

31 Mar 09

LMC Members

MEETING NOTES:
SOUTHWEST REGIONAL LMC MEETING AND GPC ROADSHOW TAUNTON
26TH MARCH 2009

SOUTHWEST REGIONAL LMC MEETING

Conference Motions. Perhaps LMC Conference motions might have more impact if proposed regionally. The meeting considered the following areas, but no actions were assigned to anyone:

- GMC Council Membership. There is now only one GP on the GMC Council, and even he is not elected. GPs need elected representation to avoid a loss of democratic control.
- Impact of the abandonment of the square rooting formula. PCTs are under no enforceable obligation to look after practices, particularly those serving universities, that may be severely affected by the loss of the square rooting formula. Many felt that PCTs lacked accurate data in many areas; symptomatic was that the DH had had to rely on the GPC's spreadsheet for calculating the impact of the change. If needed, a calculation of the impact per thousand patients would provide a useful comparator. The lack of quality and continuity among PCT financial staffs was unfortunate. One GP thought that PCTs avoided tackling over-expenditure by secondary care, which spent the lion's share of the budget, preferring to micromanage GP practices because that was easier. University practices provide many specific and valuable services for their special patient groups, but because these are not easily measurable they cannot be rewarded under QoF; a LES would be the better approach.
- LESs. Many PCTs seemed reluctant to grant new LESs; even in Devon the PCTs seem to be tightening up, where GPs are being asked to find 4% cuts in expenditure. In Avon and Wessex PCTs sometimes introduced LESs without consulting the LMC properly; indeed, Wessex LMCs now issue a traffic light to each LES (Red – not negotiated at all; Amber – some LMC suggestions accepted; Green – fully negotiated and agreed with the LMC.)

Darzi Centres. Private providers were no longer keen to get involved. Gloucestershire reported they would be opening in May. Avon was posing Freedom of Information requests to their PCT to find out the details of the contracts awarded there. They argued that they needed the information to protect existing practices. No reply yet.

Vascular Screening. Apparently there is new software available that can identify at-risk patients and Wessex LMCs suggested that practices should contact patients on their birthday every 6 years. Within Gloucestershire we shall take this to the LMC-PCT Negotiations. Somerset is looking to trial the system at Bridgwater. One representative feared that this was another example of 'constructive discomfort' being applied to practices with the aim of making them amalgamate with others.

Summary Care Record. Healthcare professionals should be able to access patients details easily, but others should not. Patients should have a choice, whether on an opt-in or opt-out basis. It was quite wrong for patients to have to explain themselves to the PCT face to face, as was being insisted on in some places. Organ donation was a similar issue.

World Class Commissioning and PBC. Somerset was proud of having a single county-wide consortium which had achieved a reduction in emergency and admissions. They headed the national 'league table'. Small clusters were more common, but largely ineffective. Lack of adequate support and commitment from PCTs did not help. An even more significant risk to progress was that while PCTs remained responsible for the funding but the resources were held by practices there would never be real progress. Some looked optimistically for a change of government to improve things.

South West Regional BMA Council. Although BMA Divisions would continue to exist, they were unwieldy. The BMA wanted to do more work through Regional Councils. Funding had been granted for a Chair and Secretary, and GP backfill had been agreed in principle for those attending. Resources had already been granted for a one-day conference. A business plan was needed now, to be staffed through Sean Cusack, to allow the Council to operate. LMCs were asked to send a representative to the South West Regional BMA Council meeting on 8th April in Taunton. At present no-one is available.

GPC ROADSHOW – BRIEFING BY NEGOTIATOR (BETH McCARRON-NASH)

Practice Funding. The government is determined to get rid of the MPIG, but to do that practice incomes will have to be levelled up, which will require DDRB recommendations for an increase over several years. Whether the DDRB will be able to recommend that in the current economic down-turn is debatable. And since the DDRB report has not yet been released by the Government the future of practice funding for next year is still vague. The GPC has agreed a formula with the NHS Employers whereby the whole amount of money available for funding GMS practices in 09/10 will be assigned according to an iterative ratio model. The way this will work is that:

- At the first iteration 7/19ths of the national 'pot' will be assigned to the Global Sum, and every practice has to be looked at to see if the increase recommended by the DDRB will have taken them over their MPIG.
- If it has taken them over that limit then the surplus is added back into the national 'pot' of money and in a second iteration is allocated among those practices whose global sum, even after the last addition, is still less than their MPIG.
- Once again, if any further practices have reached their MPIG the surplus is added back into the pot and re-allocated. This iterative process continues until there is no further movement on the Global Sum allocations.
- Once that has taken place:
 - 2/19ths of the original pot is added to all practices' Global Sum Equivalents.
 - 5/19ths of the original national pot are assigned nationally to QoF payments
 - 5/19ths of the original national pot are assigned nationally to Enhanced Services.

