Transforming Primary Medical Care in Southampton

Five Year Strategy

2016-2021

" The secret of **change** is to focus all your energy not on fighting the old, but **building the new** "

Socrates

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"A plan for general practice needs to ensure that the people of the city have access to high quality, consistent, sustainable primary care that meets their needs, whilst being attractive to support recruitment and retention of GPs and their allied staff."

Foreword

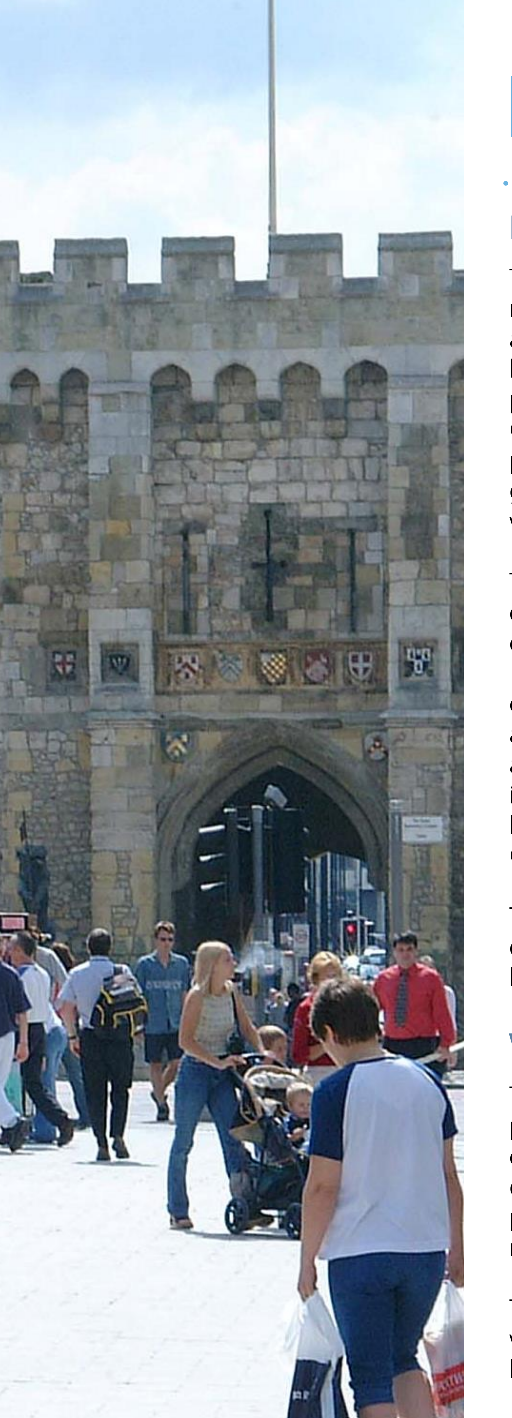
We know that general practice is the foundation upon which effective patient care rests. We also know that there are not enough GPs to provide care in the way it has traditionally been delivered – it will need to be GP led rather than always GP delivered. Indeed, the focus on person-centred, collaborative care means that GPs are increasingly working as part of a team which includes social care and the community. This approach allows GPs to use their skills in co-ordinating and managing the medical care of people with often complex medical and social issues, whilst being supported by a team who can offer very different skills and resources to complement the traditional medically focussed care delivered in primary care. We want to build on the fundamental strengths of general practice, such as the ongoing relationship with patients, continuity of care and the GP role as a trusted professional with an overview of patient care.

The GP Forward View, NHS England's five year plan for primary care, makes it very clear that, in future, services for people will be developed at a neighbourhood population level (such as a Locality Cluster, of which we have six in Southampton), rather than at a practice level. Where the partnership model is working well, this will be supported to continue, recognising the value of the this and the continuity that it provides. However, we do need to develop alternative models for those people and practices for whom the traditional model of general practice partnership is not attractive or sustainable.

A plan for general practice needs to ensure that the people of the city have access to high quality, consistent, sustainable primary care that meets their needs, whilst being attractive to support recruitment and retention of GPs and their allied staff, e.g. nurses or therapists. GP Practices (specifically, the partners) are responsible for ensuring that their organisation is able to deliver the primary medical services for which they are paid, despite the challenge of recruiting and retaining appropriate staff. The priority for the city is to shape a different model of general practice which will help GPs to fulfil these responsibilities and manage the risks to both services and the practice as a business entity.

This plan has been developed following contributions from city GPs, as well as other interested groups and organisations during a number of engagement events across the city. It has a dual purpose in that it sets out the future direction of primary care planning and delivery whilst also providing a basis for a strategy for sustainability that GP Practices lead and own.

Dr Sue Robinson
Clinical Chair and GP, NHS Southampton City Clinical Commissioning Group (CCG)



Purpose of this strategy

The transforming primary medical care strategy was born out of the need to respond to a number of **key challenges**, including financial and workforce constraints in general practice. It has been developed by a working group including five GPs and has been influenced by a prolonged period of information gathering and **engagement** with GPs, practice staff, patients and service users, local health and care providers including the voluntary sector, and other interested groups and organisations, via the GP Forum, surveys and a workshop.

