Coventry City Council

Briefing note

To: Health and Social Care Scrutiny Board (5) **Date: 21/11/17**

Subject: Primary Care Sustainability and Planning

1 Purpose of the Briefing Note:

1.1 To inform Health and Social Care Scrutiny Board (5) of the current position of primary care within Coventry and outline future primary care planning arrangements.

2 Recommendations:

2.1 Health and Social Care Scrutiny Board (5) is requested to consider the content of this report and make any comments that may assist NHS Coventry and Rugby Clinical Commissioning Group (CRCCG) and its health and social care partners in ensuring that future arrangements for General Practice are sufficiently robust to meet population needs.

3 Context and Background:

3.1 NHS CRCCG is a clinically led, membership organisation which has been in existence since 2013. The CCGs membership is derived from local General Practice provider contract holders. The CRCCG has 59 member practices located in Coventry. These practices make up the general practice provider market for providing primary care medical services for registered patients across Coventry. The practice membership includes 9 single handed practices as well as practices with multiple partners.

3.2 The number of patients registered at each practice varies considerably, the smallest practice having a registered population of 582 patients (Anchor Centre), to the largest practice with a registered population of 23,202 (Engleton House Surgery (includes Coventry University branch)). The CCG area includes practices covering a diverse population in terms of socio-economic demographics delivered from a range of premises in a variety of locations. The general practices estates profile includes premises which are directly owned by General Practice contract holders as well as premises which are leased from third parties or NHS Property Services. The CCG does not own, nor is permitted to own estate.

3.3 Providers of general practice services are independent contractors within the NHS family, and their responsibilities include delivery of a nationally prescribed Core Contract for specified primary care services. Each contract holder is responsible for the employment of staff required to deliver the requirements of their contract. General Practice contractors are required to provide specified primary care services to their registered patient list based on a geographical boundary. General practice has an obligation to register patients within the

contract prescribed boundary unless the contractor applies to the CCG through a formal process to 'Close Registrations'. List boundaries are usually but not exclusively a 2 mile radius from the practice site. Patients have a statutory right to choose to register at a local practice of their choice if they live within the practice boundary and the practice is taking new registrations.

3.4 The commissioning, contracting and performance responsibilities for General Medical Services provided in Coventry resides with the NHS Coventry and Rugby CCG under a delegation agreement with NHSE. NHSE however, retains the statutory responsibility for all General Practice contracts nationally. NHSE also retains a range of other primary care commissioning responsibilities for services such as Dentistry, Ophthalmology, and Pharmacy.

3.5 The table below provides an at a glance profile of general practice in Coventry:

	CRCCG
GP practices	58 practices in Coventry
Population	Coventry only population is c.345,000
Primary Care Delegation	NHSE Delegated responsibility to manage the GP Contracts on their behalf from April 17 responsibility
GP /Alliance	55 Practices
Main challenges	Health Inequalities – poorer health outcomes Areas of Significant Deprivation Growing population / Housing Developments Growing University population Concentrated number of smaller single handed practices (Coventry city centre)
Top 5 Workforce Priorities	Single Handed Contract holders – business continuity risk Diverse Population different needs Aging Workforce / Retirements Development of MDT and integrated working / new models of care. Introduction of new roles within primary care e.g. Clinical Pharmacists, Physician Associates, Mental Health Therapists Estate and technology to respond to new models of care & new consultation types

3.6 This background information provides important context responses to each of the lines of enquiry which the Health and Social Care Scrutiny Board (SB5) has requested, which are addressed in turn below:

4 Definition of primary care:

4.1 It is important to understand that the term 'Primary Care' collectively encompasses a widerange of contractors and services including: pharmacists, opticians, dentists, and General Practice. One overarching definition of the services provided by Primary Care is set out below:

4.2 Primary Care encompasses all health care taking place outside acute and mental health trusts, and is the cornerstone of the NHS: each year in England alone there are approximately 300 million consultations in general practice with nearly 800 million prescriptions dispensed in the community. Primary care is a multidisciplinary aspect of healthcare with a whole range of professionals contributing to the care of individual patients. Many patients are seen in their own homes by a variety of community services, and larger numbers of complex procedures and interventions are now taking place in a primary care setting. General Practice is the first line for patient care and co-ordinates service delivery for our local population / community. GP practices provide a 'cradle to grave' set of services for their registered patients, based on the individual and according to need. (*Source: National Patient Safety Agency*).

