**GPFV afternoon event for LMCs CCGs and NHSE Taunton 9th August 2016**

Dr Robert Varnham, head of development NHSE, introduced what he hoped would be a productive afternoon. Attendees were from the whole of the south west. Most were NHSE and CCG members, practices being expected in the evening meeting. Somerset, Avon and Devon LMCs were represented.

Dr Madan, the head of primary care NHSE, was seeing patients today and so spoke to us via a recorded message. He spoke about investment, the working day, IT and changes to the way primary care was to be delivered, improving the “offer” to patients. Repositioning for a more sustainable future was key and the GPFV represented a turning point.

Investment promised another £2.4b a year by 2020/21 and a £500m S&T package over the five years.

Indemnity support had been announced at £33m this year. In September winter payments for OOH would be repeated. The practice resilience programme had been announced ten days ago and maximal local flexibility was intended.

Workforce plans included the familiar 5000 new GPs, 3000 mental health therapists and so on.

In workload £16m for GP burnout, and the 10 high impact actions were key.

Practice infrastructure and care redesign with the MCP contract framework having been recently announced. The full contract was expected in September and would be locally commissioned (”organically”) from April.

We were then, table by table, invited to discuss our priorities and take a vote. Our table was joined by some NHSE managers to aid “cross pollination.” There was a most satisfactory exchange of views in which the NHSE side was apprised of the desperate state of primary care. In all fairness this seemed to be well understood by the managers but there remained the lingering sense, in your correspondent’s mind at any rate, of the “double think” at Whitehall with traditional general practice no longer really believed in by ministers whatever they might say.

After our votes, Dr Varnham decided to stick to his original running order! He rehearsed the familiar multifactorial problems facing primary care. He thought that these pressures linked in with opportunities but primary care needed to survive in order to thrive. That said, there was much innovation already going on, but often in the face of contractual opposition. Policy makers have struggled to “hear the message through the noise” of the “cry of angst” from general practice. Making Time in Primary care had found the burden of bureaucracy concerning getting paid, processing information and reporting (often the same stuff) to different organisations and helping patients navigate the system. Some 26% of 5000 GP consultations could usefully be have been diverted elsewhere in the present circumstances. The NHS standard contract had been modified from April to prevent instant discharge after outpatient DNAs and the CQC was moving to a more risk-based inspection regime, but much work could be done locally. The ten high impact changes were outlined with the plea that good ideas should be disseminated including using the bit.ly/gpcapacityforum link. The Time for Care programme would fund local development support advisors to help with preparation, perhaps with a “local showcase event,” and a “series of challenge orientated workshops” over six to nine months to get things “moving quickly.” Federation board training could also be provided. The new productive general practice suite was recommended as having been improved. “High end learning improvement tools” would be available. Money to train-up receptionists to sign post patients elsewhere would be available. Your correspondent asked if that wouldn't encourage the popular conception of “the dragon?" Liability for sending someone down the wrong route without recourse to a GP was not mentioned. Information was on the [www.england.nhs.uk/gpdp](http://www.england.nhs.uk/gpdp) website with a fortnightly webinar.

We were then asked to discuss what was going on locally and it was agreed that Productive General Practice had been a waste of time and money in Somerset. One of our NHSE colleagues explained that the new version was “module lite” and went on to describe how the Time for Care funding would sit centrally and come down through CCGs, LMCs or practices for approved schemes. There were questions about the multifarious “pots of money” and whether these really were different and risked the necessity to “re-invent the wheel” in order to make a successful bid. We were assured that schemes were to be bespoke and not necessitate repetition. Another manager pointed out that practices in distress did not have time to take out going to meetings on social prescribing, for example. Given the good work done by Somerset LMC already it was thought we might well be contenders for funding to help implement one or more of the ten high impact actions. However it became apparent that this money would probably be expected to be spent on mapping and other preparatory work (and Jill announced that she was beginning to glaze over!). The NHSE manager was made aware of the failure of PGP. She looked forward to creating a “network of change agents” and was made aware that practices and federations needed process managers to provide expertise we lacked.

There was a good question on encouraging self-care but the best answer was to encourage other agencies to tell people to “contact your practice team” rather than “see your GP.” Your correspondent’s experience is that with NHS111 patients often hear “see your GP within two hours” rather than “contact.” It was admitted that practices had little success in redirecting patients once they had contacted a practice and local campaigns about, say, seeing a pharmacist instead worked better.

An NHSE manager asked for clarification about who was paying for what, how money could be obtained and what was already in baseline budgets. It was admitted that an “at a glance guide” would be four or five pages long. Application fatigue was a risk. Another manager pointed out that much of the £500m was not new money and not all was for doing new work. The £2.4b would be distributed along traditional routes (for instance QOF, enhanced services) after negotiations with the GPC. Another worry was that new money could be lost in CCG bottom line deficits.

It was commented that STPs were a way of making primary care properly the central part of the desired patient-based integrated care that has been talked about for years. It was admitted that there was still vagueness on funding but nevertheless the new flexibility of allocation could get around previous problems with contractual limitations. It was guaranteed that Time for Care funding was ring fenced for primary care and would not involve competition bidding “nonsense.”

