PSNC Agenda

For the meeting to be held on 9th October 2013

at Devonport House, King William Walk, Greenwich, London, SE10 9JW

commencing at 9.15am

Members: Stephen Banks, Dhiren Bhatt, David Broome, Christine Burbage, Mark Burdon, Peter Cattee, Liz Colling, Mark Collins, Ian Cubbin, David Evans, John Evans, Mark Griffiths, Kirstie Hepburn, Elisabeth Hopkins, Tricia Kennerley, Andrew Lane, Margaret MacRury, Rajesh Morjaria, Andy Murdock, Garry Myers, Bharat Patel, Indrajit Patel, Kirit Patel, Rajesh Patel, Umesh Patel, Janice Perkins, Chris Perrington, Adrian Price, Alan Robinson, Omar Shakoor, Gary Warner

Chairman: Sir Peter Dixon

1. Apologies for absence

Apologies for absence have been received from Christine Burbage, Rajesh Patel and Omar Shakoor.

2. Minutes of the last meeting of PSNC

The minutes of the PSNC meeting held on Tuesday and Wednesday 9th and 10th July 2013 were shared with the committee and can be downloaded from PSNC's website.

The minutes of the special PSNC meeting held on Wednesday 11th September 2013 were also shared with the committee but these are confidential as they relate to ongoing negotiations with NHS England and DH.

3. Matters arising from the minutes

To consider matters arising from the minutes of the July meeting which are not dealt with elsewhere within the agenda.

4. Update on the Health and Care Landscape

The three Update on the Health and Care Landscape Briefings that have been published on the PSNC website since the July meeting of PSNC are set out in **Appendix 03/10/13**. Alastair Buxton will highlight points of particular interest.

5. Chairman's Report and Chief Executive's Report

6. Update on negotiations with NHS England and DH

A summary of progress since the special meeting of PSNC held on 11th September 2013 will be given.

ACTION

7. Deputies and Proxies

Following concern expressed about the attendance of a deputy at the special meeting of PSNC (when highly confidential and sensitive discussions were to take place) the Review and Audit Panel has considered whether the Constitution should be amended.

The Panel considers that the current arrangements for deputies should continue, but that where the matters to be discussed are particularly sensitive, deputies should not be permitted (but see below).

Because meetings of this kind may be called at short notice, causing members difficulty in attending, there needs to be alternative arrangements, especially where attendance by a deputy is not appropriate. The Panel recommends that in addition to the arrangements for deputies, PSNC members who are unable to attend personally should be able to nominate another member of the Committee to act as proxy so that their vote can be counted. The appointment of proxy would be notified at the commencement of the meeting. Because an appointed Proxy would be a Committee member, this facility would be available for any plenary meeting (whether highly sensitive or not).

It is proposed that the Constitution is amended in Paragraph 5:

5. Meetings

5.1 Meetings of the PSNC shall normally be held in January, March, May, July, October and November each year. Members of the PSNC shall, wherever possible, be given not less than seven days clear notice by the Chief Executive of such meetings.

5.2 A member who is unable to attend a plenary meeting of the PSNC may appoint another member of the Committee as his proxy to vote on his behalf at any such meeting provided that the proxy is declared at the commencement of the meeting.

5.3 A member who is unable to attend a plenary meeting of the PSNC may appoint a deputy to attend the meeting on his behalf, unless the Chairman or Chief Executive Officer has indicated, when notice is given under paragraph 5.1, that deputies will not be permitted for the particular meeting.

8. Regional Representative Boundaries

PSNC regions have been reviewed to ensure they reflect the new structures within the NHS. To better align LPCs with their Area Teams, it is proposed that the following amendments are made to PSNC Regions:

- Dorset transfers from South West to South Central Region
- Northampton transfers from East Midlands and South Yorkshire to East Region
- Cumbria transfers from North Western to North Eastern Region

The Committee is asked for its approval to amend the Annex to the Rules to effect this change.

Currently, the regions are set out in the Annex to the Rules. It is further proposed that the Annex is removed from the Rules, so that it can be amended by a decision of PSNC, without this having to be a Constitutional amendment. The Rules will need amending to provide a suitable framework. The following is the proposed amendment to the Rules, with deletion of the Annex:

11.3 Regions of PSNC

11.3.1 The PSNC has 13 regions.

11.3.2 PSNC shall determine the LPCs that form each region.

11.3.3 The regions and their respective LPCs will be published by PSNC.

~~11.3.1 each of which includes the area covered by one or more Strategic Health Authorities in England, as they were constituted on 14 October 2009, and set out in the Annex to these Rules.~~

~~11.3.2~~11.3.4 One representative may be elected in each of the PSNC regions.

