Notes from a Meeting of the Somerset GP Providers Confederation held at Taunton Racecourse on 3rd May 2016

Attendees:	Dr Nick Bray	BBF/Somerset LMC Chair
	Len Chapman	South Somerset
	Dr David Davies	West Somerset
	Dr Emeline Dean	CLIC
	John Dicker	South Somerset
	Jill Hellens	Somerset LMC
	Dr Joey HcHugh	North Sedgemoor
	Dr Barry Moyse	Taunton Deane, Somerset LMC
	Dr Mike Pearce	Mendip
	Tracy Pike	BBF/SPH
	Dr Carol Reynolds	North Sedgemoor
	Sharon Rowe	West Somerset
	Rachel Stark	BBF/SPH
	Dr Harry Yoxall	Somerset LMC

1. **Apologies**
   Received from Pauline Greer.

2. **Aims & Objectives of the Meeting**
   The meeting was convened to discuss, in confidence and without direct involvement of other parties, matters relating to GP federations and to decide if this meeting format is of value and whether future meetings should be held.

3. **Commissioning Localities & Provider Federations**
   Although some locality managers have been keen to try and separate commissioning locality and provider federation conversations into strictly distinct meetings, most areas find that the same matters need to be discussed by the same people in both contexts. In practice the input and role of commissioning localities has waned, at least for the present, so conflicts of interest at Federation level are unlikely.

4. **Sharing Innovation**
   All federations are working on schemes to make better use of the primary care workforce.
   Mendip is looking at bids to the Primary Care Transformation Fund for video consultations (there is EMIS software to support this) as well as a employing shared ECP. With the CCG they are developing a workforce plan to upskill HCAs and extend GP consulting time.
   West Somerset is piloting remote MDT meetings, initially for cardiac palliative care. Some funding has been obtained Nurses are using Skype to communicate, and the Dunster & Porlock PPGs also have virtual meetings. In BBF there is a pilot for a named consultant to assess emailed referral letters and then see appropriate patients in the surgery. This works well clinically and currently TST fund this, but although the CCG has agreed that in theory they should not lose any PBR funding the financial arrangement is currently not working quite as it should. Practices are collecting data on the additional costs that they themselves are incurring.
   In South Somerset there are complex care arrangements for GP (usually) extensivists based in hubs to supervise various aspects of patient care, by agreement with the GP, for a period of time,

for those Patients considered at greatest risk of admission. In rural areas the service will be nurse led. Enhanced Primary Care is a separate development strand that plans for more work to be moved out of existing hubs and into a genuinely practice and community-based service. These are both attracting Vanguard funding. The scheme is also paying for health coaches to work with patients in with slightly less advanced condition, for example by encouraging them to attend clinic appointments, going with them if necessary. Some of the coaches have a health background, others just have the right people skills and are quick learners. However, the services are still not joined up. Whilst the coach may take a BP, she cannot take bloods. The Partnership phlebotomy service will take bloods, but not do any blood pressures! Enhanced Primary Care in this form does seem to be working, but clear benefits may not be seen for several years. Demand in some practices is close to 10% of the list per week. If Vanguard funding is going to be cut as feared, all this work may be at risk. One innovation that really seems to be working is the whole-team huddle where all patient facing staff meet very briefly (often standing) to discuss specific patient concerns and management plans for the day. Participation by non-practice staff seems to be variable. The meetings do boost morale.

In North Sedgemoor the Village Agents are taking on some of the health coach role, paid for from the Primary Care Collaboration Fund. In CLIC there is a Partnership employed home care pharmacist visiting housebound patients on polypharmacy to increase compliance, reduce over-prescribing and cut the risk of interactions and drug-related harm. Just this week two practices have each employed an ECP nurse on behalf of the federation to undertake a small number of home visits on behalf of member practices, again using PCCF funding, but indemnity cover has proved challenging. CLIC is also working with Taunton Federation to employ clinical pharmacists, but the cost of employment is high and getting agreement on how to use them most effectively may be tricky.

5. **Collaborative Working – Opportunities & Constraints/**
6. **Federation Positions on Somerset Together**

GP engagement in collaborative work with other practices and secondary care providers is clearly variable, West Somerset arranged for Alf Collins to talk to the federation about STOG, but practices are still wary about commuting themselves financially to an untested scheme. In South Somerset most practices are interested in participating, three are already integrated and another six or seven are pursuing that route with just one small practice rejecting all involvement. There needs to be a balance between integrated and participating practices for workforce stability and also because of competition law. Symphony and OBC have now become inextricably linked. Mendip feel that involvement in discussions about the proposed East Joint Venture (potentially involving both RUH and YDH) is important but the other providers still do not fully understand that general practices are still independent businesses, and cannot be represented by one person with executive authority on behalf of them all. BBF is most immediately concerned about the risk of local practice failures and the likely impact of these on other practices. Much more detail is needed about just what each tier of JV involvement will mean. Direct discussions between West GPs and senior TST management about collaboration outside STOG continues.

However, GP involvement in the CCG appears to be weakening, and there was concern that for it to strive too hard to meet unachievable savings may in the end be counterproductive.

7. **Workforce Attraction Strategy for Somerset**

The LMC has been participating in the Somerset Attraction strategy which has had some modest outputs. A BMJ campaign was considered, but rejected as too expensive and probably too many LMCs have signed up already for Somerset to get much value from this. The CCG has now agreed to provide matched funding for an LMC driven attraction campaign based on social media. General practice in the county has not been proactive enough in telling prospective GPs about what Somerset does differently - such as SPQS - and designing advertisements and schemes to appeal to 'Generation Y' GP training completers. LMC Attendance at a career fair in Bristol generated a lot of interest and three practices have been approached by new GPs as a consequence. Forming early relationships with medical students and working with F2s may also be very helpful.

8. **Future Role of Somerset Primary Healthcare Limited**
   Several board members of SPH are retiring and the company is therefore restructuring to shift its focus. It is also planning to issue a new class of shares to allow the company to work directly with other providers on behalf of particular localities. Ideally the board will in future include representatives from each federation. SPH could also provide direct administrative support for groups of practices or federations.

9. **Anticipating & Responding to Practice Closures**
   Various federations have considered how they might manage the collapse of a local practice, but with the current recruitment pressures and the rapid growth of the population in some localities, capacity to absorb the list of a failed practice is very limited in even the best served communities.

10. **Any Other Business**
    None.

11. **Date of Next Meeting**
    It was agreed that the evening had been useful and a further meeting will be arranged by the LMC office at end of June or the beginning of July.