The purpose of the strategy is two-fold. **Firstly**, it addresses the expectations that the way in which care is delivered will change, as outlined in NHS England's *Five Year Forward View* and *GP Forward View*, in order to meet the needs of people and support the delivery of Better Care and the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) locally; and **secondly**, it acknowledges the workforce challenge and recognises the importance of building a strong team of motivated and engaged health and care professionals across a range of disciplines with the GP at the core.

The intention is to produce one document that will appeal to everyone, recognising that individual elements will be of more or less interest to specific audiences.

What is the primary care strategy not?

The future model of Primary Care will integrate the roles of other professional groups such as clinical pharmacists, dentists and ophthalmologists. This will form the basis of further strategic development following the adoption of this strategy. This strategy is presented as a key building block for wider system reform recognising general practice is at the heart of the health system.

The primary care strategy aims to capture the core objectives of what the future model of general practice in Southampton should look like but is not an implementation plan – a delivery plan will form Phase 2 of the change process and actions will be developed across access, quality, workforce, infrastructure and collaboration. This strategy recognises the value of the traditional partnership model of General Practice, and seeks to build upon those strengths, whilst offering an alternative option. No practice will be compelled to enter into any new contract against their wishes.

How does this strategy align to the CCG's vision and transformation programmes?

Southampton City CCG believes that general practice provides the **foundation** for all other health services and that a strong and sustainable general practice is crucial to securing health care services in the future. Here in Southampton, there are significant programmes of transformation underway. General practice is one of the key strategic work programmes for Southampton City CCG in 2016/17 and beyond and will support the delivery of the CCG's overall vision to deliver *"A Healthy Southampton for All"*.

Our latest **GP patient experience survey** (July 2016) shows that we have strong local practices and are achieving comparable success in some elements of access to appointments;

- → 96% have confidence and trust in their GP *(95% nationally)*
- → 97% have confidence and trust in the nurse they saw *(97% nationally)*
- → 92% were able to get a convenient appointment *(92% nationally)*
- → 63% were able to see their preferred GP always or a lot of the time *(58% nationally)*

However, general practice in Southampton is under the same pressures as observed nationally and will need to work differently in order to remain sustainable– **workforce challenges, increasing elderly population, rise in prevalence of long-term conditions, increasing costs and increasing patient expectation** means that general practice needs to change radically if it is to be sustainable and meet the needs of our population.

Case for change

Case for change

National drivers for change

General practice is facing significant challenges which, if not resolved, will significantly impact the whole **health and social care system** and our ability to care for people effectively at home and in the community. It is the first port of call for the vast majority of the population, with over **90% of all contacts with the NHS taking place in general practice**, and if it fails the whole NHS will fail.

The GP workforce has expanded more slowly than the acute, hospital-based medical workforce and there is national concern around the intensity of workload in primary care. Total direct face-to-face and telephone contacts with patients increased by **15.4%** across all clinical staff groups between 2010/11 and 2014/15. During the same period, the average patient list size increased by **10%**. This is compounded by significant **workforce issues** - over the last five years there has been an increasing issue with the recruitment and retention of GPs, practice nurses and practice managers. In addition, there is a national shortage of GPs with many **retiring** early – some in their 50s.

General practice services also need to meet expectations to be more **accessible** to the population. For example, in a recent survey of patients in Southampton, feedback showed that high numbers of patients would like to see more evening and weekend appointments.

As also seen in the acute sector, the **population is becoming over-reliant** on general practice and we need to support our population to build independence and take responsibility for managing their own health wherever possible. National studies suggest that as many as **27% of face to face GP appointments could be avoided** given appropriate resources (including 7% of people who could be seen by another health professional and 6% who could self-care, i.e. manage their illness themselves). A survey of local practice managers suggests that the figure could be even higher.

An effective general practice model is critical to improving the health and wellbeing of our population and enabling people to be cared for at home. It is therefore important that the *GP Forward View* is delivered at a local level and resources are made available to support practices. This will require investment in general practice.

To help with the demand in hospitals and to cope with the rising demand in the community, the workforce both in general practice and supporting general practice, must be increased in addition to finding better ways of working that are more efficient. Increasing the number of GPs will only be achieved if general practice becomes a better place to work whereby those who feel they have lost control of their working days regain that control. The workforce must be further expanded by investing in other care professionals such as nurse practitioners, pharmacists, mental health workers. Social workers should also be aligned to general practices and work as members of an integrated health and social care team wrapped around the practice.

90% of all contacts with the NHS take place in general practice

If all of the 300 GP trainees in Wessex stayed in general practice, this would still not be enough to replace the number leaving the profession

300 million visits to GP practices each year, compared to fewer than 25 million A&E attendances

27% of GP appointments could potentially be avoided if there was more coordinated working between GPs and hospitals, wider use of other primary care staff, better use of technology, and wider system changes.
(Making Time in General Practice - NHS Alliance and Primary Care Foundation)

18% forecast increase in consultations by 2018

8.3 average number of GP consultations per year, per person (Nuffield Health) compared to 3.9 in 1995 (RCGP)

The *Five Year Forward View* outlines objectives around focussing on preventative care, empowering patients and puts forward a number of new innovative models of care which encourage integration and a whole person approach to delivery of care. It states that strong general practice and primary care services are essential for a high quality and responsive NHS, fit for the future.