The Committee is asked for its approval to this amendment to the Rules.

The current Annex, as amended by the above, is reproduced in **Appendix 04/10/13**. It is proposed to remove reference to the now obsolete SHAs, and instead to include the names of the Regional Representatives, so that this can be published by PSNC.

RATIFICATION

9. Resource Development & Finance Subcommittee

A meeting of the Resource Development and Finance Subcommittee is scheduled to take place on Tuesday 8th October 2013. The subcommittee chairman will provide a report on the meeting.

10. Funding & Contract Subcommittee

A meeting of the Funding and Contract Subcommittee is scheduled to take place on Tuesday 8th October 2013. The subcommittee chairman will provide a report on the meeting.

11. LPC & Implementation Support Subcommittee

A meeting of the LPC & Implementation Support Subcommittee is scheduled to take place on Tuesday 8th October 2013. The subcommittee chairman will provide a report on the meeting.

12. Service Development Subcommittee

A meeting of the Service Development Subcommittee is scheduled to take place on Tuesday 8th October 2013. The subcommittee chairman will provide a report on the meeting.

ACTION – PLANNING

13. PSNC Plans - discussion

It is likely that the November planning meeting will need to be largely committed to discussions on the ongoing negotiations with NHS England and DH. As a consequence of this, the following discussion session will consider the key elements that need to be included in the PSNC 2014/15 plans which will be finalised in January 2014.

PSNC published its Vision narrative in August 2013 (see **Appendix 05/10/13** which is printed separately at the back of the agenda papers) restating the policies for future services in the four year plan, in a format for use at local and national level. This formed the basis of the seminar prior to the Partners' Dinner.

PSNC's services for LPCs were collated and published in a document 'Local Pharmacy Organisation Support Services', published in July 2013 – see **Appendix LIS 03/10/13**. Together these papers summarise key elements of PSNC's work, the other major areas relating to pricing audit, reimbursement, legislation and to funding for the national community pharmacy service.

Discussions on tables will be held to review key elements of the current PSNC plan.

The Committee is asked to confirm its support for the policies and services published in these papers. Ongoing development of these will then form part of a draft Plan, which will be considered at the November 2013 meeting (if time permits) and the January 2014 meeting, together with a report of the conclusions of the LPC conference.

REPORT

14. Report of the election of Regional Representative for Yorkshire and the Humber

Immediately following the July 2013 meeting of PSNC, at which the Constitution and Rules were amended to clarify that a candidate is eligible for election only if he personally or through his or her family, has an interest in not more than nine NHS pharmacies in England, a request for expressions of interest was sent to all members and officers of LPCs in the region. This resulted in two expressions of interest.

The formal call for nominations, which included details of the two persons who had expressed an interest, was emailed to all LPC members and officers in the region, with nominations required by Friday 9 August. One of the persons who had expressed an interest emailed the Returning Officer to inform him that as he had been appointed to Chair the LPN, he would not be pursuing election as regional representative.

Two nominations were received, which were checked against the eligibility requirements set out in the Rules.

One of them was from a pharmacist member of an LPC in the region. His shareholding in the company is 10% with his wife owning a further 10% of the shares in the company. His form was invalid, as he is not a director of the body corporate that owns the pharmacy named on the nomination. The returning Officer contacted him to confirm whether the information held by Companies House is up to date. The candidate confirmed that it was, but added that he also has an interest in pharmacies in the region owned under another company name, of which he is a director. A further company search was carried out, and this confirmed that he is a director of that second company. However, there are six shareholders in total, each owning 50 shares, (and none of those other five are family members) and so his one sixth shareholding did not meet the requirement for the shareholding to be 'substantial' as required by the Rules. He was informed by the Returning Officer that his application did not meet the eligibility criteria.

The remaining nomination form was checked, and met all the eligibility criteria. This form was submitted by David Charles Broome, who, in the absence of further valid nominations, was duly elected.

15. Other matters of report and any other business

Update on the Health and Care Landscape

Review of NHS England's Mandate

On 5th July the Government commenced a consultation on refreshing the Mandate to NHS England for 2014 to 2015. The Mandate sets the government's ambitions for the NHS as well as the funding available to achieve the kind of care people need and expect.