4.3 To further develop primary care locally, and in the context of the General Practice Forward View, CRCCG has been accepted in to a national primary care development programme led by the National Association of Primary Care called Primary Care Home. This programme focuses on supporting primary care collaboration and delivery around registered patient lists of around 30,000, to 50,000 to deliver 4 core objectives:

- Patients' first point of contact with the health and social care system
- Provide the majority of preventative and curative health needs, health promotion and care monitoring requirements
- Personalised approach to health care rather than disease focused
- Comprehensive services delivered by multi- professional teams focus on population health needs that Co-ordinate the integration of care in partnership with patients and care providers.

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5 Quality and Performance Management of General Practice:

5.1 Contracts for primary general medical services in Coventry include both General Medical Service contracts (GMS) which are contracts which are not time limited and Alterative Provider Medical Services (APMS) contracts which are competitively procured and have a contract life cycle of typically 5 years.

5.2 In Coventry there are 52 GMS contract holders and 6 APMS contracts with 1 practice remaining that holds a PMS agreement. GMS and APMS contracts are based on a nationally agreed specification. The national specification does not require general practice to offer a set number of consultations per registered population nor does it require a practice to provide a minimum patient to clinician ratio. However, the contract does set out the services that general practice should provide and also sets out the core hours that GP contract holder should offer, this being 8:00am to 6:30pm Monday to Friday. Under delegation the CCG is responsible for the overall performance management and quality assurance of general provider contracts. However individual GP performer standards and clinical competence assurance is retained by NHSE. As outlined in the CCG profile table above the quality of local general practices is very good as validated by CQC inspections which are undertaken independently from the CCG. The CCG monitors a range of indicators to assure the quality of general practice which include: Patients Experience - captured through feedback, surveys, complaints; Patient Safety - including incident reporting, policy and procedure compliance for example safeguarding; Patient Outcomes: through a range of clinical indicators related to the management of conditions. The CCG works with practices on action plans to address any areas identified as requiring

improvements and regular reports on quality are provided to CCG's Primary Care Committee; which is held in Public and has a representative from Health Watch as an observer member.

5.3 In Coventry we have:

- 2 practices rated overall outstanding
- 49 practices rated overall good
- 3 practices rated overall requires improvement
- 1 practices rated overall inadequate
- 3 Practices still awaiting inspection

6 Key Pressures on General Practice:

6.1 The key pressures locally reflect the pressures recognised nationally in the General Practice Forward View.

These being:

6.2 **Workforce and Work Load**: There are approximately 228 FTE GPs and 119 FTE nurses working in general practice across CRCCG, (*workforce data available is only provided at a CCG foot print cannot extract Coventry alone*). This equates to an average ratio of 2,158 patients per GP and 4,121 patients per Nurse. Compared to the national average, there are 206 more patients per GP and 487 more patients per Nurse. (General and Personal Medical Services, England September 2015 - March 2016; publication date: 27 September 2016). This data highlights that current demand pressures experienced by our existing clinical workforce are higher than the national average and may explain levels of staff turnover, sickness etc.

6.3 Evidence from existing workforce base line data also highlights that 31% of GPs are over 55 and 37% of nurses are over 55 across CRCCG. Local trends also indicate that around 50% of GPs / Nurses in this age range are likely to retire within 5 years.

6.4 Currently, there are a limited number of other allied professional groups employed in our local primary care workforce. Consequently, developing wider skill mix and encouraging the employment of allied health professionals within primary care will need to be supported and potentially incentivised to fill the anticipated GP deficit for our area.

6.5 Improvements in life expectancy associated with a growing ageing population, often with complex, multiple conditions, that require longer consultations to deliver personal and population-orientated primary care; has been evidenced to increase workload and demand for consultations, some of which may not require a clinical consultation and could be delivered by alternative workforce skill mix or through self-care or social care.

