 25th April 2019 be approved and signed as a correct record.

4. **TRANSFORMING HEALTH AND CARE FOR THE PEOPLE OF SOUTHAMPTON: OUR FIVE YEAR STRATEGIC PLAN 2019-2023**

The Panel considered the report of the Managing Director, NHS Southampton City CCG, requesting that the Panel considers and provides feedback on the draft Health and Care Strategy.

Dr Mark Kelsey (Chair, NHS Southampton City CCG), James Rimmer (Managing Director, NHS Southampton City CCG) and Stephanie Ramsey (Director of Quality and Integration and Chief Nurse, NHS Southampton City CCG), were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- The CCG's new management structure. It was noted that Maggie MacIsaac had been appointed to the post of Chief Executive, NHS Southampton City CCG and that James Rimmer had been appointed to the post of Managing Director. It was noted that previously the roles had been combined. However, it was explained that the CCG's new structure enabled both a clear focus on the Southampton population and the strengthening of relationships across Hampshire and the Isle of Wight. It was noted that the adopted structure reflected other CCGs across the region;
- That the changes to the CCG structure would not deflect focus away from delivering health and care to the residents of Southampton;
- The CCG explained how the strategy fitted into the local health management framework and the procedure adopted to develop the strategy;

- Panel Members expressed concern that many of the issues set out in the strategy were well known and had been flagged previously and that what was required was a plan to address them;
- The Panel was informed that the action plans to address the health inequalities in Southampton outlined in the strategy had not yet been developed. However, it was explained that this would be available for scrutiny by the Panel at a future meeting.

RESOLVED that the Panel noted the report of the Clinical Commissioning Group and requested that the strategy be brought back for review at a future meeting in order to consider the action plans that are in development.

5. **UPDATE ON PROGRESS - SOUTHERN HEALTH NHS FOUNDATION TRUST**

The Panel considered the report of the Chief Executive, Southern Health NHS Foundation Trust, providing the Panel with an update on progress at the Trust.

Dr Nick Broughton (Chief Executive - Southern Health), Dr Adam Cox (Clinical Director -Southern Health) Sharon Harwood (Area Matron, Beaulieu and Berrywood Wards – Southern Health) and Kathy Jackson (OPMH Service Manager, Southampton - Southern Health) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- The Panel was provided with an update on the reopening of Beaulieu Ward at Western Community Hospital. The Panel welcomed the reopening and were informed that the ward was fully staffed but that there had been in a reduction in the number of beds on the ward;
- Following the inquest into the two inpatient suicides in 2017 at Antelope House the Panel was also briefed on the progress against the actions recommended by the Coroner. It was noted that the majority of the actions had been addressed including the installation of door sensors. In addition it was noted that the Trust were continuing to make progress in the provision of single sex wards.
- The Panel questioned the staffing levels at Antelope House and, whilst recognising the challenges they faced recruiting and retaining qualified mental health nurses and psychiatrists, the Trust outlined the initiatives that were being employed to ensure that safe staffing levels were maintained.
- The Panel were briefed on the new management and operating structure of the Trust. The Panel also were invited to visit Antelope House to develop understanding of the services provided at the facility.

RESOLVED that the report be noted.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		CONTINUING HEALTHCARE		
DATE OF DECISION:		29 AUGUST 2019		
REPORT OF:		CAROL ALSTROM, ASSOCIATE DIRECTOR OF QUALITY / DEPUTY CHIEF NURSE, NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	Tania Emery	**Tel:**	023 8029 6904
	E-mail:	SOCCG.continuinghealthcare@nhs.net		
Director	**Name:**	Carol Alstrom	**Tel:**	023 8029 6904
	E-mail:	carol.alstrom@nhs.net		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY This paper provides a summary and briefing on Continuing Healthcare (CHC) in Southampton.		
RECOMMENDATIONS:		
	(i)	That the Panel notes the report.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To ensure the Health Overview and Scrutiny Panel has an understanding of Continuing Healthcare in Southampton.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not applicable.	
DETAIL (Including consultation carried out)		
3.	NHS Continuing Healthcare (CHC) is the name given to a package of ongoing care that is arranged and funded solely by the NHS for people who are not in hospital who have complex ongoing healthcare needs.	
4.	Attached as Appendix 1 is a briefing paper that provides detail on the following: • National criteria and responsibilities • The definition of a primary health need • Eligibility • Decision-making process / application • Reviews • Appeals • Redress payments • Choice and equity • Local information • Useful resources	

RESOURCE IMPLICATIONS	
Capital/Revenue	
5.	Not applicable.
Property/Other	
6.	Not applicable.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	Not applicable.
Other Legal Implications:	
8.	None.
RISK MANAGEMENT IMPLICATIONS	
9.	None.
POLICY FRAMEWORK IMPLICATIONS	
10.	Not applicable.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	ALL
SUPPORTING DOCUMENTATION	
Appendices	
1.	Briefing Paper – Continuing Healthcare
Documents In Members' Rooms	
1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?	No
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**	
Title of Background Paper(s)	
1.	None

Southampton City
Clinical Commissioning Group

CONTINUING HEALTHCARE - AUGUST 2019

1. Introduction and context

1.1. NHS Continuing Healthcare (CHC) is the name given to a package of ongoing care that is arranged and funded solely by the NHS for people who are not in hospital who have complex ongoing healthcare needs.

1.2. A person must be assessed and found to have a 'primary health need' as set out in the National framework for NHS Continuing Healthcare and NHS-funded nursing care.

1.3. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness.

1.4. Eligibility for NHS Continuing Healthcare is not determined by the setting in which the package of support can be offered or by the type of service delivered.

2. National criteria and responsibilities

2.1. The eligibility criteria are set nationally, by the Department for Health and Social Care. The National Framework for NHS Continuing Healthcare and Funded Nursing Care provides the details on eligibility for Continuing Healthcare and how it is implemented.

2.2. Responsibility for implementing the CHC criteria belongs to Clinical Commissioning Groups (CCGs). NHS Southampton City CCG is responsible for implementing the policy for patients registered with a Southampton GP practice.

2.3. Eligibility for Continuing Healthcare is the demonstration of a primary health need. This means that a person's health needs are deemed to be more than what would reasonably be expected to be part of social care support, as outlined below.

3. The definition of a primary health need

3.1. A primary health need is a concept developed by the Department of Health and Social Care. It is designed to assist CCGs in deciding when an individual's primary need is for healthcare (which is appropriate for the NHS

to provide under the 2006 Act) rather than social care (which the Local Authority may provide under the Care Act 2014).

3.2. To determine whether an individual has a primary health need, there is an assessment process, which is detailed in the National Framework for NHS Continuing Healthcare and NHS-funded nursing care (October 2018). When an individual has a primary health need and is therefore eligible for NHS Continuing Healthcare, the NHS is responsible for providing for all of the individual's assessed health and associated social care needs, including accommodation, if that is part of the overall need.

3.3. Determining whether an individual has a primary health need involves looking at the totality of their relevant needs. An assessment of eligibility must be undertaken by a multidisciplinary team (MDT), which must use the national Decision Support Tool (DST).

3.4. An individual has a primary health need if, having taken account of all their needs (following completion of the Decision Support Tool), it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs. Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality.

3.5. Each individual case has to be considered on its own facts in accordance with the principles outlined in this National Framework.

3.6. Therefore, the 'primary health need' test should be applied, so that a decision of ineligibility for NHS Continuing Healthcare is only possible where, taken as a whole, the nursing or other health services required by the individual:

- are no more than incidental or ancillary to the provision of accommodation which local authority social services are, or would be but for a person's means, under a duty to provide; and

- are not of a nature beyond which a local authority whose primary responsibility it is to provide social services could be expected to provide.

4. Eligibility

4.1. Eligibility is the same for all individuals, whether their needs are being met in their own home or in care home accommodation. Certain characteristics of need – and their impact on the care required to manage them – may help determine whether the 'quality' or 'quantity' of care required is more than the limits of a local authority's responsibilities.