A question about where traditional independent contractor general practice partnership fitted in the brave new MCP world was answered with drawing attention to the levels of integration permitted under MCPs giving example of the existing Vanguards being diverse. Commissioning for care and outcomes was more important than models of ownership. The strengths of general practice could be lost whatever the talk of its primacy so these would have to be designed in to new systems. It had to be accepted that even in existing larger practices continuity, for example, had to be designed in to maintain some hold on inter generational care. It was denied that NHSE had a plan to make small practices financially unviable within five years without merger, collaboration or federation. The old argument about “cock-up or conspiracy” was firmly decided in the former by Dr Varnham in his experience working in NHSE.

A change manager pointed out this wasn't about “bungs to practices to keep them going” but was about giving time to help clinicians “embed their ambitions.” This seemed to sum up the entire dichotomy in attitudes.

The point about litigation resulting from signposting was raided by a questioner. It was pointed out that receptionists essentially triage patients now as the MDOs write to remind doctors.

After tea we were regaled on improving access and that speed was no longer the prime consideration but rather the right care being delivered in the right place, at the right time, by the right person accepting that this would vary between cases. The PMs Challenge Fund which was to extend opening hours was now renamed the GP Access Fund. Improving access now included helping people to stay well, active signposting (perhaps online or via an app), using new consultation types delivered by stronger, more diverse (and cheaper) workforce whilst recognising that one size would not fit all. Benefits from schemes already had included wider access, new services, a wider workforce and more meaningful collaboration between practices, helping transformation within primary care. Reduction in ED attendances had been variable. The lessons learned were being collated to assist new entrants. There were funds to release GPs to develop schemes and to transform practices e.g. with interoperability for IT. Funding was £3 a head from the GPAF from the Cabinet Office (not the DH) and £3 from CCGs (assuming other calls on the cash including system-wide deficits could be resisted) although this was not that straight forward and a brave questioner spoke for many when she asked why “it was all so bloody complicated?” and wasn't it part of the national team’s job to press for simplicity? I think we all felt some sympathy for the managers at this point who clearly were kept in the dark and hanging on for confirmation of promised funding by central government. It appeared that when the results of the cabinet office funding had been evaluated it fell to NHSE to continue the scheme? Dr Varnam could not make “the bullshit” go away to use the expression of another CCG GP (not one of ours). There was a distinct feeling of growing futility at this point despite Dr Varnam’s irrepressible optimism. This next four years could represent the most complicated era of NHS funding.

Ian Biggs the director, primary care workforce and infrastructure programme NHSE, spoke next about the 5000 new “doctors working in general practices” (WTE and nett), mental health therapists, co-funded pharmacists and physician associates and so on and how they would all work differently. He admitted to having sleepless nights but believed it was “everyone’s problem.” Retention of workforce needed to be built into the system. Nevertheless he hoped that no one would go away and await instruction. The number of GP trainees was to be increased from 2500 to 3250 each year but attrition from schemes was recognised. Discussions with medical schools to encourage choice of general practice as a career. The “There's nothing general about general practice” campaign had received mixed reviews but had at least generated comment. Locally there needed to be plans for deployment and employment. The returners’ scheme was being standardised and being streamlined. Portfolio careers for older doctors including roles in development of services were to be encouraged.

The clinical pharmacist scheme was discussed explaining that the tapered support had been given on the condition that pharmacists saw patients and could work with clinical colleagues. This was an example of a national design, delivered locally. Some 1500 more pharmacists, i.e. one per 30000 patients, were envisaged in phase two.

All international recruitment needed to be balanced by a welcoming from local health communities who should “grab” these valuable people.

A nursing strategy for general practice was expected in the autumn.

Retention of staff was “a huge job” both nationally and locally. Anxieties about pensions were contributory and appraisal/revalidation was admitted to be a negative factor for some GPs. The draw of locum work with its flexibility, relatively good remuneration and limited responsibility was mentioned. It was commented that many of the ideas proposed might be of long term benefit but did not address real and immediate problems. The requirements for match funding had put off some CCGs. Incentives to attract new doctors with bursaries in 108 practices judged particularly hard-to-recruit practices had produced varying effects with good results in the Isle of Wight but an actual decrease in applicants to some parts of the Lake District. “Robbing Peter to pay Paul” was a risk in all of these schemes. The way in which junior doctors were being treated with couples often being sent to work poles apart was another problem.

By this point in came as no surprise to be warned that it was unlikely that “£900m capital investment in estates and technology infrastructure”“ really would be available. Part of the strategy for health economies would be to “rationalise” (a word immediately retracted) existing funded premises. There was a question about sale of goodwill in general practice but Mr Biggs could only say that as far as he was concerned GPs “going the extra mile” was what made for true value. The question of premises and existing leases and negative equity holding back collaboration was raised but Mr Biggs couldn't answer that either but did accept the need to recognise and explore the real problems