6.6 **Patient Expectations and national requirements for Improved Access (including evenings and weekends):** By 2018 the CCG is required to provide the population of Coventry with access to same day urgent appointments to 100% of the local population. The CCG has received additional funding to achieve this new requirement; currently coverage is approximately 78% of the population. Whilst we have plans in place to deliver improved access, this adds further demand for skilled clinical workforce to deliver extended

service provision. Demand for clinical workforce has driven up the costs associated with locum cover and salary rates for GPs.

6.7 These pressures collectively result in a projected net gap in GP supply and patient demand. Modelling undertaken as part of the STP Primary Care Workforce Strategy using the Health Education Demand and Supply tool, outlined in the table below, indicates that the gap between the number of GP FTEs and demand, by 2020, will be 91 FTE GPs.

	Baseline GPs and Locums	Supply/Demand gap if nothing changes (inc no increases in population) – 5 years	Population demand impact (ONS adjusted for under 10s and over 55s) 2022 (5 years)
C&RCCG	238	76	91

6.8 This projected gap is likely to be further exacerbated by new housing developments as illustrated in the table below. Consequently, it is imperative that infrastructure development plans recognise the increasing demand resulting from population growth and new housing developments. Accessing funding through 106 applications will be a priority as will flexible and creative use of these funds to assist with workforce pressures not just estates infrastructure.

CCG	Registered Population 2016	GP per Population 2014	GP per Population 2016	Number of homes planned 2017-2020	Additional patients 2017-2020	Number of GPs required (WTE)
Coventry & Rugby	491,624	1:1,325	1:2,158	5,994**	14,266	6.6

6.9 There is action both locally and nationally, aimed at addressing workforce issues. We are currently tackling immediate issues as well as developing a Workforce Strategy and Implementation Plan which should be completed before the end of this financial year. This will include developing new ways of working through the development of new staffing groups such as (but not limited to):

- Physicians Assistants, Clinical Pharmacists, Mental Health Workers, and Social Prescribing;
- Upskilling existing staff groups to develop career pathways and an improved skill mix within Primary Care working to their optimum competence to reduce unnecessary demand on GP time;
- Developing new pathways into a career in primary care, targeted recruitment and retention activities including GP International Recruitment to increase the workforce supply to primary care;
- National pilot retention opportunities aimed at delaying or offer alternatives to retirement and incentivised recruitment schemes and marketing to attract workforce to the local area.

6.10 It is estimated that up to 26% of demand on GP time could be avoided (*NHSE Releasing Demand In General Practice, NHS Alliance Study 2015*). This study found that a number of patients could have been better served by being directed to someone else in the wider primary care team, either within the practice, in the pharmacy or to a so-called 'wellbeing worker' (e.g. care navigator, peer coach, health trainer or befriender). This study estimated

that improved active signposting and alternative support could release up to 16% of GP appointments. The CCG is consequently working proactively with public health and to develop structured education programmes to support self-care and working with Third Sector partners to optimise signposting and the impact of social prescribing. It is also estimated that inappropriate demand created by hospitals accounts for approximately 4.5% of unnecessary appointments and with greater system working this could be addressed.

6.11 Consequently, strategic action to increase workforce supply, support resilience and retention of existing workforce, increase skill mix across the primary care workforce, supported by integrated interdisciplinary new models of care will be required to increase capacity within primary care. Developments in new consultation types, new technologies, reduction in inappropriate/non clinical demand; alongside upscaling prevention, signposting and self-care strategies will be required to reduce demand and workload within primary care.

7 GP Closures and Distances Patients are expected to Travel:

7.1 2 GP surgeries have closed in the current financial year (Longford and Hillfields), with the register patient lists dispersed to other local practices. A robust review of practices nearby was undertaken utilising the specific registered list postcode demographics, to ensure that patients registered at either surgery were made aware of practices closest to their place of residence and closest to the location of their current GP practice, thereby reducing the risk of an increased patient journey. The CCG provided support to local practices to register new patients and provided information to patients on local practices to assist them in registering with a local practice of their choice.