4.2. The eligibility criteria for Continuing Healthcare has 12 care domains:

- breathing
- nutrition (food and drink)
- continence
- skin (including wounds and ulcers)
- mobility
- communication
- psychological and emotional needs
- cognition (understanding)
- behaviour
- drug therapies and medication
- altered states of consciousness
- other significant care needs

4.3. These needs are given a weighting marked "priority", "severe", "high", "moderate", "low" or "no needs". If a person has at least one priority need, or severe needs in at least 2 areas, they can usually expect to be eligible for NHS Continuing Healthcare. They may also be eligible if they have a severe need in one area plus a number of other needs, or a number of high or moderate needs, depending on their nature, intensity, complexity or unpredictability.

4.4. If an individual is not eligible for Continuing Healthcare it may be appropriate to consider if their needs are best met by a joint social care and health funded package of care. This is where the CCG agrees to pay for a proportion of the package of care, and the other proportion may be paid for by the local authority.

4.5. In some cases, a person may have potential for rehabilitation; this must be fully explored by professionals before NHS-funded Continuing Healthcare can be considered.

5. Decision-making process / application

5.1. The CCG has a specialised team of nurse assessors, social workers, commissioning managers and admin staff who work within our NHS Continuing Healthcare team. This team processes applications for Continuing Healthcare funding and provides case management for individuals who receive this funding.

5.2. Financial issues are not considered as part of the decision on an individual's eligibility for NHS Continuing Healthcare.

5.3. There are two stages in the application process:

5.3.1. Step 1 - Checklist

For most people the first step is to have an assessment with a health or social care professional using a screening tool called the Checklist. This may be:

- part of the discharge pathway from hospital;
- introduced by a GP or nurse who may use it in an individual's home OR
- social workers or care managers may use it when carrying out a community care assessment.

This list is not exhaustive, and in some cases it may be appropriate for more than one person to be involved.

If the Checklist concludes a patient may be eligible for NHS Continuing Healthcare, a full assessment of their needs will be arranged using a tool called the Decision Support Tool.

If it concludes the patient is not suitable for the NHS Continuing Healthcare process, they will not proceed to the next stage. However if their circumstances change they may request another Checklist to be undertaken.

The patient or their representative will be fully involved in the assessment and decision-making process, and their views about their needs for care and support will be taken into account.

5.3.2. Step 2 - Decision Support Tool

If the Checklist indicates that the patient needs a full assessment, then a Decision Support Tool (DST) needs to be completed and submitted to the CCG with supporting evidence demonstrating the intensity, complexity, unpredictability and nature of needs and care provision. The DST has been developed nationally to aid consistent decision making and cannot be altered.

A lead professional will be appointed and will coordinate the assessment collation to complete the DST. The DST is completed in a meeting with at least two health and / or social care professionals and the person or their representative present. The professionals (or Multi-disciplinary team) will then make a recommendation on eligibility and send the application to the Continuing Healthcare team for ratification. The lead professional will also keep the applicant and their family or representative informed of the process.

The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. The tool provides practitioners with a method of bringing together and recording the various needs in 12 'care domains', or generic areas of need. Each domain is broken down into a number of levels.

The levels represent a hierarchy from the lowest to the highest possible level of need (and support required) such that, whatever the extent of the need within a given domain, it should be possible to locate this within the descriptors provided.

5.4. CCG Panel Process

If the CCG Continuing Healthcare team is unable to ratify the eligibility decision made by the multidisciplinary team completing the DST or if that team recommend that the person is not eligible for Continuing Healthcare but indicate that they may have a health need above the level that can reasonably be expected to be met by the local authority, the case is referred to the CCG CHC Panel. The CCG CHC Panel is convened weekly and has senior decision maker representation from Adult Social Care, the CCG CHC Team and is chaired by an Independent Chair. The Panel is supported by advisors from Adult Social Care and provider Health Services. The Panel considers all the evidence available to support the DST and decides if the individual is in fact eligible for CHC or if a joint funded

package of care is indicated or if there is no indication for funding from the CCG.

The CCG administrators support the Panel and ensure that the lead professional for the DST and the individual and or their family or representative as appropriate is informed of the outcome of the Panel. A detailed Panel report is shared with the individual following the Panel meeting.

6. Reviews

6.1. Eligibility for NHS Continuing Healthcare is not awarded for life and is reviewed at the three month point after the initial decision. After this eligibility is reviewed annually.

6.2. The CCG is responsible for the case management of individual Continuing Healthcare support packages, including monitoring the quality of care and arranging regular reviews. This can be through joint arrangements with Social Services where applicable.

7. Appeals

7.1. If a patient does not agree with the decision on their eligibility for Continuing Healthcare, then they may appeal. Depending on the nature and extent of the appeal, this may either be resolved by meeting with the patient or taking their case to a local panel which is multi-professional and objective of the process that has been undertaken. The panel will review the domain weightings and the evidence, in order to make an eligibility decision or request more information regarding conditions and symptoms.

If the dispute cannot be agreed locally through panel within the CCG, the patient may appeal the decision with NHS England. NHS England will compile a panel that will review the decision, the process and the evidence as appropriate to the appeal. If the decision made at this panel is not satisfactory for the patient or their representative, then they may complain to the Parliamentary and Health Service Ombudsman.

8. Redress payments

8.1. Individuals can be reimbursed for care during periods they were eligible for, but did not receive, continuing healthcare support. This is known as a redress payment.

9. Choice and equity

9.1. In light of the need to balance personal choice alongside safety and effective use of finite resources, the CCG has a Choice and Equity Policy in place. This was updated in 2019, following approval from the CCG's governing body.

9.2. It is necessary to have a policy which supports consistent and equitable decisions about the provision of care regardless of the person's age, condition or disability. These decisions need to provide transparency and fairness in the allocation of resources.

9.3. Application of this policy ensure that decisions about care will:

- be robust, fair, consistent and transparent
- be based on the objective assessment of the person's clinical need, safety and best interests
- have regard for the safety and appropriateness of care to the individual and staff involved in the delivery
- involve the person and their family/representative wherever possible
- support choice to the greatest extent possible in view of the above factors.

9.4. In addition to a person's assessed needs, the CCG may have to take into account its own resources when deciding upon which package of care to commission.

Furthermore, we support people's right to live independently and take our obligations and duties towards this very seriously.

10. Local information

10.1. The CCG must follow the nationally mandated processes and criteria as laid out in the National Framework for NHS Continuing Healthcare and NHS funded nursing care (October 2018). Failure to do so, for example by not fully involving social care in decision making would leave the CCG open to challenge as part of the local and national appeal processes.

10.2. In Southampton we have 211 clients receiving CHC funding. This figure does not include joint funded care packages with Southampton City Council.

10.3. In the last year, the CCG has continued to focus on delivering significant improvements to the quality of care provided whilst obtaining best value for money. We work with University Hospital Southampton NHS Foundation Trust and Southampton City Council to ensure assessments for long term care needs are completed in the community setting rather than the acute hospital. During the last five months only one full CHC assessment has been completed in hospital. Completing assessments in the community delivers a better experience and outcomes for the majority of people.

10.4. We have also started a process of integration with Southampton City Council's Adult Social Care teams. The CHC learning disabilities team is now co-located with the council team for learning disabilities, working to one jointly appointed line manager. It is anticipated this integration work will progress further during 2019/20.

10.5. We also actively participate, as one of the development partners, in the National Strategic Improvement programme for CHC, supporting and contributing to national work that seeks to improve the consistency of outcomes and experience for everybody involved in the CHC process.

10.6. We have revised and updated a number of procedures relating to CHC in line with new national guidance and have purchased a new database system to manage the caseload which went live on 1 April 2019.