GPs and practice teams provide vital services for people. They are at the heart of our communities, the foundation of the NHS and internationally renowned. However, with limited financial resources and a national workforce recruitment challenge, coupled with unprecedented pressure, it is clear that action is needed. It has been widely accepted for some years that the NHS is faced with the challenges of an increasingly elderly population with an associated rise in the prevalence of long-term conditions, increasing costs and increasing patient expectation and will need to change radically if it is to be sustainable and meet the needs of the population in the 21st century.

Case for change

Local drivers for change

In Southampton, primary care is under the same pressures as observed nationally. General practice still largely operates in small independent businesses and these have provided good care, particularly holistic and continuing care. However, it increasingly appears that this business model is unsustainable because of our local challenges;

Southampton's workforce challenges:

1 in 5 of the Southampton GP workforce is **aged 55+**, with many retiring early

Ageing practice nurse workforce

Insufficient numbers of GPs in **training**

Recruitment is difficult; practices carrying **vacancies**

Our quality and infrastructure challenges:

- Patient experience remains low compared to other city populations
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- Variations in the premises from which primary health care is delivered
- Information sharing across health and social care IT systems is suboptimal

Southampton's demography challenges:

15% increase in **over 65s** (2015-21)

20% increase in **over 85s** (2015-21)

23% of the population live in the **most deprived** small geographical areas **in England** (known as LSOAs – Lower Super Output Areas)

12% of the population is aged **20-24** (Higher than average student/younger population)

11,282 (4.6%) forecast increase in **the overall population** (2015-21)

22.3% of the population have a recorded ethnicity **of other than white-British**

People **die earlier** in the most deprived areas than those in the least deprived:

Women **3.2 years** earlier

Men **6.7 years** earlier

17.6% of the population were **born outside the UK**

300% increase in the population recorded in the **other white** ethnic group in the last 10 years

Southampton's health challenges:

20.3% of **children** in Year 6 are **obese**

22% of **adults are smokers**

25% of **adults are obese**

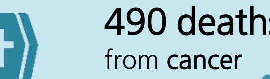
75% of the over 65s population is living with **2 or more long term conditions**

29,000 adults are registered with **hypertension**

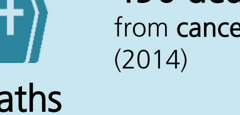
32% of the population (all ages) **have a long term condition**

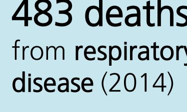
5,500 adults are registered with **COPD**

490 deaths from **cancer** (2014)



483 deaths from **respiratory disease** (2014)

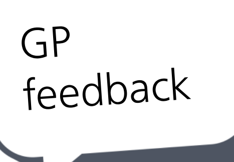




12,000 adults are registered with **diabetes**

15,000 adults are registered with **depression**

Listening to our GPs and patients



- In late 2015, we ran a survey and asked Southampton GPs for **their biggest challenges or frustrations in their day-to-day work.**
- This is what they told us and the key themes that came out;

TIME WITH THE PATIENT AND COMPLEXITY

"10 minute appointments are **never long enough** for most patients, they either have a list of problems or complex multi-morbidity"

"Over-running on a regular basis due to more and more **complex patients**, and those requiring more time"

CAPACITY AND WORKLOAD

"Not enough **time** in the day, too many targets to reach that takes time away from patients"

"So **busy** sorting the day-to-day stuff I can't look forwards"

PATIENTS

"Too many patients seeking medical appointments for social/non health related problems"

"Unrealistic and **unreasonable demands** from the public. General lack of common sense, inability to cope with minor illness"

INTEGRATED WORKING

"**Poor interface** between primary, secondary and community care. Time wasted trying to ring back social workers and members of community psychiatric services"

STAFFING

"We are running so tight that any unplanned sick leave or annual leave completely throws the practice"

SATISFACTION

"Each day is **14 hours** long with a minimum of 3-4 hours of **administration**"

"Having to spend so much time dealing with minor problems by telephone triage and proportionally less time dealing with medical problems that use my experience"

DEVELOPMENT

"Lack of **support** for GP's wishing to develop leadership **skills** to fill gaps left as our Senior colleagues retire in next 5 years"

Patient feedback

- We also ran a survey and asked Southampton patients for the **three things they most value about their GP service**.
- The three areas below received the most votes and this is what they told us;

APPOINTMENTS (ACCESS)

"Get an **urgent, same day** appointment when I need one"

"Speaking to a GP on the **phone**"

"Making an appointment for a non-urgent matter in advance, at a **convenient** time"

"**Early** and **late** appointments for workers"

"Having a GP practice **close to my home**"

SERVICE

"Caring and **person-centred** approach"

"**Preventative** measures, such as injections for influenza"

"Personalised services"

"Good organisation and **communication** between staff and patients"

CONTINUITY

"Seeing my **GP who knows me**, or seeing an alternative GP who has enough **information** in front of them to know about me and what's going on with me"

"Records **sharing** between GPs and other health staff"

"My GP reviews the **whole picture** of all of my long term conditions, not just the one thing I'm seeing her about today"

Our vision

Our vision on a page

Our Vision

Building a model of general practice in our city that will be the strong, effective and sustainable foundation of our integrated health and social care system.