8 Planning for the future of Primary Care:

8.1 CRCCG has submitted a local General Practice Forward View Plan to NHSE which has been fully assured this plan sits alongside and support delivery of our Primary Care Strategy; together these documents set out the future direction for primary care development across CRCCG. In addition the CCG is a key partner within the STP and is working with system partners on key work streams related to Urgent Care, Out of Hospital Care as well as Proactive Prevention as core components of a future integrated care system which will wrap around and support delivery of primary care services that meet the needs of our local population.

8.2 Estates Strategy: The CCG has commissioned a comprehensive GP estate profile which includes utilisation rates across Coventry. This work is nearing completion and it highlights the general practice estates pressures associated with projected demographic growth and anticipated housing development. CCG recognises the level of growth which will be taking place across Coventry City over the current Local Plan period (2011-2031) and this has been factored into the estate utilisation work – highlighting the current estate requirements and projecting future estate requirements for 2031, at the end of the plan period.

8.3 Initial indications emerging from this work are that there a number of sites that may require development to absorb additional patient population that will be generated by the growth. The ability of the current estate to facilitate new models of integrated care and co-location is also another consideration. We have a number of estates initiatives in progress to

respond to primary care demands. This includes the proposed new General Practice Provision in Folleshill.

8.4 Local Estates Forum (LEF): The first Warwickshire North CCG and Coventry & Rugby CCG combined Local Estates Forum (LEF) took place in July 17. The decision to combine the LEFs was taken due to the closer working arrangement between the two CCGs and because there are a number of cross border developments planned over the plan period. The LEF provides an opportunity for local health planning matters to do discussed and it is attended by a range of stakeholders including district/borough planners, NHS England and NHS Property Services as well provider trusts. The discussions held in the LEF feed into the STP Strategic Estates Group and also into wider infrastructure conversations through Council Infrastructure Board.

8.5 Engagement with Planning Process: The CCG has been working with Public Health and the Planning Department at Coventry City Council to develop a systematic response to planning applications and apply for Section 106 monies associated with new developments in Coventry. These responses will request contributions from developers to be invested into Primary Care needs. They will be evidence-based, and calculate the likely cost of the health needs of the new population and the extra primary care demand.

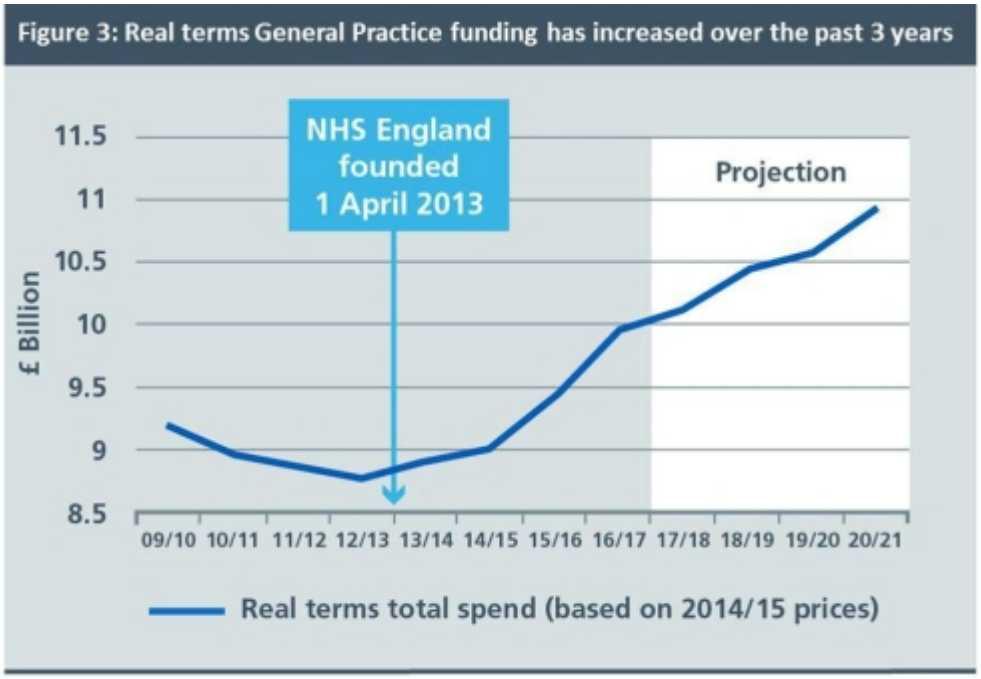
8.6 Workforce Strategy: The CCG is currently developing a primary care workforce strategy across the STP foot print in collaboration with a range of partners. This strategy identifies the key workforce/ workload pressures and will inform the implementation of a local delivery plan to address the projected workforce gap and local workforce issues. The CCG are working closely with Heath Education England colleagues, NHSE, and with our local Community Education Provider Network (CEPN) to identify and engage in a range of local and national initiatives to address the workforce gap. Funding has already been attracted to the City through the GP Federation for Clinical Pharmacists. A number of practices are investing in Physicians Associates and the CCG is actively promoting access to training opportunities to upskill the Primary Care Workforce.