11. Useful resources

11.1. The full CHC national framework can be found at:

https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

11.2. A helpful video, outlining the process for patients, families and carers can be found at https://www.youtube.com/watch?v=9xE2oGVRqvY

12. Conclusion

The CCG requests the Panel notes this report and considers the information presented at the meeting.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		PRIMARY CARE IN SOUTHAMPTON		
DATE OF DECISION:		29 AUGUST 2019		
REPORT OF:		PETER HORNE, DIRECTOR OF SYSTEM DELIVERY, NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	Phil Aubrey-Harris	**Tel:**	023 8029 6904
	E-mail:	phil.aubrey-harris@nhs.net		
Director	**Name:**	Peter Horne	**Tel:**	023 8029 6904
	E-mail:	phorne@nhs.net		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY This report provides an update on the planning and delivery of primary care in Southampton.		
RECOMMENDATIONS: That the Panel		
	(i)	Notes and provides feedback on the report. Further information on the outcome of the Primary Medical Care Commissioning Committee, due to take place shortly after this report is submitted, will be provided prior to the HOSP meeting on 29 August 2019.
	(ii)	Determines whether engagement around the proposed estates and access review of primary care in Southampton constitutes formal public consultation under NHS Act (2006) at this time.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To ensure the Health Overview and Scrutiny Panel has an understanding of primary care in Southampton and new developments, and considers the implications of the proposed estates review.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not applicable.	
DETAIL (Including consultation carried out)		
3.	The CCG has had delegated commissioning responsibility for primary care since 2016 and the briefing paper attached as Appendix 1 details the state of primary care in Southampton today, in addition to future developments.	
4.	General practice is the foundation upon which effective patient care rests. In Southampton we believe GP practices deliver around 1.4 million urgent and routine appointments per year.	
5.	Primary care services across England are adapting in light of changing patient need, demographic changes, public expectations, market forces and other factors. We are supporting practices with this process of change, while	

	also ensuring our patients receive the highest quality primary care services in the city. Currently, there are 27 GP partnerships in Southampton, delivering care to almost 290,000 people living in the city and its immediate surroundings. These are made up of around 200 GPs (of which around 110 are partners) as well as nurses, other healthcare professionals and administrative staff. The practices operate from around 40 sites across the city.
6.	In light of developments in primary care, the CCG is planning to commence a structured programme of work in 2019/20 to deliver detailed estates plans for primary care services on a locality-by-locality basis that will refresh estates strategies for primary care and associated out-of-hospital services. Initial focus will be on the east locality in the city.
7.	As a supplement to the publication of the NHS Long Term Plan in January 2019, NHS England also issued their new five-year GP Contract Framework. The Framework has been negotiated and agreed nationally between NHS Employers (on behalf of NHS England) and the General Practitioners Committee of the British Medical Association (on behalf of GPs). In summary the new Framework includes a range of far-reaching developments and investments with the intention of transforming primary care for the future. One of the main elements involves the establishment of Primary Care Networks (PCN).
8.	The aim of PCNs is to build on the core of current primary care services and enable greater provision of proactive, personalised, co-ordinated and more integrated health and social care. PCNs are based on GP registered lists, typically serving natural communities of around 30,000 to 50,000. In Southampton our practices have worked together in clusters for a number of years, and the development of PCNs can be seen as an evolution from this successful way of working.
RESOURCE IMPLICATIONS	
Capital/Revenue	
9.	Not applicable.
Property/Other	
10.	Not applicable.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
11.	Not applicable.
Other Legal Implications:	
12.	None.
RISK MANAGEMENT IMPLICATIONS	
13.	None.
POLICY FRAMEWORK IMPLICATIONS	
14.	Not applicable.

KEY DECISION?	No

WARDS/COMMUNITIES AFFECTED:	ALL

SUPPORTING DOCUMENTATION

Appendices	
1.	Briefing Paper – Primary Care in Southampton
2.	Primary Care Networks in Southampton – Maps and additional details

Documents In Members' Rooms	
1.	None

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?	No

Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	No

Other Background Documents

Equality Impact Assessment and Other Background documents available for inspection at:

Title of Background Paper(s)		
1.	None	

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Southampton City Clinical Commissioning Group

PRIMARY CARE IN SOUTHAMPTON - AUGUST 2019

1. Introduction and context

1.1. General practice is the foundation upon which effective patient care rests. In Southampton we believe GP practices deliver around 1.4 million urgent and routine appointments per year.

1.2. Primary care services across England are adapting in light of changing patient need, demographic changes, public expectations, market forces and other factors. We are supporting practices with this process of change, while also ensuring our patients receive the highest quality primary care services in the city.

1.3. Currently, there are 27 GP partnerships in Southampton, delivering care to almost 290,000 people living in the city and its immediate surroundings. These are made up of around 200 GPs (of which around 100 are partners) as well as nurses, other healthcare professionals and administrative staff. The practices operate from around 40 sites across the city.

1.4. Alongside the NHS Long Term Plan[1], NHS England also published the new 5 year GP Contract Framework[2] in January 2019, the supplementary. The Framework includes a number of far reaching developments and investments in primary care designed to promote sustainability and quality.

1.5. One of the main requirements of the Framework is for every practice to be part of a local primary care network (PCN). The aim of PCNs is to build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. PCNs are intended to build resilience in primary care through encouraging practices to work together. PCNs are based on GP registered lists, typically serving natural communities of around 30,000 to 50,000. In Southampton our practices have worked together in clusters for a number of years (as part of the cities Better Care Programme), and the development of PCNs can be seen as an evolution from this successful way of working.

1.6. The CCG has had delegated commissioning responsibility for primary care since 2016 and this paper details the state of primary care in Southampton today, in addition to future developments.

[1] "NHS Long Term Plan" – NHS England (January 2019)

[2] "Investment & Evolution – Five Year framework for GP Contract Reform" – NHS England (January 2019)

2. Patient list sizes and contracting arrangements

2.1. There are 27 GP partnerships in the city:

Practice name	Type of contract	Patient list (1 July 2019)
Aldermoor Surgery	GMS	8,211
Alma Road Surgery	GMS	9,739
Atherley House Surgery	GMS	5,311
Bath Lodge Practice	GMS	9,988
Bitterne Surgery (West End Road Surgery)	GMS	14,427
Brook House Surgery	GMS	5,614
Burgess Road Surgery	PMS	9,453
Chessel Practice	GMS	10,405
Cheviot Road Surgery	GMS	15,491
Highfield Health	GMS	6,522
Hill Lane Surgery	GMS	9,292
Homeless Healthcare	APMS	439
Living Well Partnership	GMS	27,944
Lordshill Health Centre	GMS	11,757
Mulberry Surgery	GMS	6,228
Nicholstown Surgery	APMS	18,571
Raymond Road Surgery	GMS	4,625
Shirley Health Partnership	GMS	14,285
St Mary's Surgery	PMS	23,866
St Peter's Surgery	GMS	5,861
Stoneham Lane Surgery	GMS	7,151
The Old Fire Station Surgery	PMS	8,865
Townhill Surgery	GMS	5,511
University Health Service	GMS	18,087
Victor Street Surgery	GMS	12,279
Walnut Tree Surgery	GMS	4,281
Woolston Lodge Surgery	GMS	14,810
Total patient list in Southampton:		289,013

2.2. Southampton has seen an increase in its registered patient population of approximately 3.5% over two years. Around 5% of patients registered with city practices live outside the city boundary.

2.3. GP partnerships are typically made up of self-employed independent contractors, rather than NHS employees. Additional staff, such as salaried GPs, practice nurses and administrative staff, are mostly employed directly by the GP practice and not the NHS.

2.4. There are three types of contract used for primary care nationwide:

- General Medical Services (GMS) contract: this is a nationally negotiated GP contract and the most common type of primary care contract in Southampton. It is negotiated annually between the British Medical Association's General Practitioners' Committee and NHS Employers. The Carr-Hill Formula has been used as the basis of core funding for GMS practices for over fifteen years, which in a nationally set formula but also takes into account patient needs, demographics such as age and gender, mortality ratios, and cost of living in geographical areas.

- Personal Medical Services (PMS) contract: this is also nationally negotiated but also includes some locally negotiated elements between NHS England and the practice partnerships in order to provide additional flexibility for the practice and the services it provides. PMS contracts are an alternative to GMS contracts for the commissioning of Primary Medical Care Services. In 2015-16 NHS England reviewed PMS contracts and these contracts are now being bought in line with GMS contracts to ensure parity for practices and patients alike. In Southampton there are three practices that the CCG currently commissions primary care services for via PMS contracts. These are St Marys, Burgess Road and Old Fire Station Surgery.