There have been crucial developments and new evidence that has emerged since the publication of the first Mandate, which have prompted the proposed changes. The main proposed changes reflect these core priorities:

- the actions being taken forward by NHS England in response to the Francis Report to transform the care people receive;
- working with NHS England to develop a vulnerable older people plan, which will improve support for older people and those with long term conditions, particularly through reform of primary care given its pivotal role within communities; and
- the need for the NHS to contribute to the recovery of the economy and make better use of resources in light of the challenging financial climate.

Other changes being proposed include:

- an update to the current objective to challenge NHS England to make measurable progress towards avoiding at least 10,000 excess deaths per year by 2018. Screening programmes, early diagnosis of disease, suicide prevention and tackling obesity are all mentioned as ways to achieve this target;
- introducing the 'friends and family test to general practice by December 2014 and the rest of NHS funded services by the end of March 2015;
- a requirement to work with Monitor, following its Fair Playing Field Review, to drive progress towards a fair playing field for the benefit of people receiving NHS care, including through setting clear expectations for commissioners on the approach to procuring services;
- providing more support to the NHS to go digital by 2018;
- clarifying that work on variation and unacceptable practice must include reporting on the quality of services at GP practice level and also at the level of consultant-led teams for a number of specialties;
- taking steps to ensure NHS organisations recover the costs they incur from overseas visitors, where appropriate; and
- taking more effective action to reduce fraud and unlawful activity affecting the NHS.

Proposals to improve care for vulnerable older people

The proposals include every vulnerable older person having a named clinician responsible for their care outside of hospital, ensuring accountability is clear and care packages are personalised and tailored around individual needs.

The other proposals include:

- better early diagnosis and support to stay healthy by improving the role GPs play in supporting people to stay healthy and taking an active role in managing the health of their local populations;
- improving access to primary care through new types of services such as rapid walk-in access services, helping patients connect with their GP in different ways through new technology, making booking appointments easier and building on existing services and opening hours;
- providing consistent and safe out-of-hours services;

- enhancing choice and control by giving more choice about location and type of service such as seeing a preferred GP or nurse and the option of doing this face-to-face or by email and telephone; and
- better sharing of information and joining up services so care can be provided in a coordinated way.

Jeremy Hunt said the immediate focus is on the most vulnerable and elderly, but this is only the starting point of a much broader transformation in out of hospital care.

Over the summer, the Department of Health will seek views on the proposals, test them and the best ways to implement them. It will work with NHS England to set out a plan for improving out-of-hospital care for vulnerable older people. The final plan will be published in October and will be reflected in the refreshed Mandate to NHS England for 2014/15.

The following questions have been posed as part of the consultation:

Staying healthy for longer: concentrating on prevention and managing long term conditions

We want to improve the GPs' role in supporting people to stay healthy, taking a proactive role in managing the health of their local populations. This involves identifying the people most at risk in the communities they serve, and ensuring fast access to specialist care. But also supporting people to better manage their own care.

- How can we strengthen the incentives, or increase flexibility, for GPs to effectively manage the health of the local population?
- In your experience, how do you suggest people can be better supported to manage their own care?
- Can you share any best practice examples of how to strengthen prevention and early diagnosis in primary and community services?

Named clinician: providing a single, named contact to coordinate an individual's care

We are proposing that the most vulnerable older people would benefit from having someone in primary care who is responsible for ensuring that their care is coordinated and proactively managed. Just as patients in hospitals are under the care of a named consultant, we need to ensure that when a vulnerable older patient needs follow-up, or ongoing support having left hospital, somebody is accountable for ensuring their care happens. This clinician may not provide the care directly themselves, but they would be the person who has ultimate responsibility and would be easily contactable by a patient or their family.

- How do you identify vulnerable older people or people most at risk in the local area?
- Who do you feel is best placed to perform the role of a named accountable clinician in a primary care setting?
- Named clinician: providing a single, named contact to coordinate an individual's care

Improving access: making it easier to book appointments and get advice

We want to improve people's access to primary care through new forms of provision including rapid walk-in access. New technologies such as e-consultations, telecare and web consultations offer new ways for people to connect with their GP and local services. We also want to make it easier for people to book appointments, online, for example, as well as building on existing services and extended hours.