The expected outcome can be summarised in the following table, but it will be impossible to predict the actual changes for any particular practice until some firm figures are released on the DDRB recommended uplift for 09/10:

Type of Practice	Global Sum Equivalent (GSE) (GS + CF)	Remarks	QoF and ES
Practices with a global sum only in 08/09	Increase in Global Sum higher than the DDRB headline percentage rise	Amount will vary depending on the Carr Hill factor, but could be a significant rise.	QoF and ES rise lower than the DDRB headline percentage rise.
Practices with a small correction factor in 08/09 but which will have 'moved off MPIG' in 09/10	GSE rise could be higher or lower than the DDRB headline percentage rise.	Smaller initial correction factor leads to a bigger rise.	QoF and ES rise lower than the DDRB headline percentage rise.
Practices with a correction factor in 08/09 and 09/10	GSE only rises slightly, and below headline DDRB percentage rise.	Correction Factor becomes smaller as Global Sum rises.	QoF and ES rise lower than the DDRB headline percentage rise.

The main beneficial effect of all this is that any increase agreed by the Government will not all be clawed back by a reduction in the Correction Factor (as happened last year); everyone should see some increase in income. But if the same ratio model is followed in future years it will not be fair to all practices, so this is a one-year compromise to allow the negotiators time to find a fairer model acceptable to both NHS Employers and the profession.

Seniority Payments. The government wants to get rid of seniority payments as well. The GPC negotiators take the view that:

- If this is going to happen then the money should be kept within primary care for the benefit of practices.
- The size of the fund involved would be frozen at the time the move takes place. It would therefore be better to do it now, while there are so many senior GPs earning large seniority payments. In a few years many will have retired and their places will be taken by very junior partners earning very little seniority payments, or even by salaried GPs, who are not entitled to any seniority payments at all. Primary care as a whole would be financially harmed by delaying what many see as inevitable.

How strongly do practices feel? We shall be discussing this at the April LMC so that Dr Fellows can take our considered views to the GPC meeting on 23rd April.

QoF Prevalence Calculations. NHS Employers had wanted to get rid of both the square rooting and the 5% cut-off at one blow. The phasing-in of it over 2 years is therefore another 'win' for the GPC Negotiators, and fulfils a resolution from the LMC Conference that money should be paid for work done.

QoE. She was also pleased that thanks to heavy lobbying from LMCs and the GPC the government had backed off local QoFs – at least for now. She also pointed out that practices should take care with the new Depression indicator, as it is time limited.

Directed Enhanced Services (DESS). The GPC advice for dealing with DESSs that come out so late in the year is to do the work anyway, since the funding will be rolled over into the new financial year but kept separate from that year's allocations. The procedures for getting that funding to practices has still not yet been agreed, but negotiations are continuing.

HPV Inoculations. This programme has been rolled out full of inconsistencies, and lacking clarity on many issues. The GPC is still trying to get them ironed out.

Pandemic Flu. The GPC will be issuing guidance on 'buddying up'. Meanwhile they would stress that all levels of staff should be consulted when making practice plans for dealing with a pandemic. Disease is no respecter of persons.

MRSA Screening before admission to hospital. The GPC would welcome feedback on how this is being managed, particularly about what happens when a patient tests positive.

Practice Accreditation. This has been piloted by 30 practices of which only 2 scored less than 65%. This probably reflects a substantial amount of work by practice managers, albeit spread over the year, together with involvement by GPs. The GPC is working with DH, NHSE and RCGP to reduce the workload when the system goes live – which is unlikely in the next 2 years.

Revalidation. This is still being negotiated and piloted. Issues include:

- The introduction of a personal prescribing number, complicated by the way dispensing practices merge their prescribing figures.
- Concern that sessional GPs may have difficulty obtaining 'multisource feedback'.
- Patient surveys – what should be in them, how can GPs be protected against those who slander them etc
- What is a 'health-assessed credit' anyway?
- Who pays if a GP fails revalidation? There could be an impact on PCTs, practices and partners.

Practices are encouraged to access the RCGP website every month for the next 5 months. You have the chance to influence planning in this important area. Please copy your comments to the LMC for information.
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Patient Surveys. While on the subject of surveys, one LMC suggested that it would be sensible to spend £150 or so a year on a separate, validated survey to provide ammunition in the event of an appeal against the results of the huge and inappropriate national survey, which the GPC had tried hard to have amended without success. Such a private survey would also prove useful to support individual appraisals, particularly if the national survey result is adverse.

[Signed on the original]

Mike Forster
Lay Secretary