- Alternative Provider Medical Service contract: this is also locally negotiated and more flexible, and is open to a wider range of providers, including the independent sector. The CCG commissions two primary care services under an APMS contract. This is the Solent GP Surgery and the Homeless Healthcare team; both are operated by Solent NHS Trust.

- GMS and PMS contracts are in perpetuity. The APMS contracts in Southampton have a maximum of a 5 year term and are subject to public procurement regulations.

2.5. Like other areas of the health and care system, General Practice faces significant pressures at present associated with increasing demand from our ageing population, increasing workload and resource constraints – in particular workforce shortages.

2.6. Unlike other areas of the health service, primary care services are predominantly delivered by small businesses (GP partnerships) and shifting market forces are placing considerable strain on this operating model. In a recent review of the partnership model[3], commissioned by the Secretary of State for Health in 2018, it was concluded that if the GP partnership model were to survive in the future, then changes would be necessary. The review recognised the benefits of GP partnerships in terms of their efficiency and ability to be highly patient centred but also recommended the need for practices to work together to promote resilience and to bring in more skill-mix to support GPs in their working day.

3. Improving access to primary care

3.1. Since 2015 there has been a 'GP Hubs' service that offers additional choice and capacity for patients, including appointments at evenings and weekends. This service is available to anyone registered with a GP practice in Southampton, and ensures appointments with a doctor or nurse are available from 8am - 9pm every day of the week (including weekends and bank holidays). This appointment takes place at the patient's GP practice or at one of six hubs throughout the city.

3.2. These appointment slots are for a variety of different appointments, and can be booked through the patient's GP practice when they are open or by phoning NHS 111 when the practice is closed. NHS 111 is free to phone and available 24 hours a day, 365 days a year.

3.3. From June 2019, GP Hubs became more joined up with GP Out of Hours appointments. Following a procurement process, Southampton Primary Care Limited (SPCL; a federation formed by GPs in the city) took on the new contract to deliver Extended and Urgent Primary Care Services for five years, which evolved out of the original plot of GP Hubs. The new contracts means GP Hubs continue to run and there is now a more streamlined way of working with GP Out of Hours services (which run outside of normal GP opening hours) and NHS 111. This service also has close working relationships with other services in the city, such as the Emergency

[3] "GP Partnership Review" – Commissioned by Secretary of State for Health (January 2019)

Department, the Urgent Treatment Centre (formerly known as the Minor Injuries Unit) and community nursing services. With the award of this new contract, the federation will be able to build on their success to date.

4. Quality

4.1. GP services in England are independently regulated by the Care Quality Commission (CQC), which monitors and inspects providers of health and care services on quality and safety standards. Practices rated as good or outstanding receive inspections at least every 5 years; practices rated requires improvement or inadequate will be inspected within twelve and six months respectively of the previous inspection.

4.2. At the time of writing, all GP practices in Southampton are rated as 'good' by the CQC.

4.3. The CCG actively supports practices with a range of quality initiatives, such as support with reporting and investigating incidents and complaints; regular training opportunities through TARGET (Time for Audit Research Governance Education and Training) events; and mock CQC visits.

4.4. The CCG also analyses information on patient satisfaction through its ongoing community engagement work and the national GP Patient Survey[4]. In the most recent survey, published in July 2019 based on research undertaken between January and March 2019, we have seen some improvement on the previous year's results on a number of the questions for Southampton GP practices. The city's practices also perform just above national average on questions relating to advice and care when GP practices are closed. Our Primary Medical Care Commissioning Committee, is looking at the responses in more detail to identify areas where we can make improvements.

4.5. The management of primary care patient complaints is not a delegated function to the CCG and therefore these are investigated directly by NHS England on the behalf of patients.

5. Workforce

5.1. The sustainability of primary care is reliant on its workforce, and we recognise there are challenges nationally and locally around recruitment of GPs.

[4] https://www.gp-patient.co.uk/

5.2. GPs are supported by a vast range of other clinical and non-clinical staff within practices, such as practice nurses, advance nurse practitioners, pharmacists, dispensers, managers, receptionists, and medical secretaries. Further information is provided in Section 6 regarding new roles which will be recruited to Primary Care Networks.

5.3. NHS Digital provides data for primary care workforce. The latest figures for the overall primary care workforce in Southampton were published in March 2019 and are shared below:

Staff group	Headcount	Full time equivalents (FTE)
GPs	200	138
Nurses	122	84
Admin/Non-clinical	449	309
Direct patient care (e.g. pharmacists, physiotherapists, healthcare assistants)	57	36

5.4. The same data shows that 21% of GPs (by FTE) in Southampton are aged 55 or over. This is above the national average of 19.6%.

5.5. The city's Better Care programme has an active workstream focusing on the planning and delivery of fit for purpose workforce to deliver our new models of integrated care for the city – including primary care. The CCG is an active contributor to this work.

6. The New GP Contract Framework and Primary Care Networks

6.1. As a supplement to the publication of the NHS Long Term Plan in January 2019, NHS England also issued their new five-year GP Contract Framework. The Framework has been negotiated and agreed nationally between NHS Employers (on behalf of NHS England) and the General Practitioners Committee of the British Medical Association (on behalf of GPs). In summary the new Framework includes a range of far-reaching developments and investments with the intention of transforming primary care for the future.

6.2. One of the main elements of the Framework involves the establishment of Primary Care Networks (PCN).

6.3. The aim of PCNs is to promote quality and resilience in primary care services through encouraging GP practices to work at scale. Practices are requested to join together to form a network, typically serving communities of 30,000 to 50,000, by May 2019. The CCG was obliged to approve PCNs before the nationally-set start date of July 2019.

6.4. There is obvious resonance between the development of PCNs and the cities Better Care Programme, for which the CCG and SCC are key stakeholders. PCNs provide further impetus for primary care engagement within the cities integrated care agenda and investments via the new Framework will help fast-track primary care working at scale with other stakeholders. The CCG is currently working with PCNs and stakeholders in Better Care to reconcile these two work programmes with the Better Care Programme moving to a geographic arrangement of 3 city localities. These localities will form the local delivery arrangements for communities, PCNs, community health services, mental health services, social care services and voluntary sector organisations to come together to deliver new models of integrated care.

6.5. PCNs are asked to focus on delivering services. The planning and funding for health services remains with commissioners. PCNs are accountable to CCGs for the delivery of services.

6.6. PCNs are asked to provide a range of primary care services and recruit to specific roles, including for a clinical director post. Clinical Directors will provide leadership for the PCN development and will provide clinical oversight for services delivered by the PCN. The CCG will engage with PCN Clinical Directors in the development of local commissioning plans.

6.7. An important part of the Framework involves additional investment to promote growth in workforce and skill mix within PCNs. In 2019-20 additional funding will be made available for each PCN to recruit a whole-time Social Prescriber and a whole-time Clinical Pharmacist. These new posts will complement the existing primary care workforce and are intended to relieve GP workloads to enable them to focus on activities more appropriate to their registration as senior clinicians. This “Additional Roles Reimbursement” will be further extended in 2020-21 to include additional Physiotherapists and Physicians Associates and in 2021-22 to include

Paramedics. By the end of 2021-22 this could mean an additional 36 whole time staff working within primary care in the city.

6.8. In addition to funding for these new posts, CCGs must commit to recurrent funding to support PCN development and infrastructure. In Southampton this will equate to around £450k per annum. The national funding originates from the Prime Minister's announcement in June 2018 of ring-fenced funding for primary and community services. In each CCG area, the funding comes through a directed enhanced services payment (DES), which is an extension to the core GP contract and is offered to all practices.

6.9. There are seven national priorities for all PCNs to implement over the next five years. These are:

- Structured medication reviews
- Enhanced health in care homes (which gives patients access to consultations outside core hours)
- Anticipatory care with community services
- Personalised care
- Supporting early cancer diagnosis
- Cardiovascular disease case-finding
- Locally agreed action to tackle inequalities

In addition to this the CCG may seek to commission further services from PCNs.

