

**PAUL ROBLIN, SECRETARIAT CHIEF EXECUTIVE**

This year I have decided to add more personal opinion into my report, in an attempt to encourage debate and allow all GPs to influence the position LMC takes on issues: I always welcome comment and feedback.

Having reviewed last year's report, it was immediately apparent that some issues were still active, whilst others that seemed important then have receded into the background.

"Extended Hours" was a political imposition and a controversial use of public money, but to preserve income, many practices seem to have knuckled under and accepted this limited OOH working. Where we are now seems a long way from the 2008 controversy over Impositions A and B: you've probably even forgotten these terms.

Darzi Centres are now opening up, with variable threats to patient numbers and the income of local practices. LMC continues to argue that as part of the inevitable future cost cutting, PCT spending on such centres is not immune from review, and they should not be treated more favourably than traditional practices.

What has been new in the past year? Well, Swine Flu seems to have been a dominating feature of 2009, and practices are to be congratulated on rising to the challenges of its various phases. We began with the emergence of the disease in Mexico in late April, followed soon after by its sporadic appearance in the UK. Despite UK planning, the initial containment phase felt rather chaotic. The nature and severity of the illness was unknown and PPE (Personal Protective Equipment) hard to find. Opinion on its need varied and this did cause some friction between LMC and PCTs. However, as the clinical nature of H1N1 became more certain, anxiety levels over PPE seemed to drop. GPs were also faced with the unexpected work of swabbing possible cases. This often proved time consuming, especially when the local process for getting specimens to laboratories remained unclear.

As case numbers rose national policy changed from containment to treatment. Surgery workload increased both for the ill and those worried by the media. GPs were initially the sole assessors and prescribers of antivirals, but eventually the government got the Pandemic Flu Service up and running, and this did seem to divert patient queries away from surgeries. There is, however, a widely held view that the illness was over-diagnosed and other important conditions missed by lay assessors.

During the summer holiday period disease activity seemed to drop, (conforming to the predicted phasic nature of a pandemic) but with the reopening of schools in September, more cases emerged as part of a brief phase 2. By late October a vaccine had been developed but supplies were limited. Government announced the start of a vaccination campaign without making it clear to the public that supplies would trickle in to practices. Not learning the lessons of this communication error, they later did the same when initiating vaccination of all the under fives before national or local agreement on its delivery had been reached.

The burden of flu was always going to fall mostly on community services. Given the media criticism of GPs after the 2004 contract, GP leaders have been keen to publicise how well practices have responded. With some minor carping from some prejudiced journalists, this seems to have been effective. No doubt we will see further phases of swine flu over the coming years, and the hope is that it will not mutate to something clinically more serious. LMC will continue its advocacy of the GP view as the disease changes and PCT plans alter.

Another theme of 2009 has been PCT reaction to the recession. NHS funding is predicted to be virtually static for the next five years, which with inflation and increased demand, actually means cuts have to be made. PCTs have talked about the unaffordability of current consumption of NHS services and many have looked to divert activity (both elective and emergency) away from secondary care. We are now faced with multiple guidelines, referral templates, and in some areas, attempts to make C+B mandatory. To the coal face GP, referring into secondary care often feels like an obstacle course, which will succeed in reducing referrals solely because no one can navigate the system. As I approach the age when I might need to use the NHS more, I am increasingly fearful of the service I might receive.

Nevertheless, GPs need to play their part in making sure the NHS pot is spent wisely. I have always been a believer in the community workup and treatment of patients, and am probably at one of end of a spectrum of doctor behaviour when it comes to hospital referral. As an ex-screener of referrals in my area, I have also seen the variation in clinical threshold and risk tolerance amongst GP colleagues. My view is that the new ways general practice is organised has led to a reduction in continuity of care, and in these circumstances patient trust is reduced, people play safe, and we refer on much more easily. I certainly do this as a GP locum. If we can reverse this trend towards defensive medicine then patients and doctors may get more out of the NHS.