Our Objectives

- Primary care services that are responsive to change and working effectively as part of a **whole system** to meet the needs of the population;
- Equitable, **person-centred** primary care for a registered list of patients benefiting from improved access to services and **continuity of care** where needed;
- **Collaborative** model that appeals to professionals;
- System-wide culture of **learning** and **continuous improvement**;
- People are educated and empowered to take responsibility for **managing their own health,** with a particular focus on **prevention;**
- Health and social care based around **clusters of practices** in a neighbourhood;
- Primary care system based on **quality** and reducing health inequalities where possible;
- **Technology** options are readily available to support the care of those people who prefer that option.

Our key areas of focus and outcomes

Access

- ✓ People can access their surgery **8am to 6.30pm**, Monday to Friday
- ✓ Pre-booked and same day appointments, **7 days** a week
- ✓ Integrated community based primary care pathway for **urgent care** 24 hours and 7 days a week
- ✓ Patients are encouraged, educated and empowered to **manage their own health**
- ✓ Innovative **technological solutions** to support access are embedded

Quality

- ✓ Reduced **variation** in the quality of care delivered across all practices
- ✓ Standards for **screening** and **immunisations** are achieved
- ✓ Improved patient **satisfaction** and **experience**
- ✓ Health professionals have all the **clinical knowledge and skills** required to deliver safe and effective care
- ✓ Practices are engaged in **incident/event reporting**
- ✓ Practices are **rated good/outstanding** by the CQC

Workforce

- ✓ Practice teams are **motivated and engaged**, incorporating a range of skilled professionals
- ✓ Professional **development** and **succession** planning are embedded principles
- ✓ GPs and other health and care professionals working in the city are **supported** to achieve their preferred **career pathway** and develop special interests, so facilitating recruitment

Infrastructure
(Estates and technology)

- ✓ Modern premises that are **fit for purpose**
- ✓ Flexible, **multi-use space** is available which is adaptable to service needs
- ✓ A **resource centre** is located in each of the six clusters across the city
- ✓ Clinical **computer systems** are **interoperable**, i.e. provider systems are connected, facilitating communication and information sharing
- ✓ Innovative **technological solutions** which empower people to manage their health

Collaboration

- ✓ GP practices operating within a business framework that ensures **sustainable** primary care
- ✓ Practices are **working together** to build a resilient service which operates **at scale** but remains focused on the registered population
- ✓ Primary care is fully engaged with the local **integrated provider** group, i.e. the cluster.
- ✓ The **operating model** delivers improvements to health outcomes, patient experience, access and workforce

The future model of primary medical care

At the centre of this model is the **patient**.

To meet the needs of a changing population and those of an evolving health and social care system, primary care in Southampton must:

City
Cluster
Practice
Patient
Self-care & prevention
Integrated
Integrated
Integrated
Out of hours GP services
GP services evenings & weekends
Daytime GP services Mon-Fri
Primary Care Services
Integrated Services
Specialist Services

1. Generate a **viable, sustainable** service that is, and continues to be, responsive to the needs of all registered patients, recognising the variety and diversity of those communities and their needs, and providing them with access to the level of care that they need at the appropriate time.
2. Be creative in the approach to service provision, **working in collaboration** as required to balance same day access for treatment of acute illness with **continuity of care** and **proactive care planning** for those with routine or ongoing health needs, providing services in the **evenings** and at the **weekend** in a way which is simpler to access and navigate.
3. Take a **multi-disciplinary** approach to the provision of primary care services, with other health professionals such as nurses (including mental health), clinical pharmacists and therapists actively caring for patients as part of an **extended practice team** and supporting the delivery of Better Care and the STP.
4. Ensure that people have **access in a primary care setting,** such as a GP surgery or health centre, to the health professional best able to support them, with co-ordination and oversight provided by the GP, recognising the health benefits to be gained by **working more closely with other primary care services**, such as optometrists, dentists and community pharmacists.
5. Focus on **improving quality and health outcomes**, with particular emphasis on **preventing illness, safe care, proactive care planning, self-management** and using the principles of **making every contact count**, with the patient firmly at the centre of their care arrangements.
6. Embrace **innovation** and utilise **technology** to provide alternative solutions to traditional methods of delivering care.
7. Create a structure that supports **workforce development** by providing entry points and learning opportunities at all stages in the professional career pathway, supported by flexible contracting arrangements (independent or employed) that meet the needs of individuals.