6.10. PCNs also have the opportunity to work together with other stakeholders and analyse the needs of their patient population. We expect PCNs to accomplish this by engaging with local communities and existing Patient Participation Groups (PPGs).

6.11. In Southampton, six PCNs have been formed and have gained approval by the CCG, covering all of the city's GP practices. Details of the PCN memberships, their geographical boundaries, patient list numbers and other details, can be found in Appendix 2.

7. Proposed mergers and site closures

7.1. Since 2013, when the CCG became a statutory body, a number of practices have opted to merge together to become larger organisations with higher numbers of registered patients.

7.2. There were 36 GP practices in April 2013, which have gradually merged to become 27 practices at the time of writing. During this same time period, no practices have opted to hand back their contracts and close.

7.3. A practice merger is when two or more businesses join their practices together to form a single practice. This is often prompted by the desire to make efficiencies and work at scale, such as through a greater combined workforce and using one clinical system.

7.4. Some practices have opted to close branch sites of their business. This includes the Regents Park surgery site (part of the Shirley Health Partnership), Spitfire Court (part of Woolston Lodge) and Bargate surgery (part of St Mary's surgery).

7.5. If a GP practice wishes to merge with another or to close one of its existing sites, it must make separate applications to the CCG to do so. It must also first express its interest to the CCG prior to sending in a full application. The CCG will then advise the practice of its next steps, which then concludes with a formal application to be sent to the CCG. The CCG's Primary Medical Care Commissioning Committee will then choose to approve or decline the application on behalf of the CCG. The committee can reject applications on grounds such as patient safety and cost.

7.6. Although the CCG is a GP-led organisation, no GPs are allowed to sit on this committee and they have no role in the decision-making process.

7.7. Under GP contract regulations, GP practices have the right to apply to the CCG to make variations to their contract. In most cases GP contract regulations are weighted in favour of the contractor and the CCG has an obligation to approve applications that are reasonable. There is significant precedent for this and if contested, arbitration is via judicial review.

7.8. As a part of any application to merge or close a site, the practice / practices must provide evidence of benefits for patients, how the changes will support the sustainability of the practice and how any risks or issues will be mitigated.

7.9. Most recently, Bath Lodge Surgery and Chessel Practice have applied to merge their businesses together to become the Peartree Practice. This would be a formal contract merger and, if approved, would lead to the creation of a single practice with one GMS contract. The CCG management has made a recommendation to the Primary Medical Care

Commissioning Committee to approve the merger application. This is due to be decided on Wednesday 21 August 2019. The CCG will provide a separate update to the Panel following the decision.

7.10. Bath Lodge Surgery and Chessel Practice have also applied to close the Bath Lodge surgery site, subject to the approval of the contract merger. This would mean the merged practice will consolidate its services from three to two sites: Chessel Avenue and Sullivan Road. The CCG management has made a recommendation to the Primary Medical Care Commissioning Committee to not make a decision on the application at this time. This is to provide the CCG with time to commence and conclude the first phase of an extensive strategic estates review of primary care premises in the city (details of this can be found in section 8 below). The first phase is due to focus on the east of Southampton. The decision on the application to close the Bath Lodge surgery site is due to made on Wednesday 21 August 2019. The CCG will provide a separate update to the panel following the decision.

8. Primary care estates review

8.1. The CCG is planning to commence a structured programme of work in 2019/20 to deliver detailed estates plans for out-of-hospital services on a locality-by-locality basis that will:

a. refresh estates strategies for primary care and associated out-of-hospital services including development of Cluster Resource Centres, up-to-date national policy and local strategic developments;

b. consider current estate – including but not limited to condition, compliance, utilisation, functional suitability, quality and environmental management, geographic orientation, tenure, and opportunities for development.

c. consider emerging future care models of care – including but not limited to core primary care, Primary Care Network (PCN) network services, Better Care Southampton emerging integrated care models and new ways of working and access (e.g. via video consultations);

d. engage with local stakeholders including most notably local communities, citizens and patients, care providers and other relevant stakeholders, ensuring that estates plans resonate with organisational priorities;

e. consider opportunities for development and improvement of estate including review of development opportunities, potential sites and available funding sources;

f. explore options and present pragmatic preferred solutions that are most widely supported, maintain choice and access, are fit for the future and are affordable;

g. consider risks and blockages to delivery and how these might be mitigated, including but not limited to existing leases.

8.2. The work will produce detailed estates plans for primary care for each city locality that will form a core component of the CCG and partner organisations delivery plans for 2020/21 and beyond.

8.3. In light of the proposed site closure of Bath Lodge surgery, the CCG has decided to start the initial phase of this estates review in the east locality of Southampton, with a view to further phasing of the work to cover the central and west localities between January 2020 and September 2020. These timescales may be dependent on the availability of any third parties commissioned to support the review.

8.4. It is our intention that the review will consider and engage on options and will generate consensus and evidence to support a preferred arrangement for future primary care estate. A report from the review will form the plans for the commissioning of primary care estate for the east of the city going forward and will inform future investment and decisions relating to primary care estate and access points.

8.5. The CCG believes that extensive patient and public engagement is required for this estates review to be reflective of patients' needs. The CCG will liaise with the HOSP to determine whether this engagement will constitute formal public consultation under NHS Act (2006).

9. **Conclusion**

The CCG requests the Panel notes and provides feedback on the report. Further information on the outcome of the Primary Medical Care Commissioning Committee, due to take place shortly after this report is submitted, will be provided prior to the HOSP meeting on 29 August 2019.

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NHS
Southampton City
Clinical Commissioning Group

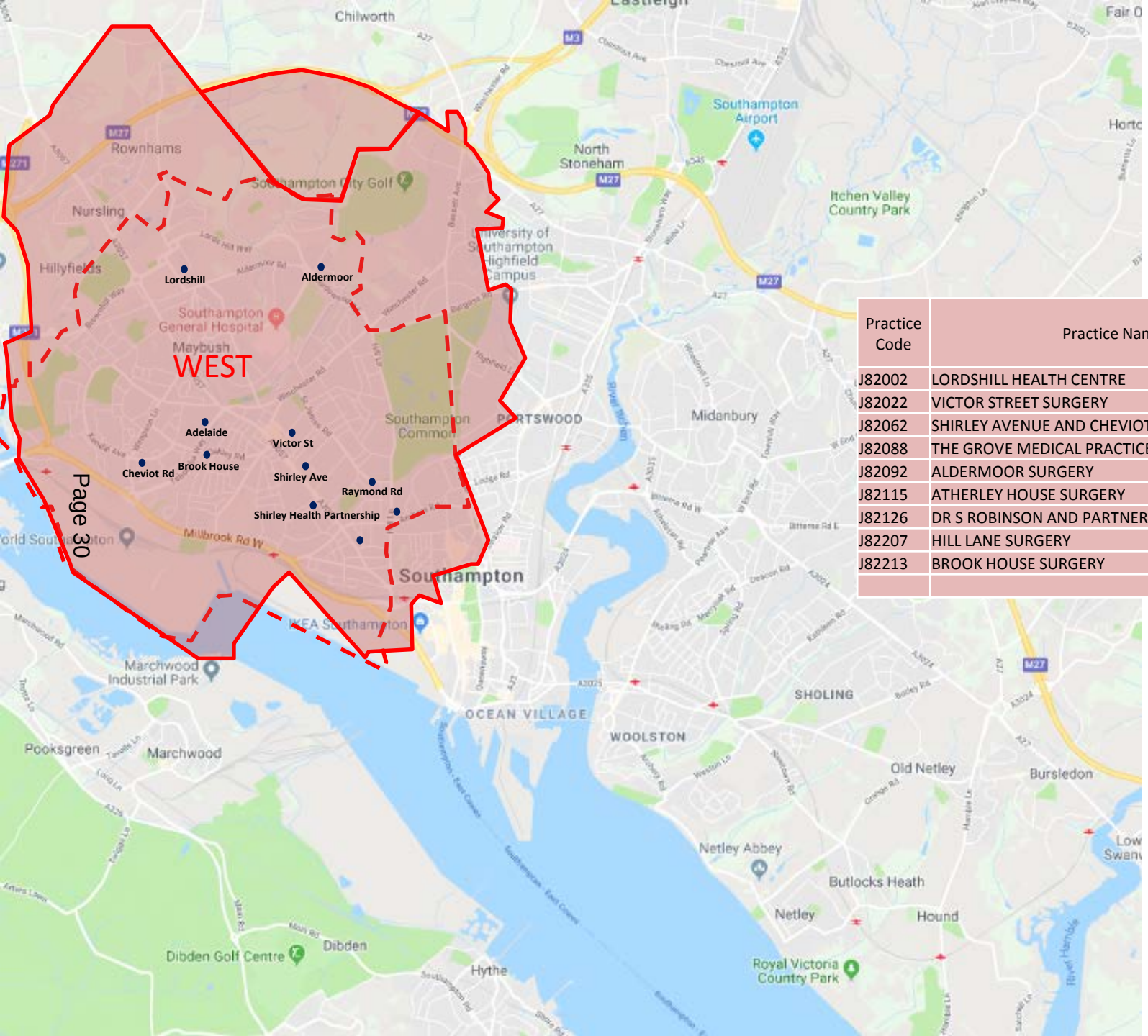
Primary Care Networks for Southampton City CCG

