



BBOLMC Annual Report for 2010

January and the aftermath of Christmas provide me with a prompt that another year has passed, and it is time to write a new BBOLMC Annual Report.

Historically I have used the Report as an opportunity to look back at the broad themes that have affected GPs, practices and LMC over the previous year.

BBOLMC acts for three independent LMCs, Berkshire, Buckinghamshire and Oxfordshire each with issues in common but separate enough to present the Marlow office with different problems to help solve. For the 2010 version I will concentrate largely on the themes as I see them. I write personally so please let me know if your perception differs from mine: I welcome alternative views and debate.

The White paper and GP Commissioning seem to have dominated at least the latter part of the year, but I'll come to that later. 2010 began and ended with weeks of snow and travel problems. Staff in practices all across the Thames Valley should be congratulated on their professionalism and ingenuity in actually getting to work and maintaining a service to patients. I wish the media would report this as much as they do the issues they choose to beat us with.

The early part of 2010 saw LMC faced with late notification of an SHA plan for a DNACPR system that would affect all GPs. The project team felt that by consulting GPs employed by PCTs they had consulted the representatives of the GP profession and this was sufficient to get advice on a workable system. It still amazes me how ignorant non primary care organisations are of the role of LMCs. I have to be vigilant that the views of LMC and practices are obtained when other parts of the NHS are changing systems.

Issues with Appraisal and Revalidation continued to appear at intervals. We began with the enforced temporary closure of the appraisal website on security grounds. We ended with the loss of national funding for the same site and uncertainty about what electronic systems PCTs would choose to fund for appraisal administration in the future. There has also been slippage in the start of Revalidation pending more detailed analysis of pilot schemes.

Some PCTs chose to make their Medical Directors Interim Responsible Officers (ROs), by internal processes that many found contentious. LMC has been reassured on the interim nature of this arrangement. Indeed with the abolition of PCTs planned for 2013, it is now unclear what body will appoint and host the ROs of the future or hold performers lists.

GP frustration with unnecessary obstacles to patient referral continues to be an issue, and with the savings required by Government, I don't think this will go away. In the latter part of 2010, we've already seen attempts by PCTs to put embargoes on important elective referrals. This has been part of the QUIPP initiative for PCTs to achieve financial balance by the end of the financial year.

Complaints about C&B seem to be less evident and as a result some PCTs have assumed it is easy to use and are contemplating withdrawing LES funding. This ignores the overheads practices have to fund to deliver this booking function on site. This could become one of many battle grounds of the future. Please let me know.

I share your frustration with complicated PCT referral systems that patient and professional find difficult to navigate. Whether its MSK hubs or hospital booking bureaus, referrals seem to get lost and we have to chase round an opaque system and face the wrath of angry patients. LMC continues to voice the problems PCT systems throw up for coal face clinicians.

Primary care teams seem to have been under threat for some years and many of you have expressed your concern. In many areas district nurses and health visitors have been reorganised on a geographical basis. Community nursing colleagues have become more distant from individual practices, and increasingly request formal written referrals faxed or emailed to another site.

Some nursing teams have been forced to use IT systems that cannot communicate with GP systems. What this will do to an integrated primary care record I do not know.

During the year, the Government Transforming Community Services initiative forced PCTs to find new hosts for their community provider arms. Each Thames Valley area behaved differently and with variable real consultation. Most chose a vertical integration model, with the new host organisation being an acute or mental health secondary care trust. It remains to be seen whether community nurses become more an outreach of secondary care responding to a hospital agenda or remain part of a primary care team delivering integrated comprehensive services. My hope is that new GP Consortia will commission a service that preserves primary care teams and contributes to the philosophy of "care close to home" (and out of hospital where possible).

Some PCTs have initiated or completed reviews of their PMS contracts, driven mainly by financial pressures. At times this has been contentious and LMC has found itself in a difficult position. There is undoubtedly variation in per capita practice funding both between and within GMS and PMS practices. LMC arguing for differential funding for one group could be unfair to the other. The result has been that I have tried to act as a supportive advisor to PMS groups, ensuring the rules and solutions found elsewhere were widely known. Unsurprisingly, there has usually been a regression of

per capita PMS funding towards a GMS average. Given the financial environment we now live in this was probably unavoidable. I will continue to give support to those struggling with new reduced funding flows.

I can't imagine many of you will think life is getting easier in general practice. The old image of general practice only seeing coughs and colds and referring much to hospital without workup is long gone. My own surgeries in Oxford City West have a significant proportion of complicated aging patients, requiring management of several long term conditions previously the province of hospital out patients. Multiple morbidity contributes to 10 minutes often not being long enough to do a thorough job and I run late. My old GP partners in Summertown would never believe this.