The future model – key areas of focus

Access	▪ Patients are still registered with a **local practice** which has its own team of doctors, nurses and other staff. ▪ Improved access arrangements mean that people can book a planned appointment in their own surgery during normal working hours or they can choose a more **convenient** time in an alternative location within the cluster across **7 days** a week. ▪ Having an **extended primary care team** to absorb some of the more routine work means that GPs have more time to spend with people with long-term chronic illness or complex health needs who need more support (GP led rather than GP delivered).	▪ GPs, practice nurses and other practice staff work mainly in their own practice but may also spend time working as part of a **cluster or city-wide arrangement** which provides services 7 days per week and out of hours. ▪ Access to **urgent primary care** will be simplified across the system.
Quality	▪ Consistency of care to **reduce health inequalities** and support patient empowerment for **self-care** impacting on population health and wellbeing. ▪ Through clinical and management leadership providing **best care and best experience** for people and carers across all health and social boundaries. ▪ Practices throughout the city are rated as **good/outstanding by the CQC**.	▪ Adopting **new technologies** and innovations in healthcare to enhance patient care and quality of life. ▪ Developing key **skills, knowledge and experience** of all general practice staff to support right care, in the right place by the right person .
Workforce	▪ Nurses and other health professionals have an **extended role** in the primary care team, including; nurse triage for same day appointment requests; medication reviews and nursing home support from clinical pharmacists; management of musculoskeletal conditions by a physiotherapist or extended scope practitioner; a mental health worker to support people with low-level mental health needs.	▪ There is plenty of **opportunity** for GPs and practice nurses to develop special interests and work closely with specialists.
Infrastructure	▪ Practice premises are **modern, accessible and efficiently** run. ▪ Fully **digital primary care pathways** will be in operation and working effectively as part of the local health system, such as; online assessment and self-help advice; online consultation; online appointment booking and prescription ordering and tracking; home monitoring and tele-healthcare. Patients and staff will be supported to make best use of these options.	▪ IT systems are fully **integrated** across primary, community and secondary care services and, with patient consent, clinicians have access to a patient's electronic medical record regardless of which service is being used.
Collaboration	▪ GPs work **collaboratively** in a new workforce structure that allows them to spend more time with their patients, to meet the growing demands of an aging population and fulfil the expectations of a more accessible service. ▪ An acute **home visiting service** operates during working hours, so GPs now only visit people who have complex problems or who need end of life care. Housebound people and those in nursing and residential homes are looked after by a special team which includes a GP, a community matron and a physician for older people. ▪ All practices are part of a wider cluster network of services, along with other practices in the neighbourhood. This helps to provide access to a broader range of specialist clinical staff and services close to the patient's home.	▪ An **integrated primary, community and social care team** work together to care for people with long-term chronic conditions. The GP and other health professionals involved in a person's care work together to agree a care plan which is accessible at all times. The plan includes the person's personal health goals, guidance and support on managing their condition themselves and advice on what to do if they become ill.

The future day in the life of a patient...

I have a new medical problem...

- I need some advice about a new medical problem and I go online to my surgery website. I'm taken through an **online assessment** which gives me some initial advice and guidance on **managing my condition myself** and takes account of my pre-existing conditions.
- If I need support from a health care professional I will be directed to the member of the **primary care team who can best meet my needs**. This may be a GP, nurse, pharmacist or other health or care professional. Today I am advised to see a GP who will be able to see the assessment I have already done.

My consultation options...

- There are a number of consultation options open to me such as **online consultation, telephone support or surgery appointment**, all of which are bookable online via the surgery website or by telephone.
- I have a **choice of day, evening or weekend** appointments either at my own surgery or at another location in my neighbourhood.

During my consultation...

- There is **sufficient time** given for my consultation to meet my needs. My doctor suggests investigations and discusses **a management plan** with me. I am able to have the **blood tests straight away**, and the physician's assistant is able to organise the **onward referral** for hospital-based investigation with me, rather than the doctor.
- If I have any investigations, I am able to either check that they are all normal by **logging onto the practice App**, or will be contacted by the physicians assistant to explain the issues and arrange any further follow-up needed.

My prescriptions...

- I enquire about a repeat prescription at reception; it has been sent **electronically** to my preferred pharmacy. The surgery pharmacist suggests I book in with her for a **medication review**.

My feedback...

- After my appointment I get an email from the surgery **asking for feedback on my experience** to help them improve their services, which I take a few minutes to complete and send back to them.

Later that evening...

- If my condition deteriorates at 9 o'clock that evening, I contact **NHS 111** and after completing an assessment process I am put through to an experienced GP who is able to **access my complete medical records**. I am offered an appointment at my **local cluster hub**, so it is not too far for me to travel.
- The out of hours doctor **updates directly into my own GP's records** and notifies the practice that I have been seen and sends a separate alert of any urgent actions which need to be taken.
- I know that, unless it is a life threatening emergency when I would need to be seen in the emergency department, **all of my care is centred around my GP practice**, which I will contact with any concerns.
- If I need to be seen outside the normal surgery hours of 8am to 6.30pm or I opt for a more convenient evening or weekend appointment, I understand **that I may have to travel a short distance to my local hub**, of which there are three across the city.

My overall experience...

- My experience of using primary care services today has been **very positive.** I have been able to access both advice and services in a way that not only addresses my needs but also suits my preferences.

The future day in the life of a GP...

Consultations and home visits...

→ There is a **designated doctor** available to deal with **urgent** patient enquires, clinical queries and calls from other health professionals. This may be in my practice or provided by a central service in the evenings.

→ The people I consult with today will already have been through a **triage process or online assessment**, the details of which are available to me in the clinical record. My consultations are a mix of **surgery visits, telephone calls and online consultations**.

→ The **health professionals** who manage the routine care of my housebound patients and nursing or care home residents are a critical part of my practice team. My home visits are now focused on providing end of life care and responding to requests from clinical colleagues.

→ Acute home visiting is now managed on a **locality basis** and the GP working in that service can view medical records with patient consent and **update directly into the record**. I am alerted to any follow up actions requiring attention.

Collaboration...