Consumerism and patient choice has continued as a political imperative during 2009, and I don't anticipate this will change, whoever wins the general election. The government now seeks feedback from patients via the National Patient Survey. The QOF payment thresholds for PE7 and PE8 altered in 2009, and some practices saw an

income drop. I attended many of the appeals by practices and not one in the Thames Valley succeeded. The main reason was that centrally the survey is regarded as a patient perception survey and any associated payment not a reward for the systems practices have in place. We must take this view on board. The GPC has recently published posters and leaflets designed to encourage practice friendly patient answers and LMC is researching how you might produce your own evidence for use in appeals

We seem to have been talking about Revalidation for years, without getting very much closer to its implementation. There was some progress in 2009: most of us now have licenses to practise, rather than our previous GMC registration. The BMA has voiced concerns about the bureaucracy, time involvement and cost of the current proposals, especially during a recession. Its recent Revalidation Update commented that more questions were arising than being answered, and that there was a long way to go before doctors had a realistic idea of what revalidation meant for them as individuals

I have concerns that many of the proposed processes seem vague, and from what we know, tick box like. I would like to see processes that minimise the opportunity cost of collecting evidence and assess the real qualities of a good doctor rather than what is easy to measure. Despite current reassurance, I fear we may have a one size fits all solution imposed on us. This is especially likely to occur if designing a revalidation process tailored to personal circumstances proves too difficult in the time allowed by politicians. The BMA and LMC is committed to ensuring that the final system is fit for purpose and doesn't interfere with a doctor's ability to deliver care.

The modern GP workforce is no longer dominated by partners, with an increasing proportion of salaried GPs and peripatetic locums. LMC and GPC recognise the importance of representing all types of GP and ensuring that their organisations are inclusive. During 2009 there seemed to be increasing dissatisfaction nationally amongst sessional GPs, and a view amongst some that they should seek representation outside the BMA. The BMA has responded to this by setting up a GPC group to look at the role and representation of sessional GPs. Part of this work is an ongoing survey of sessional GP's about their work and conditions, professional aspirations and thoughts about representation. I hope that any changes arising out of this will meet the needs of GPs who might currently feel disenfranchised and excluded.

Judging from the behaviour of some PCTs in 2009, a new threat to GP workload and income may emerge in 2010. As directed by government, most PCTs plan to separate off their community arm. Where this has already begun, some potential threats have emerged. It is difficult to write a contract with providers of community nursing services, which actually specifies the tasks their nurses should perform. The traditional primary care team has relied on custom and practice in dividing up tasks

between district nurse and GP, but this probably won't work in the NHS market. I worry that managers will stop nurses performing tasks that they believe are part of GP core services, even though the GP contract was priced with this historic division of labour in mind. Whereas district nurses can just stop such work, practices would find this more difficult, and venesection, wound management or vaccination of the housebound may fall on practices or become a chargeable service. LMC will argue for any such movement of activity to be properly resourced and hope this approach will be supported by practices staying strong and saying "No" when appropriate.

When I last wrote, BBOLMC was hoping to appoint a Medical Director. Despite both national and local advertising, this has not been possible. BBOLMC therefore remains a small organisation, with me as the main negotiator. I hope we still manage to fulfil the majority of your needs, but please let me know if this is not so. We have appointed paid Chairs to each of the five local LMCs (LRCs) in the Thames Valley, and these courageous GPs have given me fantastic support over 2009. I wish to thank them for this. Behind the scenes, the Marlow office staff works tirelessly to make sure you are informed about important news and that the various meetings run efficiently. I would not be able to function without them, so thank you Pauline, Michelle, Gillian, Carol and Dave (IT).

Finally, the LMC exists to listen to and voice the concerns of its levy payers, whether partners or employed GPs. This does not mean that we concentrate solely on money: your quality of professional life is equally important and we try to troubleshoot the frustrations you experience in your work. Please continue to let LMC know about the issues you face and we will try to help.

Of course if any of you fancy being a LMC Medical Director I would be delighted to hear from you.

Best wishes for 2010  
Paul Roblin