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Part of my standard preparation for the Annual Report involves reviewing the County LMC and LRC minutes for the previous year. This year in particular, it surprised me how quickly events had moved on over 12 months.

2008 began with the furore over Impositions A and B for Extended Hours. Just prior to Christmas, government had requested that the GPC endorse a more onerous DES for Extended Hours than the one close to agreement with NHS Employers. They made it clear that failure to recommend "Imposition A" would result in "Imposition B", involving a permanent reduction in maximum QOF points and loss of a 1.5% uplift to GP income. GP opinion varied. Some talked of a campaign to eradicate traditional GP contract types in favour of APMS contracts and mass resignation being the only option. Others warned that this issue was not one justifying war with government: the public would not understand.

The GPC refused to comply with the government without consulting and balloting the profession. To ensure all GPs were fully informed on the issues, each Thames Valley county held extraordinary open meetings. The ballot result for England was announced at the end of February. It showed a 92% vote for "Imposition A", qualified importantly by 96% support for neither imposition being acceptable, ("A" was just the least bad). Additionally 98% were critical of the government method of negotiation.

Faced with a continuing media and government campaign denigrating GPs, many GPs subsequently chose to limit the damage to income. Progress nationally on formal DES paperwork was painfully slow. National guidelines were issued to PCTs and with encouragement from LMC many developed Extended Hours LESs with attractive flexibilities permitting nursing hours and GP concurrent working. Some, but not all practices signed up to these. Certainly the anger of the early part of 2008 seemed to subside and Extended Hours for many became something to just get on and do.

This resigned acceptance of extended hours has been upset in recent months by misinterpretation of the formal DES Directions by some PCTs. PCTs have withdrawn their LESs after a short lifespan, and now offer only the unattractive DES. This is despite PCTs having reached their 50%

target for strict DES sign up. The prospect remains that other PCTs will follow suit. Most commentators agree that government intransigence on workforce flexibility during extended hours is illogical and not in patients' interests. But when did that ever matter to a government wishing to demonstrate its power?

Linked with Extended Hours has been another 2008 imposition. All PCTs must commission a new GP-Led Health (Darzi) Centre, opening seven days a week, 8-8pm and offering both list based care and walk-in services. PCTs faced with local growth or major local access problems may find this concept fits with their own plans, but in many spending £1m per annum on a Darzi Centre doesn't make sense. The LMC has in one selected area balloted patients and confirmed the obvious. Patients believe money could be better spent in other ways, if only local PCTs were free to commission unhampered by government dictat. As I write this report, contracts will soon be placed. It remains to be seen whether the recent financial downturn will frighten off private commercial providers. I hope many PCTs will decide that the funding required by such companies for the specified services is too high a price to pay.

October and November saw the announcement by GPC and NHS Employers of their contract agreement for 2009/10. For some time, GP opinion has been divided over the justification for the Square Root and 5% cut off adjustment made by QMAS in handling clinical prevalence within QOF. It has now been agreed that these two adjustments will disappear, the former next April and the latter a year later. Inevitably some practices with low prevalence will lose out financially with this change. Student practices and those comprising young families seem obvious candidates.

As often happens, problems deemed too difficult to sort out nationally are often bounced downwards for local LMC action. The GPC was refused permission to supply LMCs with government listings of those practices likely to be hit hard, yet expected LMCs to begin local discussion over compensatory funding flows. BBOLMC therefore developed its own prevalence calculator for practices to assess how the changes will affect them. Once armed with the size and scope of the problem LMC can start meaningful dialogue with PCTs.

At the same time a nineteenth formula was announced that will uplift Global Sum by a higher % than MPIG. An explanation of how this will work

for any uplift recommended by the Review Body appears at <http://www.bbolmc.co.uk/nineteenthform.xls>. The formula agreed by GPC essentially means that although most practices will receive some uplift to total funding, much of any GS uplift will again be counterbalanced by a Correction Factor reduction. BBOLMC will be seeking PCT help for those faced with a double financial hit.

Obstacles to getting patients referred continue to trouble GPs across the Thames Valley. Most PCTs continue to push C+B, but one actually incentivises practices to use its own RFC instead! As an active clinician, I share the frustration of many who find the new systems impractical and time consuming. When you're in the business of getting patient problems sorted, the bureaucracy we've seen imposed in the past 5 years seems Machiavellian. I support efforts to help local health economies live within budget and spend taxes wisely but there must be a better way to reduce cost in secondary care than introducing systems in which referrals are lost or people just give up trying to navigate over-complicated processes.

Some of you will know that I have initiated dialogue in the latter part of 2008, over modernising LMC structure. Constant reorganisation of the NHS means local decision makers have varied in their geography over time. We now have 5 PCTs and this has increased the importance of our liaison meetings with them. Some have questioned the role of County LMCs where that county contains 2 PCTs, and it's possible that a regular meeting of TV LMCs might be a better option. As debate continues, we constantly have to keep in mind the possibility of further NHS reorganisation and the need for LMC structure to remain flexible.

For the whole of 2008 I have been working as sole BBOLMC negotiator at the Marlow office. I hope you feel LMC has still dealt with your issues during this time. During 2009 we plan to increase our workforce with a new Medical Director, and I hope some of you reading this might find such a position attractive.

The summer of 2008 saw the GPC "Support Your Practice Campaign". This followed a government inspired media campaign against GPs. The committee organising this initiative was chaired by a Thames Valley GP, Prit Buttar, and he is to be congratulated on his work. In early June his team presented a petition signed by 1.3 million patients to 10 Downing Street. The PR battle is still not won, but to me, there has seemed less

frequent adverse media commentary about GPs over the last 6 months. Is this wishful thinking?

No LMC report on 2008 would be complete without mentioning Eric Rose, who retired from partnership and medical politics in September. He was one of my predecessors as Berks and Bucks LMC Secretary and for decades has been a prominent national GP figure. General practice has lost an articulate and selfless advocate. I wish Eric well in retirement.

I have no doubt the LMC will be working even harder on your behalf in 2009. Please let me know the issues that trouble you both locally and nationally. I may not win them all but that won't stop me trying.

Best wishes
Paul Roblin