The stress levels in general practice can never have been higher, especially as other NHS resources that could support us are dwindling or more difficult to access. I continue to believe that whatever the Daily Mail says, we provide phenomenally good value for money. Yet last year (as for several years before this) our % increase in Global Sum Equivalent was low at 0.41%. This was well below inflation and below the annual increase recommended for staff by the NHS Review Body. LMC will continue make this point in every appropriate forum.

Many areas have experienced issues with "Fast Follower" adoption of the Summary Care Record (SCR). Some PCTs were seduced by a free DOH Patient Information Program into an early SCR initiative. The problem was that after the patient mailing, consent to upload part of the GP record to the national spine was assumed to have been given if no objections were received. On top of this, access to an opt-out form was made particularly difficult on websites. You will have received emails from me during the year, outlining GPC objection to the consent model. Thankfully by the end of 2010 peace had broken out between Connecting for Health and the GPC and a sensible compromise solution was reached. Please let me know if you experience SCR problems.

QOF seemed to be relatively trouble free in 2010. Even the anticipated income drop through alteration to the prevalence calculations seemed not to materialise in most cases. Many of you rightly object to your income for the patient experience points being dependent on a small sample of poorly remembered access experiences by patients. This position is held by LMC and GPC and representations to get something more valid continue to be made nationally.

Sessional GPs are an important part of the modern GP community and this was reflected in the paper produced by the GPC in June and by a much expanded GPC subcommittee for Sessional GPs. I have always been keen to ensure all GP voices are heard and represented and feel communication is key to delivering this. As result, I have pushed hard for PCTs to take their performers list responsibilities seriously and develop email communications systems to all individual GPs on their list. There has

been some dragging of feet, but we now seem close to getting a working solution. All GPs will then be able to receive important local and national documents that aid their clinical work and learn about work and training opportunities including those within GP Consortia.

Of course the big event of the year was the 6th May election and a subsequent Coalition Government. Other than Coalition plans to cut spend in public services, the main consequence for health was the publication in July of a White Paper. This announced the abolition of PCTs by 2013 and Government intention to hand future commissioning decisions to yet to be formed GP Consortia, all this at a time when the NHS was required to save 20 billion per annum. The Health and Social Care Bill is due to be published on 19.1.11 and the media is currently having a field day with the wide divergence of opinion amongst commentators.

"How to do it" details for those trying to form Consortia have been hard to come by from the centre. Whilst this creates uncertainty, the absence of prescription could be taken as an opportunity to develop locally sensitive ways of working. Local Medical Committees have made conscious decisions to allow bottom up development of Consortia. Excessive leadership behaviour from LMCs would have been as inappropriate as if it came from PCTs or SHA. LMC has monitored the evolution of embryonic Consortia to ensure that their development was all inclusive and genuinely reflective of the views of local practices. So far, LMC has had to raise few objections.

There are now several pathfinders in the region, although many of the most rapidly developing groups have not yet attracted this label. I hope we will end up with commissioning networks that are mutually supportive, deliver economies of scale yet preserve what is best about small cohesive localities. I do not underestimate how difficult this could be.

As some may have been aware, BBOLMC has been working with a reduced workforce since late 2007. I am delighted to announce that in September Jim Kennedy joined the team as Medical Director. He has wide NHS experience both as a clinician and manager, and has already impressed. He has recently taken on the Berkshire portfolio, but at times will have dealings with practices from the other two counties. Welcome Jim.

H1N1 Flu remains an issue. It first hit the UK in 2009, and dominated PCT and practice activity for some months. The Pandemic was finally labelled as ended in August 2010. Nevertheless the UK has seen the predicted waves of disease activity, with resultant increases in patient attendance and GP workload, plus vaccine and antiviral scares and shortage. Information has sometimes been retrospective or contradictory. I have tried to supply you with succinct relevant information without causing overload or confusion, but have probably not always succeeded. My apologies.

I am writing this in early 2011. GP Consortia and commissioning are likely to figure highly over the next 12 months, but if previous experience is anything to go by, something unexpected will also crop up.

LMC is always there to help practices with any problem. Please pick up the phone or email us.

Our details can always be found on the website www.bbolmc.co.uk

Some may not appreciate how much content there is on this site. What we say to PCTs on your behalf (and Consortia in the future) is recorded there in the minutes for your area.

Please take the time to read them regularly and give us feedback.

Finally I would like to thank all my colleagues on LMCs and in the Marlow office. Pauline Michelle, Gillian, Carol, Dave (IT) and Jim and are all vital to the way we function. Many thanks for your conscientiousness, competence and friendly support.

I also cannot do my job without the feedback and comment practices give me. This supplements what I hear from LMC reps. GPs may not always hold the same opinions but it is vital that LMC is exposed to the whole spectrum of view. Please continue to feedback to LMC. Only then can we articulate something useful and be of benefit to our levy payers.

Best wishes for 2011.

Paul Roblin
CEO of BBOLMC
18.1.11