→ My primary care team includes **other clinical disciplines** which allows my patients with complex needs to schedule one appointment to review their medical, nursing, pharmaceutical and care planning needs at a single visit.

→ I no longer have to spend time trying to sort out system wide problems because there appears to be nobody else willing to take responsibility. The wider integrated primary, community and social care **multidisciplinary team (MDT)** now collectively takes responsibility for each patient and has an **allocated care manager** responsible for coordinating their care.

→ I also have meetings about **significant events** with my MDT colleagues.

My time...

→ I have more time to spend with **patients with more complex needs** now that people are better supported to **self-manage** and some of my workload has moved over to other practitioners. I also have time for reviewing test results, correspondence and emails.

→ Any tests or investigations I have ordered today were arranged **electronically** to avoid delay and duplication of effort.

→ At the end of the day there is **time to catch up** with colleagues and complete outstanding admin and paperwork.

→ My days remain full but they are **manageable** and I am less frustrated as the interface between services is working effectively and demand is more reasonable.

My development...

→ Not only do I provide clinical sessions in my practice but I also work additional sessions **in other specialist areas** that interest me and keep our health system thriving. I am involved in **GP training** and a **mentoring programme** which encourages GP growth and development opportunities.

Key areas of focus

Access

Quality

Workforce

Infrastructure (Estates and IT)

Collaboration

Access

Overall objective: People are provided with access to the level of care that they need at the appropriate time, with same day access and services available in the evenings and at the weekend, 7 days a week.

What will success look like?

People can telephone or visit their surgery any time between **8am and 6.30pm**, Monday to Friday.

Pre-booked and **same day** appointments are structured across **7-days per week** to meet peoples' needs.

Providers of primary and secondary care services work together to co-ordinate a fully integrated community based primary care pathway for **urgent care 24 hours a day, 7 days** a week.

Patients are encouraged, educated and empowered to **manage their own health** and understand when clinical intervention is needed.

Innovative and **technological solutions** to support access, for example online consultations, apps, home monitoring and telemedicine, are embedded as part of core primary care service delivery.

Creating sufficient capacity within primary care will ensure people have a good experience and encourage them to choose primary care as their first point of contact. Whilst patients may continue to access non-urgent or routine care from the surgery where they are registered, they may also choose a more convenient appointment in the evening or at the weekend at a different location.

Professional clinical advice will be available to all patients within Southampton 24 hours a day, 7 days a week to meet urgent medical needs. The challenge moving forward is to integrate and simplify services in a way which enables patients to understand where and how to access care when they need it. This may be at their surgery during the day or at a hub or primary care centre outside of surgery hours.

Prevention, self-management and care planning are key factors in managing demand. People will be supported to manage their own health where possible and to access professional advice when needed. Adoption of digital ways of working will be promoted to support this. This includes digital access to appointment booking, online assessment for acute problems, prescription ordering and medical records, as well as encouraging people to manage their health and wellbeing through easy access to advice and self-care tools. Self-referral routes will be available to support direct access to appropriate specialist services without the need to see a GP first.

Long term illnesses will be supported by digitally enabled pathways of care, for example allowing people to self monitor conditions using their own devices (such as phone, computer or medical device) and share data with their NHS record. This will enable online assessments to be completed to streamline the annual review process for both patient and practice.

Overall objective: People are provided with high quality care which is safe and effective, meeting their needs. People have a positive experience, which is dignified, compassionate and focused on them as a person.

What will success look like?

The quality framework shows evidence of **reduced variation in the quality of care** delivered across all practices

Expected standards for **screening** and **immunisations** are achieved across the whole population, using the principle of making every contact count

Patient reported outcome measures such as the GP Patient Survey and Friends and Family Test demonstrate improved **satisfaction** and **experience**

Health professionals have all the **clinical knowledge and skills** required to deliver safe and effective care to meet the needs of the population

There is evidence that practices are engaged in **incident/event reporting** and peer review to support a culture of ongoing **learning** and **development**

Practices throughout the city are rated **good/outstanding by the CQC**

Some variation is to be expected as a result of individual needs and preferences and the variability of populations; however, it is important to ensure that any unmet needs are addressed. Exploring and understanding variation between practices allows sharing of best practice and helps to narrow the gap.

There are a number of factors that may influence outcomes and create variation including; clinical knowledge and skills, patient preferences and choice, and availability or proximity of services.

A good example of how quality variation is being addressed is through the Diabetes Accreditation Scheme. Diabetes continues to be a priority for the city and work is ongoing to improve outcomes.

The CCG is developing a quality framework model for general practice to identify core standards of quality and provide an opportunity for continuous improvement. The high level indicators to identify the domains of quality will be;

- Leadership – corporate responsibility and accountability for service delivery and improvement in general practice
- Patient safety and experience – ensuring safe and compliant services in a patient focussed system
- Workforce and workload – supporting the management of service demands, competence and capability of staff and improvement in general practice
- Population outcomes – responsibility for the health and wellbeing of population
- Performance – accountability for delivery of indicators and targets as agreed

The quality framework model is still in development and is taking account of both national and other CCGs' best practice. A wider discussion with local GPs is planned over the next few months before the model is adopted by the CCG. Once agreed it will be a valuable asset to monitoring progress of transforming general practice in Southampton.

