Somerset Together – Yes But Are We?
Tuesday 9th February 2016 at Taunton Racecourse

Sue Roberts thanked everyone for coming. Over 90% of practices were represented by 140 delegates showing how important the subject for discussion was.

The LMC was looking for a sense of what the thinking was in the health community. Questions for the CCG were to be sought from this meeting.

She posed the first of the three questions and most agreed that general practice needed to change...again. Most practices admitted to not having an agreed practice view. The last question about what level to enter at was therefore ignored.

Outcome based commissioning was seen as a way of improving services and sustaining practices by encouraging prevention, improving outcomes by moving money into community services. The CCG wanted to see joint working by April 2017 although the new enhanced service was due to start in April this year. The CCG had chosen to avoid having to go through the tendering process by adopting the most capable provider route. Sadly GPs could not form a MCP entity.

The four levels were outlined. Level 1 would mean losing enhanced service contracts from 2018 staying with the GMS contract alone. Level 4 was full integration with the accountable joint venture. Level 1 would see a reduction in funding in the years to 2020 but the current figures were inaccurate. It was worth bearing in mind that many ESs lost practices money.

Strengths of the new scheme included aspirations of better health, outcomes and so on but there was the promise of money actually following the patient into the community for once. New money could come to the community providers. Those at levels 3 and 4 would have real influence on commissioning and some might like the prospect of being employed by the AJV without premises and business concerns. The CCG would find it easier to deal with two AJVs. Trusts saw a way of preventing illnesses to help with their deficits. Some would see it as an existential life-line.

Weaknesses included the lack of evidence. Symphony had taken three years of talking about structures. Evidence from Spain was difficult as GPs had all been salaried before. The Cambridge elderly care project which had failed had not included GPs. The King's Fund could only say that OBC “may be” the answer to CCG's woes. The public would have to be engaged in preventative measures. Practices might lack the time and expertise to engage in meaningful negotiations. What was the need to rush? Stable practices might doubt the whole business case. What would be the mechanism to make sure that someone else could provide ESs to level one practice patients?

Opportunities included a common IT record, better coordination of care, breaking down barriers between providers, the training of doctors across different specialities, AJVs would have real clout with NHSE. Practices might have a real chance to influence where work is done and to resist the transfer of inappropriate work. All this might make recruitment and retention easier.

Threats included fear and resistance to change but failure could destabilise the whole system and there was no “plan B.” Would all this end the partnership model? The government's seven-day NHS agenda was unclear at present. PMS practices which opted out would lose their premium at once and not spread over

five years. A two tier funding mechanism could destabilise practices. Was there a way of getting back to GMS from level four and what would happen in five years? Might the AJVs be ripe for commercial take over? There would be no national voice for negotiation.

Some myths about the new enhanced service were explored and many of the elements were already being done by practices such as the workforce survey, patient activation measures and medicines management. There was also a recognition of currently unfunded work. Dr Roberts was sure that the LMC could make this work for practices until 2017. In 2017-18 enhanced service money would be ring fenced at practice level and shared out in an equitable manner after negotiations. The AJV would not form until November and then practices would have to negotiate their involvement by April 2017, a tight schedule.

The LMC would certainly recommend practices taking up the ES this year. However there were real concerns about the business case for levels 2 and 3. Independent legal and financial advice concurred. The LMC would guide practices and keep on talking. Level 4 would appeal to the committed and to struggling practices. The trusts also faced challenges within the short time frame. The GPC had been asked about the potential loss to level 1 PMS practices being outside the intended spirit of the review.

Opening the discussion to the floor she invited comments. Dr Vriend from Street said that it would be useful to know which ESs would go into the pot" and secondly would social care and SomPar be making contributions. SR confirmed it was only CCG ES and would provide a list.

Dr Hickman from North Curry pointed out that the premise of the founding of the NHS was on preventing ill health too but it had not worked. He also asked what an AJV would actually look like. SR said that Symphony was the model best understood at present. Better explanation was indeed required.

SR asked if the tight timeframe was itself an obstacle to progress?

Dr Smith from W Coker asked what difference all this would really make to his working week? Would it really attract more GPs to the area? SR said that one idea was to have different health worker.

Dr Horman of Blackbrook praised the quality of young GPs and thought the chances offered already by SPQS were already attractive and that more changes, "doing a Somerset," being radical would be attractive.

Dr Murdoch from Wells agreed that SPQS had created much interest. Somerset Together might not be vehicle but not standing still was not going to help.

Dr Balian from Crewkerne, chairman of the Symphony program, answered the question about the GP's working life. He discussed health coaches, musculoskeletal technicians and clinical pharmacists to join the primary care team. Opportunities to allow more flexible careers was a feature as the prospect of partnership in one place was 30 years was less attractive these days.

