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.

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[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.