July 2019

Agenda Item 8
Appendix 2

WEST PCN

Clinical Director(s) :
Dr Dan Tongue
Dr Sanjeet Kumar



Practice Code	Practice Name	Raw Pop @ Jan 19	Weighted Pop (GSUM)
J82002	LORDSHILL HEALTH CENTRE	11,540	11,357
J82022	VICTOR STREET SURGERY	12,308	12,168
J82062	SHIRLEY AVENUE AND CHEVIOT ROAD PRACTICE	15,515	14,615
J82088	THE GROVE MEDICAL PRACTICE	14,560	13,494
J82092	ALDERMOOR SURGERY	8,179	7,758
J82115	ATHERLEY HOUSE SURGERY	5,211	4,713
J82126	DR S ROBINSON AND PARTNERS	4,516	4,604
J82207	HILL LANE SURGERY	9,337	8,687
J82213	BROOK HOUSE SURGERY	5,545	5,184
		86,711	82,580

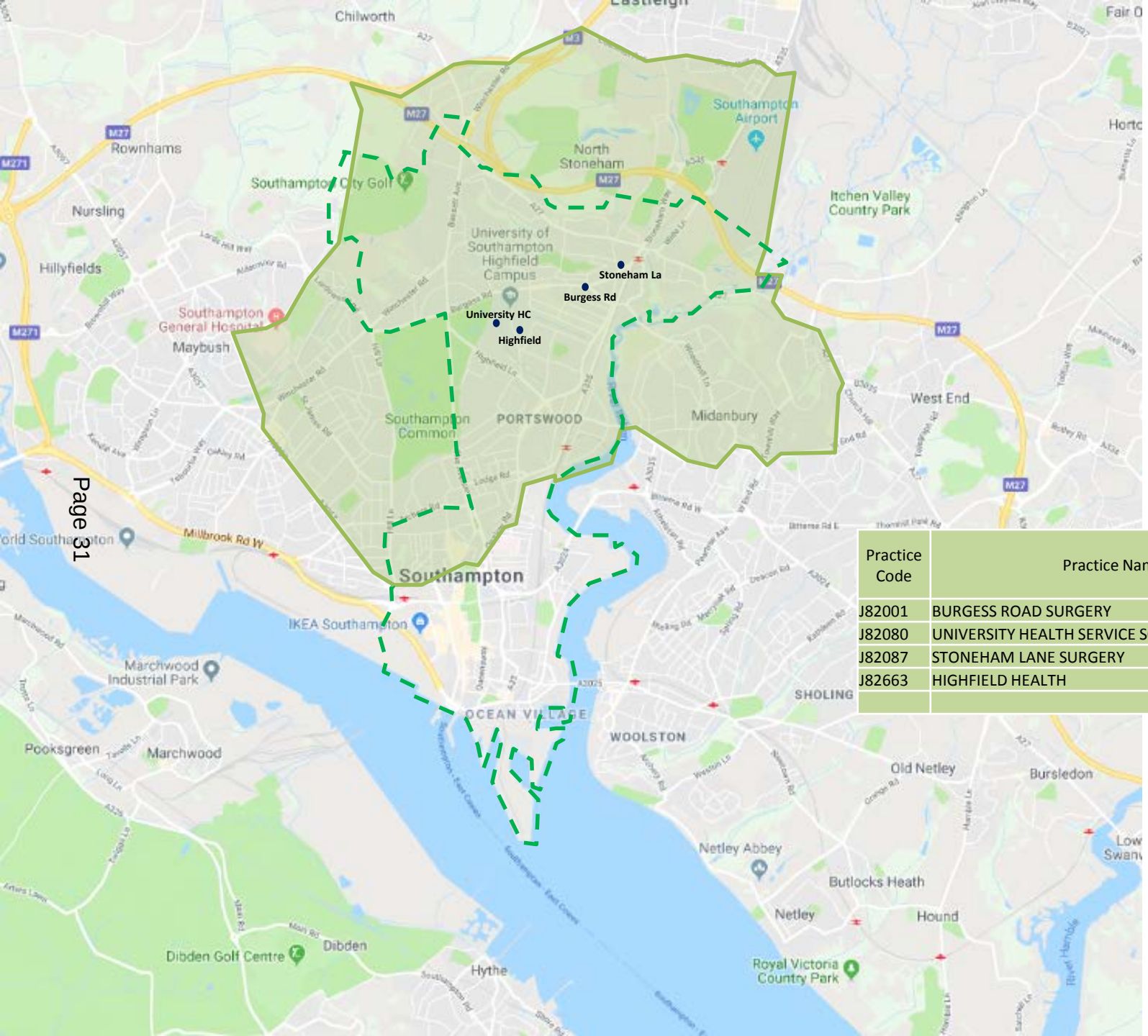
Plus circa 5k patients from Solent Adelaide – Solent as associate member of PCN