We are aware that there are many innovative ways of working that are already underway to improve access to primary care, especially general practice.

- Can you share some examples of introducing new technologies and new ways of providing primary care services?

- What are the barriers to introducing new technologies to improve access?

Out of hours: ensuring a safe and consistent service

Alongside improved access to GP services, we need consistent and safe urgent care services. People often need out of hours care but are unable to access support or know who to turn to for advice. We want better access for patients across primary care and hospital services, including 111 and emergency services.

- How can we best ensure clear accountability for out of hours services?
- What is the role of other primary care services, for example, pharmacists, in providing safe and consistent out of hours care?
- Do you have any examples of good practice and innovation in out of hours provision?

Choice and control: providing clear and accurate information to help patients make decisions

We want to offer more choice and control to patients, carers and families. The GP Patient Choice pilot ran from April 2012 to March 2013 looking at new ways for people to access primary medical services when they live outside a GP practice's boundary area. We will consider the findings of the GP choice pilot evaluation and recommendations to extend GP choice.

People also need clear and accurate information about the quality and availability of services. Feedback from patients is an important part of this. The 'friends and family test' will be introduced for general practice as part of the wider roll out for all services by end of Dec 2014.

We also want to encourage new provider models that will offer meaningful choice about the location and types of service people need, including choice of seeing your preferred GP or nurse.

- How do you think patient choice can be supported in out of hospital care, for example more transparency, flexible provision and support for decisions?
- What do you think are the barriers to enabling choice in out-of-hospital services?
- Do you have any examples of patients who have been supported to achieve better outcomes through the use of choice and control?

Joining up services: sharing up to date and accurate information and supporting coordination of care

People often require a range of services from the NHS and social care to help them live well and independently. People should not have to repeat their information and medical history. It should be available to those who are providing the care, in a coordinated and timely way. We will explore how all clinicians and carers can have access to the same information about patients regardless of setting. Better information sharing will also help people and carers to manage their own care more effectively.

We want more integrated care across health and care settings, with a stronger role for general practice operating at scale. Integrated out of hospital care can be achieved through closer work on commissioning, but also through stimulating new approaches to out of hospital provision. Too often there are real and perceived barriers to closer integration between services, which we need to overcome.

We are aware that Clinical Commissioning Groups and general practice are already developing new approaches to integrated services, to improve the overall quality of care their population receives. We want to build on these approaches, to support ambition of high quality out-of-hospital care while retaining the traditions and values of the family doctor.

- What do you see as the main barriers to achieving integrated out of hospital care and how can these be overcome?
- Do you have any examples of integrated out of hospital care happening in your local area and having a positive impact on patient outcomes?

- What do you think are the main barriers to data sharing between services to support patient care?
- Can you highlight any examples of where data sharing to support patient care is happening effectively?

NHS England – The NHS belongs to the people – A call to action

On 11th July NHS England called on the public, NHS staff and politicians to have an open and honest debate about the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of its patients. This is set against a backdrop of flat funding which, if services continue to be delivered in the same way as now, will result in a funding gap which could grow to £30bn between 2013/14 to 2020/21.

The publication *The NHS belongs to the people: A call to action* sets out these challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remains flat and rising expectation of the quality of care. The document says clearly that the NHS must change to meet these demands and make the most of new medicines and technology and that it will not contemplate reducing or charging for core services.

The document sets out a number of the latest facts on the NHS, including demand, the changing demographics of the patients being treated and the growth in long term conditions. These include:

- Between 1990 and 2010, life expectancy in England increased by 4.2 years;
- The difference in life expectancy between the richest and poorest parts of the country is now 17 years;
- Around 80% of deaths from major diseases, such as cancer, are attributable to lifestyle risk factors such as smoking, excess alcohol and poor diet;
- One quarter of the population (just over 15 million people) has a long term condition such as diabetes, depression, dementia and high blood pressure – and they account for 50% of all GP appointments and 70% of days in a hospital bed;
- Hospital treatment for the over 75s has increased by 65% over the past decade and someone over 85 is now 25 times more likely to spend a day in hospital that those under 65;
- The number of older people likely to require care is predicted to rise by over 60% by 2030;
- Around 800,000 people are now living with dementia and this is expected to rise to one million by 2021;
- Since it was formed in 1948, the NHS has received around four per cent of national income; and
- Modelling shows that continuing with the current model of care will lead to a funding gap of around £30bn between 2013/14 and 2020/21.