Dr More from Yeovil said there was nothing wrong with level 4 if you didn't mind being employed. However he questioned the influence at the lower levels with the financial risk to practices.

Alison Foulkes from SPH asked that the CCG should write to every practice with real calculated figures and that the intermediate levels were obscure as far as practices' roles as MCPs were concerned.

Dr Munro from Yeovil intervened to ask the CCG about the aspirations that will only bear fruit in 10 years' time. The new money was only going to be marginal.

Dr Balian offered to bring some of the answers to the questions so far to the LMC.

Dr Tuff from Taunton asked about withdrawal from AJV from the intermediate levels. SR said that this would be all part of negotiations.

Dr Smith from W Coker asked what would happen when the AJV funding ceased. Why didn't the CCG just pay practices?

Dr Groessens from Langport asked where all these extra practitioners would work?

Dr Barthakur from Creech asked who would be looking after his patients in a small practice while he was away negotiating?

A new GP Cathryn Dillon agreed that there were many ways to communicate. Out of 450 GPs in South West only 5% did not want an extended role but felt this proposal was very radical.

Dr Miell from Burnham thought it all sounded nebulous and feared that existing practice plans to increase the range of services would be made redundant. He asked about Weston hospital and its role in a joint venture?

Dr Barthakur from Creech spoke up again. The hard figures were missing. He thought much of what was being proposed was already being done in practices and questioned the benefits that would ensue.

Dr Murdoch thought that doing nothing would be suicide as secondary care would continue to suck in money.

Dr Hickman was concerned about the ES in detail meaning practices being told even more what to do on pain of losing funding. The new contract was "all or nothing" he said. Who would look after his patients if he stopped providing these services?

Dr Dean from Chard thought that acute trusts would dominate boards and that "ordinary" GPs relied on the CCG as their membership organisation at present.

Dr More responded to Dr Barthakur saying that the complex structures were designed to avoid existing protective legal frameworks. So many of these proposals contained services that had already existed under Fundholding and PMS plus but had been closed down "because the hospitals needed the money." There was a theme emerging.

Dr Horman said she remained idealistic that health promotion could work quicker than in a decade. Demedicalisation could work. Some of things GPs did could be better done by others.

Dr Thomas from Street asked how all this linked in with Symphony? SR said that the Vanguard project was the AJV in the East of the county. Theoretically it would be self-supporting eventually with "all the savings." The structure in the West would be informed by the Eastern experience but might be different. The pilot had not yet been proven but was being rolled out just the same.

Dr Badham from Taunton pointed out that the trusts would be putting 2.5% of their deficits into the joint venture without individual risk but practices were being asked to risk 5% of their money at total risk. Also if the LMC could not represent the intermediate levels in negotiation who would? The business case for these was really not made but SR said that the CCG would be asked for more detail.

Alison Foulkes asked what would happen if everyone wanted to join level 4 would pay to buy them out? She was concerned about the commitment of the county council to commit social care funding. The smoking cessation contract had been rumoured to have ended early.

Dr Hughes from Glastonbury spoke of the progress made in federations but thought that negotiators working on behalf of other practices would be very difficult.

Dr Barthakur spoke again. He asked about record sharing and IT and the poor record of the NHS on this so far and doubted the timescale.

Dr Gailey from Wellington felt that financial security was lacking. The ILT had been pulled after two years so he doubted the council could be relied upon. He felt that previous experience of contract negotiations was not encouraging.

Dr Dolman from Axbridge thanked the LMC and the audience for the questions which he would take back to the CCG and praised SR for her leadership over the last four years.

Dr Yoxall then summarised the discussion. General practice needed to do something. He asked ironically if anyone had trouble recruiting. Sixteen practices were now in difficulty. OBC was not the only scheme going on but sustainability and integration needed to be encouraged. The purchaser-provider split could be reversed. The concept of a wellness service was attractive but had not been borne out. He asked about the costs of double running. The ES would provide an attractive income stream. Workload could be improved by negotiation. However this was virgin territory with little evidence to support it. The timescale had to be got right. Where was the capacity to manage the transition at a time when we were working flat out? The business case needed to be made out practice by practice. Continuity arrangements needed to be made rock solid. Negotiating practical details would be crucial and would take time. The number of patients ringing at 8:30 would not change in the meantime. He thought that Dr Horman's comments about young GPs were immensely encouraging. Dr Murdoch had suggested breaking the biomedical model of illness and thus would be helpful. Dr Balian had provided hope for a real workforce revolution. Dr Dillon, the founder of GP+, had also been helpful.

The risks of involvement with local government whose funding was being cut daily were very real.

Echoing Dr Dolman he thought the answer (like the elephant?) was in the room.