**Somerset GP Provider Support Unit Launch Meeting 14th July 2016**

Harry Yoxall outlined the background of demand and recruitment and retention problems. He thought that STOG would be subsumed into the STP. The overriding need was to balance the budget. There seemed little chance that the promised £2.4b in the GPFV was really going to come to primary care despite all the other good ideas it contained.

Indemnity problems were created by the traditional MDOs being out of steps with new models of care. The AHSN were looking at providing alternative cover.

There was a philosophical choice between flexible, independent practices working together in networks or joining larger, collaborative multilevel organisations.

Adrian Poole of Porter Dodson spoke next about the work in progress. Federation working and practices working together could be supported with legal templates. The Symphony and SomPar models were being studied. Practices were not like a normal business sale with GMS and PMS contract continuation (nominee GPs avoided the need for re-tendering) and the prohibition of the sale of goodwill. He outlined the key documents required for vertical integration starting with a confidentiality agreement, heads of term and offer, due diligence (boring and laborious but vital), partnership agreement for those remaining, and the vital deed of adherence and retirement. NHSE had been responsive but the requirement for 28 days’ notice was a problem. Property ownership was a stumbling block sometimes. Salaried GPs needed to establish terms and conditions. Participation versus integration with possible break clauses should be considered. Beware of TUPE considerations: involve staff early.

Karen Lashly from SPH spoke next. The threat of the need to tender for contracts seemed to have largely receded and now the group was supporting practices, enabling federation (provider unit) projects and enabling contracting with foundation trusts. Federations owning designated shares in SPH could be subcontracted via the SPH board with a trust singly or in combination.

Berge Balian discussed progress made by the Symphony programme. Pooling budgets would streamline and improve care in the community. Symphony Healthcare Services currently incorporated three practices and the complex care hub. South Somerset Primary Healthcare would unite participating practices to link with the Symphony IACO which would be commissioned by the CCG, NHSE and adult social care. SomPar could be part of the ACO. Adult social care could not join the ACO, a major handicap. SHS was “technically” owned by YDH but would behave like a primary care organisation. Participating practices would need a coherent voice and vehicle organisation and discussions about this were at an early stage.

Regarding salaried doctors although the BMA model contract was used there was an additional element to expect working patterns more like a partner’s clinical work i.e. not 9-5. “Employed partners” was another possible pattern.

Andrew Dayani from SomPar said how contract pressures away from personal care had led to recruitment and retention problems. SomPar was looking to support practices by making an offer to doctors when the opportunity arose. Furthermore community trusts and primary care should be as one. MIUs and community pharmacists could divert work from primary care. Practices in difficulty had approached the trust for help and SomPar did not intend to be predatory. Nevertheless two practices had required take-over for different reasons. Salaried doctors would work alongside musculoskeletal workers and ECPs. Community hospitals could be used to divide work streams with urgent care provided there after patients had contacted their own practices. SomPar could provide superannuation through nominee partners. Salaried GPs would be put on a consultant payscale with additional payment for additional responsibility.

HY went on to describe the GPC concept of the urgent care hub to buffer urgent demand to ensure safe working hours. The GPC believed that this should be provided at least in part from new or recycled funding. It was suspected that NHSE would expect practices to fund it themselves. The aim was in line with the GPFV and the additional practitioners described in that document could be deployed in the UCH without the need for more complex integration of practices with universal IT access being essential.

BB said that it was likely that there would be a single ACO for the whole of Somerset by 2018-19.

Practices wishing to explore various levels of horizontal integration needed to start working together to explore how far they wanted to go in what areas and then the PSU could design suitable documentation. Evolution was more practical than revolution and the retirement of a practice manager was a good opportunity to work more closely together!

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