Locality geographic boundary

PCN absolute boundary

NORTH PCN

Clinical Director :
Dr Vikas Shetty
Dr Matt Prendergast



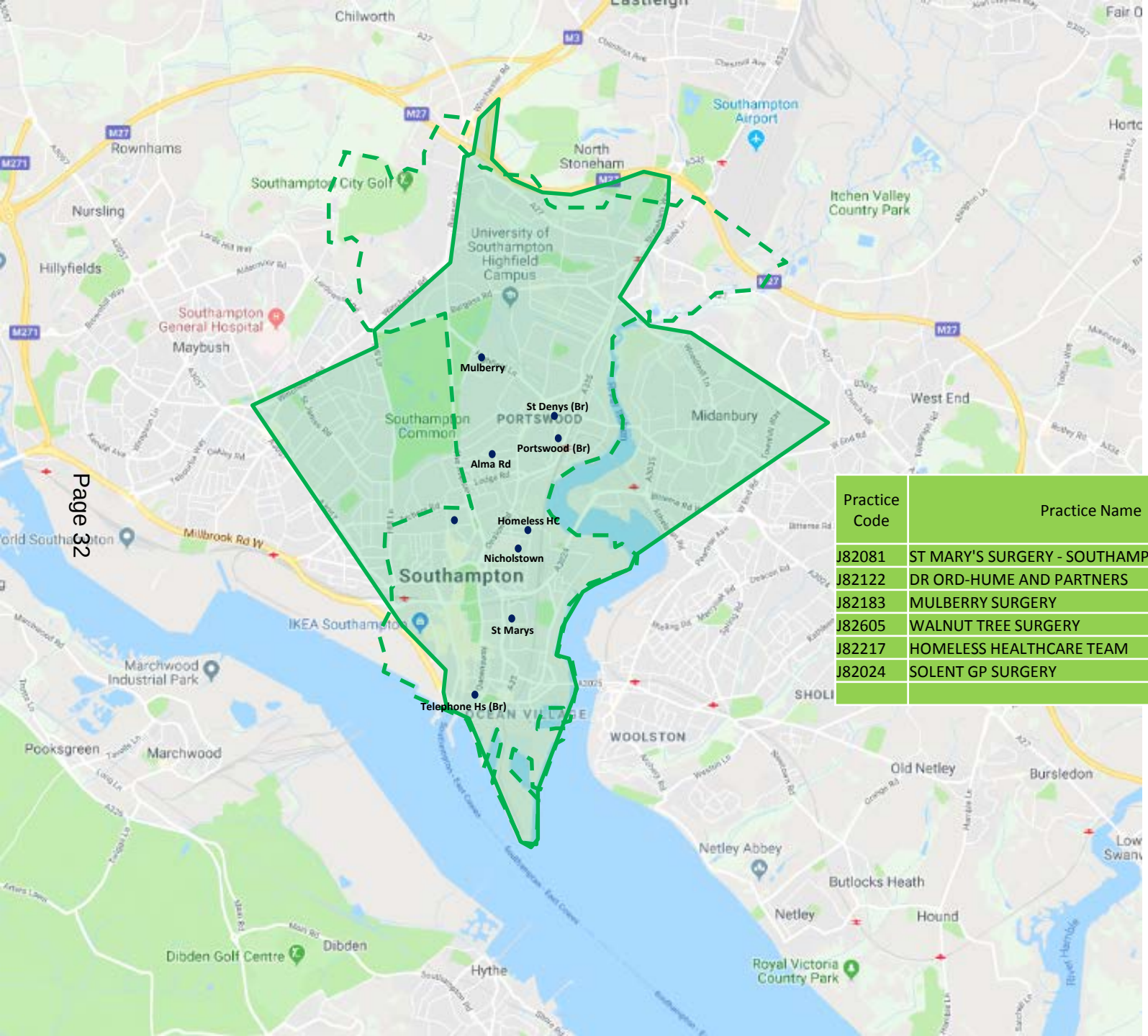
Practice Code	Practice Name	Raw Pop @ Jan 19	Weighted Pop (GSUM)
J82001	BURGESS ROAD SURGERY	9,503	7,662
J82080	UNIVERSITY HEALTH SERVICE SOUTHAMPTON	19,037	12,798
J82087	STONEHAM LANE SURGERY	7,124	6,845
J82663	HIGHFIELD HEALTH	6,675	5,058
		42,339	32,363

Locality geographic boundary

PCN absolute boundary

CENTRAL PCN

Clinical Director :
Dr Fraser Malloch



Practice Code	Practice Name	Raw Pop @ Jan 19	Weighted Pop (GSUM)
J82081	ST MARY'S SURGERY - SOUTHAMPTON	24,249	21,410
J82122	DR ORD-HUME AND PARTNERS	9,746	10,335
J82183	MULBERRY SURGERY	6,174	5,911
J82605	WALNUT TREE SURGERY	4,259	3,970
J82217	HOMELESS HEALTHCARE TEAM	465	374
J82024	SOLENT GP SURGERY	18,075	17,615
		62,968	59,615

Minus circa 5k patients from Solent Adelaide – Solent as associate member of West PCN

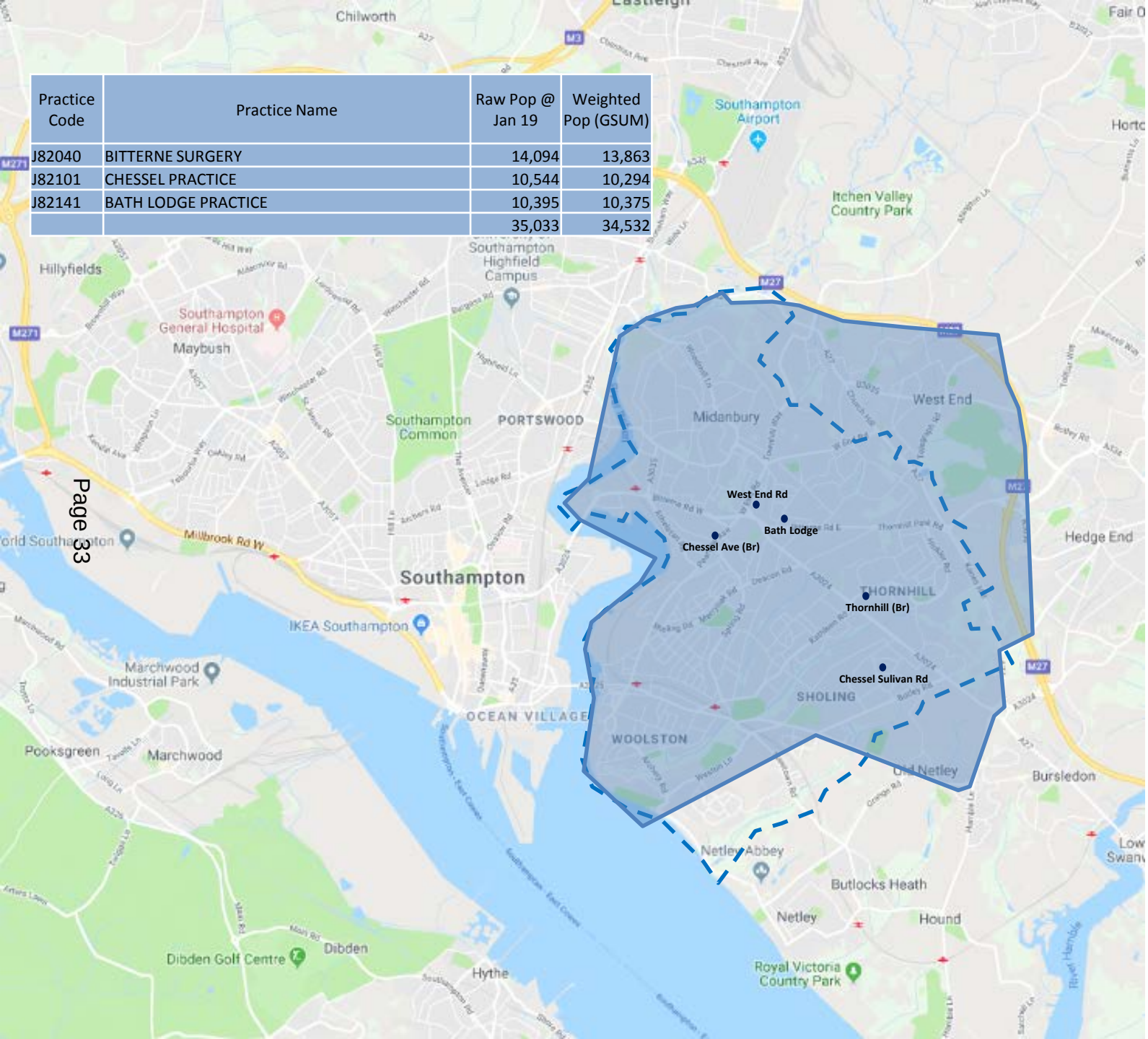
Locality geographic boundary

PCN Boundary

BITTERNE PCN

Clinical Director :
Dr Sundeep Benning

Practice Code	Practice Name	Raw Pop @ Jan 19	Weighted Pop (GSUM)
J82040	BITTERNE SURGERY	14,094	13,863
J82101	CHESSEL PRACTICE	10,544	10,294
J82141	BATH LODGE PRACTICE	10,395	10,375
		35,033	34,532