8.7 The CCG are also scoping the level of interest with Member practices in pursuing the GP International Recruitment scheme which NHSE and HEE lead on, pending the level of interest and support from our Members. We are also exploring partnerships with developers and other providers to maximise recruitment effort and to market the local area as a place to come and work.

9 The Financial Position of Primary Care and financial trends over time:

9.1 The NHS Five Year Forward View acknowledged that there was a significant disparity in funding between that of hospitals and that for primary care. Hospital funding has been growing at twice the rate of the investment in local doctors' services.

9.2 The NHS published the General Practice Forward View to set out how the NHS would address the challenges, not only financial but workforce and infrastructure. The table below is taken from the Next Steps Forward View published by the NHS earlier this year. It gives a view of the trend in investment.



9.3 In December 2015, NHS England published indicative budget allocations for Primary Care Medical services for the next five years at CCG level. The figures for Coventry & Rugby CCG are provided below. (*This information is not available at Coventry only level*). The figures for 2019/20 and 2020/21 are indicative only. The annual increase in the allocation per capita demonstrates the national commitment to addressing the differential compared to secondary care services.

Primary Medical	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Allocation £K	56,978	59,010	65,542	66,700	69,189	72,476
Allocation per capita £	-	120	129	132	136	141
Growth %	-	3.6%	8.6%	4.1%	3.7%	4.8%
Per capita growth %	-	2.3%	7.4%	2.9%	2.6%	3.7%

9.4 The budget spend for Coventry practices only is as follows:

- GMS Contract - £42,566,389
- PMS Contract - £1,337,054
- APMS Contract - £2,893,327

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9.5 This is not the totality of spend on Coventry from the CCG's delegated allocation for primary medical services; other service lines cannot currently be split between Coventry and Rugby.

9.6 In addition to the above specific allocation for Primary Medical services, the CCG also incurs related expenditure against its core commissioning budget.

9.7 For 2017/18, budgets linked to Coventry GP services funded by the CCG from other sources may be summarised as follows:

	2017/18 Budget £000s
GP Extended Access	1800
GP Out of Hours	2000

10 The current interface between Primary Care and other partners:

10.1 The City Council interfaces with Primary Care as follows: GP surgeries make a number of referrals to the City Council where there appears to be a social care need. The City Council, through Adult Social Care then follow these up with the person for assessment and other sources of support where required.

10.2 GPs are key partners in the delivery of Integrated Neighbourhood Teams where clusters are based around GP clusters, working with older and frail people with complex needs. There are currently three INTs which the cover the whole City geographically but with limited capacity. INTs provide support to priority high risk clients. INTs consist of Social Workers, GPs, Community Matrons, Community Mental Health Nurses, Occupational Therapists, Physiotherapists, and Care Navigators, led via CWPT.

10.3 Primary care colleagues are key participants in adult safeguarding work including referring causes for concern, participating in planning and investigative processes and the implementation of protection plan. Primary Care is also actively involved in the work of the Adult Safeguarding Board

10.4 Opportunities for further improving integration will primarily be progressed through the delivery of the Out of Hospital model which is specifically covered elsewhere on the HOSC agenda.