Workforce

Overall objective: Motivated, engaged and integrated workforce with the right skills, behaviours and training, available in the right numbers.

What will success look like?

Practice teams are **motivated** and **engaged**, incorporating a range of **skilled professionals** delivering the appropriate level of care to meet patients' needs.

Professional **development** and succession planning are embedded principles for all providers.

GPs and other health and care professionals working in the city are supported to achieve their preferred **career pathway** and develop special interests, so facilitating recruitment.

20% of the Southampton GP workforce is over 55, with many taking early retirement (GP workforce audit 2015). This coupled with a shrinking GP talent pool at national level, calls for modernisation of the workforce model locally to ensure the city can successfully compete in the skills market.

The future primary care workforce model includes a range of skilled professionals including GPs, nurses, pharmacists and allied health professionals. These will be assisted by trained support staff including health care assistants, mental health workers, clinical support workers and other similar roles. The emergent new model of primary care will help to attract professionals into the area and build resilience into the primary care system. Career development opportunities will be available across all disciplines allowing professionals to build a portfolio career, gaining experience in other specialist areas. The workforce structure will allow flexible working arrangements that improve work/life balance.

The plan requires strong leadership for successful implementation and local providers are asked to adapt to meet the changing needs and work to create these new roles.

Infrastructure (estates and technology)

Overall objective: Fit for purpose premises which enable access to clinical services out of hospital, 7 days a week. Interoperable, integrated IT with innovative digital solutions which enable proactive care, better access, better coordination and modern care.

What will success look like?

Completion of a **modernisation programme** ensuring that primary care premises are fit for purpose, provide increased capacity and enable services to be delivered 7 days per week.

Flexible, **multi-use space** is available which is adaptable to service needs and can accommodate innovative and collaborative projects for health and social care provision in partnership with other agencies.

A **resource centre** is located in each of the six clusters across the city providing; a multi-occupancy base for the integrated team supporting all practices in the cluster; multi-use space for training, outreach services and other local initiatives; and information and tools to support people to manage their own health.

Premises and **technology** developments support a culture of learning and education for both staff and patients.

Clinical computer systems are **interoperable**, facilitating communication and information sharing between all parts of the health and care system.

Creative and innovative **digital solutions** which support and empower people to manage their own health are embedded.

Across Southampton, there is variation in the standard of general practice premises. Some practices have insufficient space to deliver care that consistently improves outcomes for patients, including meeting regulatory core standards. Premises are also a limiting factor in plans to enable collaborative working, including extended hours and reducing reliance on hospital services. Delivering the ambitious plans for collaboration and primary care working at scale will be dependent upon having an estates infrastructure that is capable of supporting this new arrangement.

Resource centres will be co-located with a practice in a central location within each cluster and have easy geographical access. The facilities provided will support and empower peoples' self-help, education and healthy lifestyle with a view to managing their own health and wellbeing. This will include self-monitoring (blood pressure, weight etc.) and also online and printed information and tools to help with self-management of specific conditions. A modernisation programme will ensure that these facilities and the other practices that they support are suitable for delivering primary medical services today and into the future.

The government has made a commitment that all patient and care records will be digitally interoperable and paperless by 2020 and CCGs are required to have a digital roadmap (local technology plan) by the summer of 2016 to deliver this. This will reduce risk, waste and inefficiencies within the system, leading to a better experience for people and clinicians alike. Technology is a key enabler to deliver:

- proactive care, for example through online wellbeing assessments, health improvement resources or support communities,
- better access, for example with online service portals, telephone assessment and email appointment systems,
- better coordination, with interoperable systems allowing clinicians to share agreed information across organisational boundaries,
- modern care, for example, remote monitoring and diagnostic devices.

Collaboration

Overall objective: Sustainable and resilient GP services support delivery of integrated care in the city.

What will success look like?

GP practices operating within a **business framework** that ensures sustainable primary care.

Practices are **working together** to build a resilient service for the future, which operates at scale but remains focused on the registered population.

Primary care is fully engaged with the **local integrated provider group** to deliver true person centred, integrated care.

The **operating model** delivers improvements to health outcomes, patient experience, access and workforce development.

Collaboration, i.e. practices working together, is seen as a key enabler to the successful delivery of change initiatives. We are seeing GP practices throughout the country starting to work more closely together in order to maximise the use of their resources, be more innovative with the services they offer patients, and ultimately provide higher quality patient care. It is widely believed that new ways of working across general practice will be a key factor in ensuring a resilient service in the future and we firmly believe the development of collaborative working is essential. It will also facilitate the delivery of services that may not be easily delivered by an individual practice, such as such as appointments in the evening and at weekends, integration of extended access with out of hours and urgent care services, and other services developed at a population based level.

The move for new ways of working has been promoted by the NHS Five Year Forward View along with the NHS General Practice Forward View as the way forward for practices at a time when people are living longer and developing more complex health and care needs.

Our vision for primary care will only be possible if the service is supported by a robust and viable business model. Where the partnership model is working well, this will be supported to continue. However, we do need to develop alternative models for those people and practices for whom the traditional model of general practice partnership is not attractive or sustainable. The voluntary multispecialty community provider contract is one option and will be available from April 2017. Practices can opt to remain outside this alternative contract. All changes to practice service delivery are subject to NHS policy and require approval from the CCG.

