Nick Robinson Extraordinary Members' Meeting
11th October 2017

Nick Robinson started by presenting an overview with some reflections on the CCG and STP, the regulators' views and his perspective on the next steps. He said he had worked in and across the NHS since 1978. This he believed gave him a good insight and a fresh pair of eyes to view Somerset's problems.

The CCG was declared inadequate by NHSE specifically on system leadership, and budgetary control. System dynamics had allowed things to run away, losing the county's reputation. Performance management of providers had failed with trusts thinking that everything was negotiable and much was optional. Somerset Together and the STP had been innovative but had not followed through leading to a projected £20-30m deficit this year which was impossible to solve without a radical approach. He had been shocked by the lack of a clinical commissioning strategy. Closing inequality and more investment in mental health could never be achieved otherwise. The Turnaround process under CEP had not made any progress leading to a larger deficit and lack of confidence from the regulators. The public had not been consulted. Time, road and money had now run out. A capacity and capability review had described Somerset as a bureaucratic nightmare with too many meetings solving nothing.

Somerset Together never was and the STP had achieved nothing with organisations fighting turf wars and endless workstreams making no resolutions. The different regulators had not helped here. Massively ambitious workstreams would now never be realised.

The wider NHS had conducted a regional stocktake of the STP and Somerset had done so poorly that Simon Stevens and the NHS management board had visited to remonstrate. Organisations were still putting themselves first and the system second. We had to work together differently with better, structured leadership. The CCG had been given two weeks to construct a realistic plan. To begin, swathes of meetings had been cancelled. More important was that the real solution to the problems we face could be very exciting. Great work had been done on prevention and self-care. However, given the overall demographic and geography of the county meant that a model was needed involving primary care at scale. Primary care needed to be the bed rock of the future and so he invited us to imagine a regional, fully integrated (involving community, mental health and social care), hub-based model. Investment would be focused on where there was most need. Urgent care would also be involved requiring a fundamental strategic review of all existing services. What was killing Somerset financially was the acute trusts. Primary care on the other hand had been commended by Simon Stevens. The trusts were hanging on to quality standards by employing locum, agency and staff on overtime. This was unsustainable. Hence the need for the full acute services review.

The financial constraints of spending more on integrated, primary care and mental health would be difficult. However, it was already accepted that there were too many community hospitals. Acute care was probably costing 20% more than needed.

The second constraint was recruitment of staff across primary care, as well as in the community and acute sectors.

That said, he did not come with a worked out blueprint. Outcomes based commissioning and an accountable care organisation were solutions but were unlikely to come online quickly enough. Again, this made the case for the clinical services review.

Primary care at scale meant different things to different people. He had visited SHS practices and test and learn sites. All this needed to be captured and built into the new system. He invited us to envisage primary care in 5-10 years and to use that model to help the new plan be resilient over time. Skill mix employing new HCPs in individual practices did not seem sustainable. Working at scale did not necessarily mean merging practices. He had no preconceived view about any model but the CCG needed to provide a way of making primary care sustainable at scale, taking the best of what had been learned so far. He promised design workshops to help primary care (which was too important to fail) work at scale in whatever way was most suitable in different localities. Making the working day better would be a factor. How to get the best GP advice and feedback over the next 6-9-12 months. There were vacancies on the COG. But filling those would not be enough and he was interested in how colleagues felt consultation could be made more meaningful, with all due respect to what had gone before. This would take priority over everything else, hence the suspension of scheduled meetings and the end of enthusiasts' pet projects if they were not already demonstrating saving.

Q: What was the best performing CCG in England and was Somerset talking to it? NR: that would be part of the build but he'd only had seven weeks. People in Somerset seemed to think they were special and could design everything themselves. There was not time to do that and he would beg, borrow or steal any good ideas. Practices all seemed to articulate the problems eloquently. Organisations worked well together in crises and wouldn't it be wonderful if that sort of cross boundary cooperation could be every day. He predicted that T&S, YDH and SomPar would not exist in their present forms in two to three years' time: other areas were far advanced in this regard.

Q: What feedback have you had from social care? NR: absolute support from council chiefs and H&WB board. The council had stood back from cooperation in the past but now we're planning to release staff to work on redesign. Barriers had to be ripped down. It was going to be tough: people would be waving placards. The Dorset experience had shown that strains would be evident but industrial strength public relations would be needed to mitigate this. Already the H&WB was being targeted to involve local politicians. A clinical reference group would be created involving different HCPs. If we didn't do this NHSE would send in an intervention team to do it to us.

