LMC SECRETARIES CONFERENCE 2013

THURSDAY 5 DECEMBER 2013

SHEFFIELD LMC REPRESENTATIVES: David Savage Margaret Wicks

ADDRESS BY GPC CHAIRMAN

The Conference opened with the first address by Dr Chaand Nagpaul, Chair of the General Practitioners Committee (GPC):

Statement of Facts

- There has been a decrease in the proportion the NHS budget allocated to Primary Care, with the total budget in 2004 being 10% of the total, reducing to 7.4% in 2013/14.
- GPs made up 35% of the workforce in 2004/05, dropping to 25% in 2013/14.
- There is an anticipated increase in GP retirement in the next 5 years.

GP Contract 2014/15

Context: The context of the previous year's contract imposition was outlined, as well as the fact that the 2014/15 contract had been negotiated with an atmosphere of adverse publicity for GPs and NHS policy being driven by political announcements. However, Dr Nagpaul felt that the 2014/15 contract was a negotiated agreement with give and take on both sides and, in fact, the GPC negotiators had achieved a significant amount. A decrease in bureaucracy had been achieved, as well as a reversal of much of the 2013/14 imposition.

***Quality and Outcomes Framework (QOF)*:** Most of the imposed indicators will be removed. Funding for 238 points is to be transferred to core funding, which will not then be subject to annual unpicking. The threshold changes that were to be introduced in 2014 have been retracted. There are no new indicators. It was anticipated that this would lead to more time to look after patients and use proper clinical judgement, a freeing up of administrative and doctor time and a decrease in Post Payment Verification (PPV).

***Contractual Hours*:** There will be no change to contractual hours.

***Named Accountable GP for Over 75s*:** It was accepted that having named GPs for over 75s was not a wish of the profession, but this could be the patient's usual GP, and it did not imply that the patient had to see this GP on all occasions.

***Reducing Unplanned Admissions*:** This was being looked at by out of hours (OOH) quality monitoring audits, OOH consultations and NHS111.

***IT Changes*:** It will be a necessity for practices to have online appointments and repeat prescription requests, with many practices already doing this. However, there would be the imposition of the Summary Care Record (SCR) having to be uploaded by April 2015.

***Seniority*:** The changes would lead to a cliff edge reduction in funding for GPs over a period of time, but the GPC had managed to negotiate 6 years' stability. Partners should be aware that after 2020 seniority would be dispersed amongst the profession for when they started work, which would make more money available to more doctors, although doctors that had worked for many years would lose out significantly at that time.

Publication of GP Earnings: This should stop many of the inaccuracies quoted in the press, however, the GPC had only agreed to a Working Group to look at this, at this stage.

Choice of GP Practice: This would be voluntary, with NHS England being responsible for urgent care. The Government is keen for an October 2014 rollout.

***Ongoing Negotiations*:** These included resolution of issues around the removal of the Minimum Practice Income Guarantee (MPIG), equitable GMS/PMS funding and locum superannuation.

GPC Image, Form and Function

The importance of the GPC's image, form and function was stressed, noting that the GPC has a large infrastructure and was reforming its public image. The intention was for the GPC to lead rather than be reactive and to be the voice of the profession, as the only legitimate negotiating body. In addition, it was felt to be essential to have a strong two-way GPC/LMC axis.

GP Access

One of the GPC's priorities is to change external mind sets with regard to GP appointment delays, using examples from the Commonwealth Fund, with evidence showing that patients had the least difficulty getting access to OOH care and general practice in the UK than any other country, and that Primary Care in the UK was the most inspected in the whole of Europe and the United States.

DR CLARE GERADA, FORMER CHAIR OF THE ROYAL COLLEGE OF GP (RCGP) COUNCIL

Dr Gerada gave a speech on the role of Primary Care in the NHS. The main points of note were:

- The NHS is unique amongst any health service system because of general practice, the lifelong patient record and registered patient lists, all of which are the building blocks of continuity of care.
- Priorities included smoothing out the variability between GPs, GP premises and practice outcomes.
- It would be helpful if there was a change in the way that Primary Care worked, with increasing capacity and capability.
- There should be sharing of GP data with other organisations.
- There should be a linking with Social Service and education budgets.
- Targets in protecting Primary Care were to take down historic boundaries, improve patient access, reinforce continuity of care and more care in practices. They were laudable as objectives, but there was a feeling from the audience that these were not practicable with the current workforce and funding issues.
- Dr Gerada suggested that federations of practices could interlink with other organisations to create teams without walls and teams within teams.

NIGEL EDWARDS, SENIOR FELLOW, THE KINGS FUND

The main points of note were:

- Primary Care is the cornerstone of the NHS and compared very well with other health service organisations.
- There was variability between practices, but GPs were unfairly represented in the press and were, in general, providing good quality care.
- A number of models were being looked at around the integration of GPs with other health care teams, particularly using federations as a way of delivering care.

THE ROLE OF THE LMC IN CONSULTING WITH AND REPRESENTING THE PROFESSION

The main points of note from this Workshop were:

- LMCs should be highlighting their role, and that of the GPC, as the only representatives of providers of Primary Care. In a number of areas people were talking to commissioners as if they represented GPs, and it was important to get the message across with all organisations, including Area Teams and Health & Wellbeing Boards that this is not the case.
- There was discussion about federations of LMCs having a stronger voice with their Area Teams. We have already moved some way towards this with the formation of the South Yorkshire LMCs but, like many other areas, we are keen to maintain our individual identity and funding streams at present.
- We discussed the LMC/GPC communication axis and it was considered that the LMC Listserver was an important means of communication. Communication with the GPC in general very much depended on the efficiency and enthusiasm of the assigned Senior Policy Executives. There was also considerable variation in the contact that LMCs had with their Regional GPC representative.
- There would be a series of GPC roadshows in January/February 2014 and it was hoped that these could be opened up to a wider audience than just LMC members.

THE CALCULATING QUALITY REPORTING SERVICE (CQRS)

The main points of note from this Workshop were:

- CQRS and the General Practice Extraction Service (GPES) will support QOF for 2013/14 and QOF data should now be visible across all practices and Area Teams.
- Enhanced Services data has to be entered manually for 2013/14. Manual data entry is a complex process that is not necessarily self-explanatory, as CQRS was never designed to have to work manually. Enhanced Service CQRS guides have been produced, which can be accessed at: http://systems.hscic.gov.uk/cqrs/participation.
- GPES online training packages and guidance has been made available to assist practices: http://www.hscic.gov.uk/gpestraining.
- All practices should have received information on how they can register for GPES and CQRS updates, newsletters etc: http://www.connectingforhealth.nhs.uk/systemsandservices/cqrs/regforupdates.
- Some Area Teams are mistakenly insisting on manual data entry on CQRS and submission of paper forms, when paper forms should not be required (except ImmForm, which is a Department of Health uptake process, not a payment mechanism).

THE TRAINING NEEDS OF LMCS

The main points of note from this Workshop were:

- The priority educational needs for LMCs were listed as legal obligations of setting up LMC offices (contracts of employment, taxation etc), Any Qualified Provider (AQP) status and legal issues with regards to sitting on Performance Screening Groups (PSGs) and Performance List Decision Panels (PLDPs).
- There seemed to be genuine concern that PSGs and PLDPs had become more distant from our local knowledge and LMC representatives would need a sound knowledge of the implications of decisions when supporting colleagues.
- In addition, there were requests for training in media skills, negotiating skills and conflicts of interest.

DR D SAVAGE
Secretary