In Southampton, primary care is under the same pressures as observed nationally and we are already beginning to see collaboration in action; for example, practice mergers. The numerous benefits include:

- by combining office functions, supplier contracts and administrative and management processes, the practice becomes more financially viable.
- as a result, smaller practices can benefit from services that have traditionally only been affordable for a larger practice such as nurse practitioners or phlebotomists.
- a larger practice is able to offer a wider range of wellbeing services which support people with complex health and care needs.
- pooling clinicians means that a wider range of hours can be covered thus offering patients greater choice.
- a larger support team can lead to a reduction in administration time for clinicians allowing them to concentrate on patient care.
- there is a bigger support network for new GPs which can make a practice a more attractive prospect in the job market.
- pooling resources allows creativity and innovation to flourish which leads to a better experience for patients and a better working environment for staff.

Next steps – planning for successful delivery

Next steps – planning for successful delivery

The transforming primary medical care strategy aims to capture the core objectives of what the future model of general practice in Southampton should look like. In starting to explore how we can influence real transformational change in general practice across Southampton, we need to consider funding and workforce requirements, GP ownership and the development of a delivery plan.

Next Steps	
Funding	▪ The *General Practice Forward View* recognises that primary care has been underfunded compared to secondary care over a period of years. ▪ The changes required to deliver this strategy, such as workforce and estates, cannot be made without significant investment. ▪ Financial resources will be available to deliver change programmes, not to support the existing arrangements ▪ The government has pledged to invest a further £2.4 billion per year into general practice by 2020/21. For Southampton, this means that over the next five years the CCG will receive growth in primary care funding of £6.93m. This is, over those five years, a 22% increase on 2015/16. This increase assumes a growth of 2.93% in our list size over this period. ▪ In addition to this increase, further funding will be made available to support the development of new models of care as described in the *Five Year Forward View*. Access to this funding will be linked to transformational change programmes designed to deliver general practice at scale. ▪ Capital funding will be available to develop the infrastructure necessary to support these change programmes.
Workforce	▪ A workforce of appropriate number, skills and roles is imperative for transforming care. ▪ In January 2015, a national £10m ten point plan was released, focussing on recruitment, retention and supporting those who wish to return to general practice. ▪ To compete successfully in the recruitment market, we must create an infrastructure which will support and encourage learning, growth and development of all primary care practitioners and also provide flexibility and career development options to meet the needs of a new generation of health care professionals.
Leadership	▪ Given the national drivers and the impact these are having on practices locally, there is a certain inevitability to change. ▪ Culture and behaviour change is a key factor in success. It requires ownership of both the problems and the solutions by everyone involved including patients, GPs and all other clinicians and staff. ▪ Successful implementation of Transforming Primary Medical Care in Southampton will require the enthusiasm, commitment and support of all GPs and practice staff working in the city. ▪ There will be continuous engagement with patients and other stakeholders throughout the life of the strategy, to ensure a co-productive, i.e. joint, approach and to influence behaviours, perceptions, expectations and cultures to support the new model. ▪ Recognising the need for change is the first step on the transformation journey. Examples of initiatives that are delivering results in other areas are already emerging, for example Making Time in General Practice. There are also a range of organisational development tools available to support practices in identifying areas where change can make a positive difference.
Delivery plan	▪ Development of a detailed delivery plan is in progress and will form phase two of the change process. The delivery plan will be submitted to NHS England on 23rd December to demonstrate the CCG's plan to implement the General Practice Forward View (GPFV). ▪ Actions will be identified in each of the five key areas of focus; access, quality, workforce, infrastructure and collaboration. The markers of success identified for each of these areas will be used to map the changes necessary for achievement. ▪ Communications and engagement will be an integral part of every element of the delivery plan.

Who’s who?

Who's who?

NHS Southampton City Clinical Commissioning Group (CCG)

Our purpose as a CCG is to help meet the health and care needs of local people. Southampton City CCG is allocated a budget of around £350 million a year to achieve this and use it to plan and pay for (or 'commission') health and care services from a number of service providers (such as hospital, mental health and community trusts). CCGs were established in April 2013 with a clear remit to ensure that family doctors and other clinicians play a leading role in deciding and directing how local NHS resources should be used.

Southampton City Council and other health and care partners

The CCG works closely with the Council and other partners to ensure the right services are in place for the community. The CCG pools £68 million of their budget with £28 million from the Council in order to progress the vision for Better Care in Southampton, to integrate health and care services in order to improve people's quality of life.

Southampton Primary Care Limited

Southampton Primary Care Limited was formed as a legal entity in November 2014. It is a federation of 29 of the 31 city GP practices; the member practices are the shareholders with voting rights linked to the practice population (1 per 1,000 registered patients with a maximum of 10 votes per practice).

NHS England

NHS England sets the priorities and direction of the NHS, shares out more than £100 billion in funds and holds organisations to account for spending this money effectively for patients and efficiently for the tax payer. This includes the commissioning of contracts for GPs, pharmacists, and dentists and they support local health services that are led by CCGs.

STP

Every health and care system in England has produced a Sustainability and Transformation Plan, showing how local services will evolve and become sustainable over the next five years. Southampton is part of the STP being developed for the whole of Hampshire and the Isle of Wight.