Q: (Jon Upton) Competition rules had been a problem in tendering in the past. NR: NHSE had worked this out and would set out ways of dealing with competition rules. That said there was no way to be certain that present providers would not necessarily be the ones providing the services in a few years. Q: Where would cash-strapped trusts get the money needed to make the bids? NR: he did not know but ruthless effectiveness at the outset would be necessary with lessons learned from the rest of the country.

Q: (Andy Hill) what is your view on how primary care will support the CCG in new ways? For example everyone agreed there were too many community hospitals but no one wanted their local one to close. NR: clearly localities would have opinions but we had to convince stakeholders and the public that ultimately the changes would make things better. Hence the need to court colleagues, the public and politicians including MPs but never individually but on the whole package. Tailored support could be given to practices if agreement was reached. He did not promise it would be easy. Something "new and shiny" had to follow.

Q: (H Sampson) asked when would the external regulators come in? NR: did not know but the plan required in two weeks was the next step but realistically he felt we had until Christmas. They would not bother with public involvement with decisions being taken regionally.

Q: (John Edwards) you have not mentioned OOH and the confusion among patients about the different services on offer. NR: He couldn't sort that out quickly but OOH would be part of the long term plan. In the meantime the providers had been spoken to in a way that had not happened before. The NHS was focussed on A&E winter pressures, cancer treatment targets and the money. That is all that the centre wanted to talk about. Influenza vaccination was a number one priority.

Q: (BB) have you had discussions about how to get GP engagement with the day job being so busy? NR: SGPB would be a useful vehicle but the CCG could not go around all the practices. He hoped that a more defined framing of the questions would help. He was open to suggestions.

Q: Would practices managers also be involved? NR: why wouldn't they? Primary care and the CCG would also have to learn together as the latter took over the management of GP contracts in the next two years. More financial levers would therefore be available - if not actually used - to make real change. The LMC and SGPB would be consulted. For example, suppose a geographical gap in provision opened up, how would replacement services be commissioned? He did not mean this to be threatening in any way.

Q: how were we to get through the winter without funding for community services? Was it more of the same until the spring? NR: Agreed. There was no more money but that did not mean we could not fix some problems across boundaries. He wanted practices to tell him what the problems were.

Q: (James Hickman) GPs had been repeatedly told that if only we did health promotions all would be well despite there being so many frail elderly living longer. This may have led to loss of faith. You have said how good primary care was on prescribing and referring but always it seemed that a little more of the same would help? NR: He had commended primary care earlier but sustainable local communities through the council and voluntary groups would help eventually but he agreed not soon enough. Urgent acute admissions were going up and he wanted to know why? Local trusts had had endless toolkits to look at this but nothing had been achieved. Other places had extended prior approval and OASIS but they did not seem to be best suited to Somerset. Outliers would be challenged but what he wanted to do was to sustain primary care and make it more resilient but clearly one could not rest on laurels.

Q: Recruitment was the most pressing matter. NR: He had attended the LWAB involving HY, HEE and HR directors. He had been encouraged by progress made at YDH with foreign nurse recruitment but did not feel he understood GP staff recruitment well enough. He thought that a strategic view to deliver recruitment in five years' time by starting training now. For example, what if a nurse trained in Somerset had a "passport" to guarantee working across all sectors in the county? Again he asked where would the most attractive site for recruitment of the new HCPs, across the county or within practices?

Q: (Geoff Sharp) reminded us of the closures of all beds in Shepton Mallet and Chard community hospital. What could GPs say to patients, what better was on offer? NR: This had been decided primarily for safe staffing reasons and SomPar had had no option but to close the beds. Legally the changes could only be "temporary." The CCG as commissioner had directed SomPar not to do this in future because the whole system review would otherwise be jeopardised. Something better would be coming but we cannot say

what it will be yet. However, if the CCG found that any commissioned service was becoming clinically unsafe then it would have to call it out. He expected the CCG to absorb as much of the heat as possible.

Mr Robinson thanked everyone for coming and had found the questions useful. He appealed that anyone with a worry, problem or who had heard rumour to come to him and the CCG rather than "letting it fester." He promised to keep GPs informed.

The meeting closed at 9:06.

Dr Barry Moyse

Deputy Medical Director