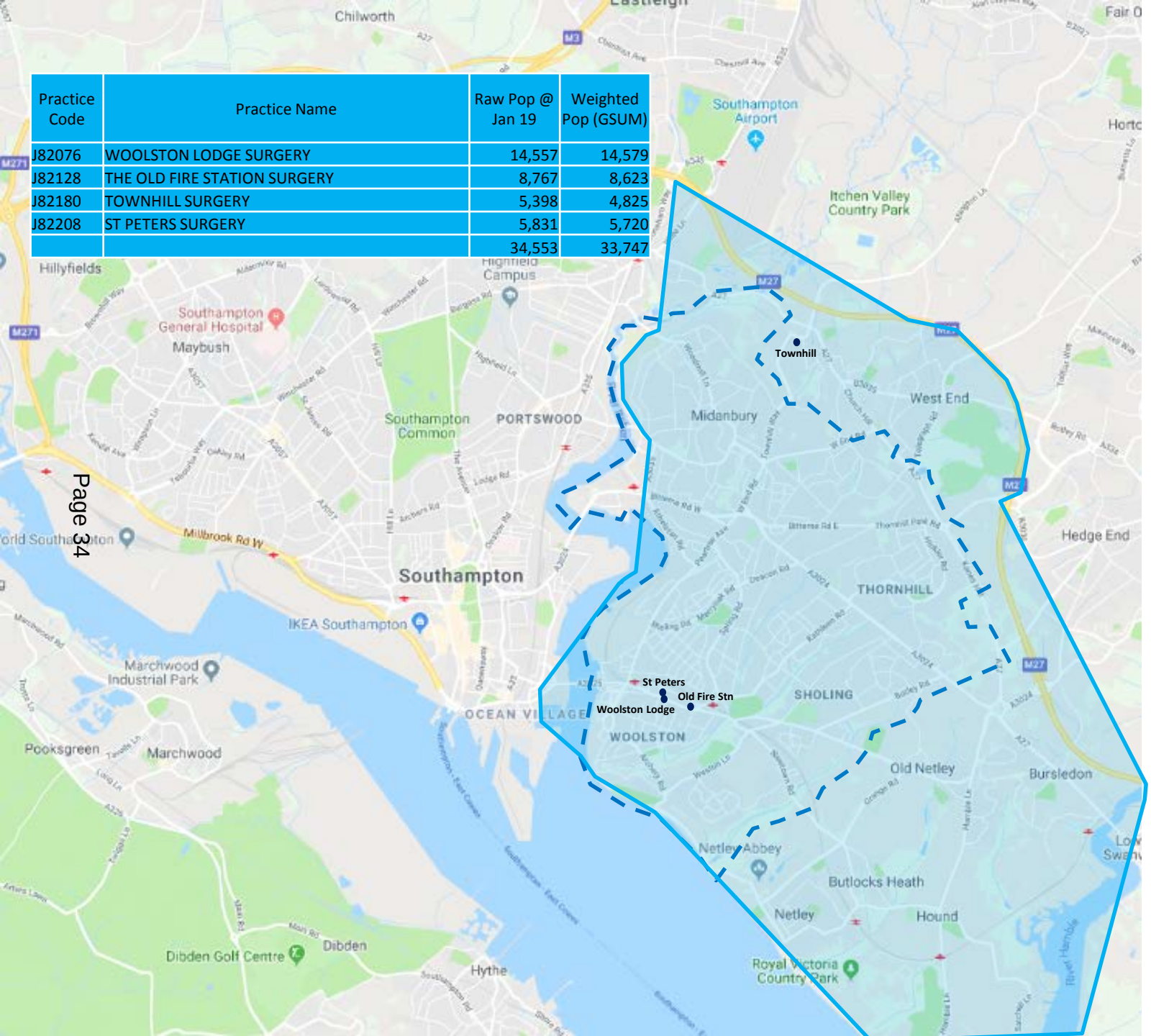
Locality geographic boundary

PCN absolute boundary

WOOLSTON & TOWNHILL PCN

Clinical Director :
Dr Nigel Jones

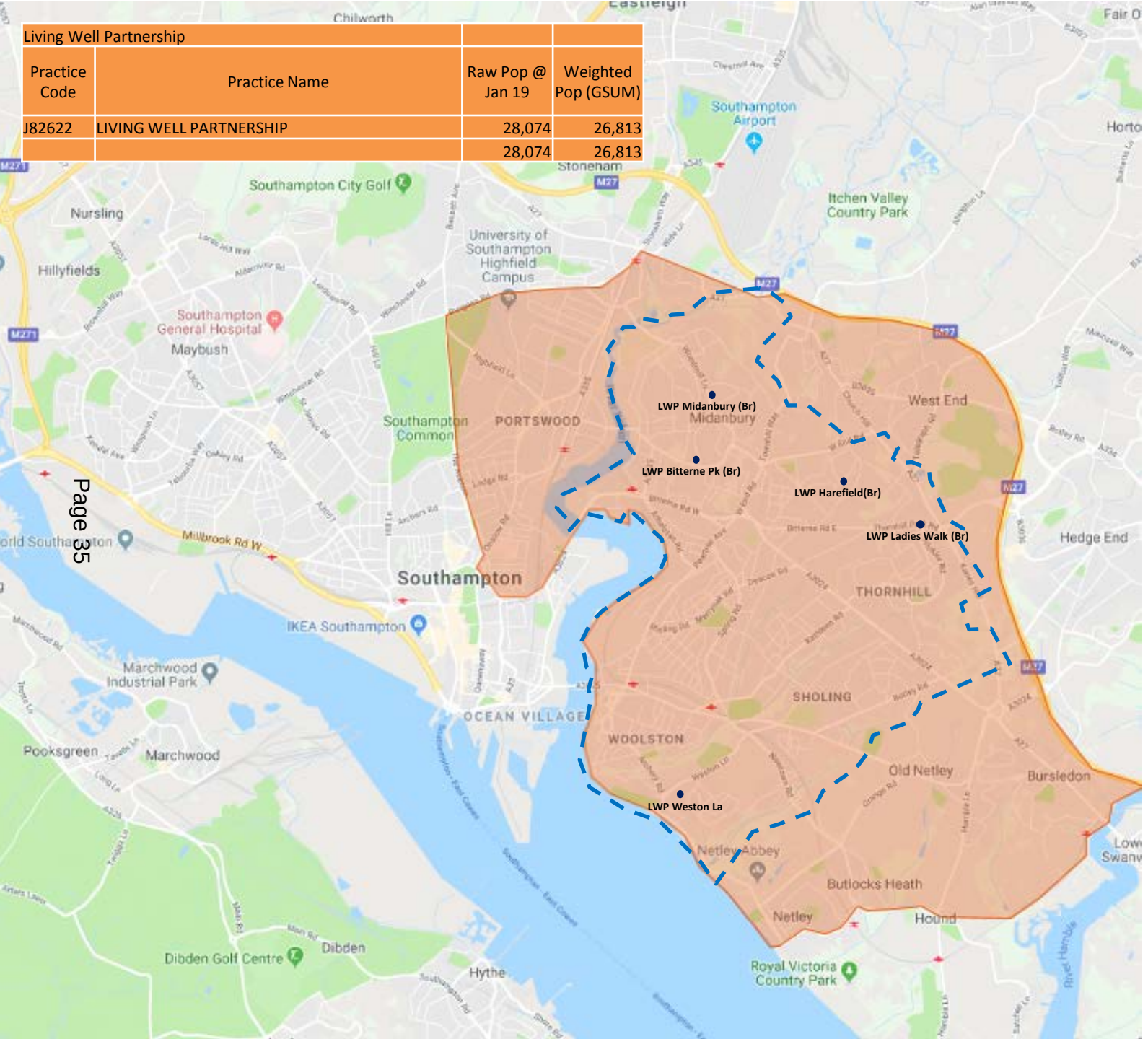
Practice Code	Practice Name	Raw Pop @ Jan 19	Weighted Pop (GSUM)
J82076	WOOLSTON LODGE SURGERY	14,557	14,579
J82128	THE OLD FIRE STATION SURGERY	8,767	8,623
J82180	TOWNHILL SURGERY	5,398	4,825
J82208	ST PETERS SURGERY	5,831	5,720
		34,553	33,747



Locality geographic boundary

PCN absolute boundary

Living Well Partnership			
Practice Code	Practice Name	Raw Pop @ Jan 19	Weighted Pop (GSUM)
J82622	LIVING WELL PARTNERSHIP	28,074	26,813
		28,074	26,813



LIVING WELL PCN

Clinical Director :
Dr Sam Davies

Locality geographic boundary

PCB absolute boundary

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