NHS England along with other national partner organisations will be providing support for the organisation of local meetings to discuss these issues. These meetings will provide the mechanism for patients and the public to have a say in how the NHS of the future will look.

All feedback from these meetings, as well as national events and online contributions via NHS Choices, will be published and used to help shape a longer term strategy for the NHS. This will need to be in place by early 2014 to feed into commissioning plans for GP-led Clinical Commissioning Groups in 2014/15 and 2015/16.

The document's executive summary says:

> The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals.

These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five-year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future;
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures;
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans;
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

Alongside the publication of *The NHS belongs to the people*, David Bennett, chief executive of Monitor, has said his organisation estimates that the NHS needs total savings of between £28bn and £44bn between 2010-11 and 2021-22 to protect its finances and maintain quality of care.

He said that Monitor's review had looked across the whole system at all the possible ways the system could address this gap. They had concluded that over the period there were potential savings of up to £12.1bn from improving providers' efficiency, up to £4bn from integrating care and shifting it to different settings, and up to £1.9bn from service innovation. Additionally they estimate the NHS could make £7.5bn one-off savings from reorganising its estate and selling off excess land and buildings. In the best case scenario total savings would be £2.5bn short of its lower estimate of what was needed.

CCG finances

In last month's spending review, the Government announced plans to create a £3.8bn fund for commissioning of health and social care that will be held by local authorities. A paper being presented to the July meeting of NHS

England's Board says £3.4bn of these funds will come from CCG budgets and will require substantial savings to be made in other costs.

That £3.4bn comprises £0.9bn already transferred from the NHS annually to support local authority funded social care, an extra £0.2bn that will be added to that pot next year, £0.3bn of reablement funding and £0.1bn of carer's break funding currently included in CCG allocations, and an extra £1.9bn top sliced from CCG budgets.

For the average CCG, the establishment of the fund will mean £10m of allocated funding will be transferred to the pooled budget (in addition to the pooling of reablement and carers' breaks funding that is currently within CCG baseline allocations). This is in the context that the average CCG was allocated around £300m in 2013-14 and hence the figure is equivalent to around 3 per cent of CCG allocations.

The paper also notes that DH agreed in the spending round to a further £300m administration savings in 2015-16; discussions are ongoing about how these cuts will be split between NHS England, CCGs and CSUs.

Pressure on NHS pensions

The *Health Service Journal* (*HSJ*) reported in late July that HM Treasury plans to recalculate the value of public sector pensions and introduce a single tier pension could leave the NHS facing an annual bill of £2.5bn.

NHS Employers and trade unions are understood to have launched a campaign against the plan which they say will result in job losses and service cuts, as well as threatening the long-term future of the NHS Pension Scheme. It is understood that the proposed changes to the way pension schemes are valued could cost individual NHS trusts tens of millions extra in contributions.

NHS procurement

The Department of Health announced in early August that a 'procurement champion with private sector expertise' is to be appointed to lead the work of the NHS to get a better deal on its supplies. The announcement was made alongside the publication of Better Procurement, Better Value, Better Care: A procurement development programme for the NHS. *This document identifies* a lack of consistency and senior oversight in procurement and said the NHS relies too much on framework deals with suppliers. Health Minister, Dr Dan Poulter will lead a committee dedicated to driving down the £18bn NHS procurement bill.

Dr Poulter sets out a number of specific actions to tackle these problems. They include:

- Mandating hospitals to publish for the first time what they pay for goods and services and setting up a brand new 'price index' for hospitals, through which they will be able to see how much they are spending on different products compared to other hospitals;
- Cutting the temporary staff bill by 25% by the end of 2016 (temporary staffing currently costs the NHS £2.4 billion every year), by helping the NHS learn from the best hospitals and use more efficient staffing arrangements;
- A plan for the Department of Health to make the most of the market by working with top NHS suppliers directly to strike new, bulk deals for medical equipment like radiotherapy machines and MRI scanners; and
- Growing the UK economy by making the NHS more agile and better at working with small and medium-sized businesses; including implementing Lord Young's recommendations on pre-qualification questionnaires, including simplifying them across the NHS, or even abolishing them for low value procurements.

Berwick Review into patient safety

Earlier this year, Professor Don Berwick, a renowned international expert in patient safety, was asked by the Prime Minister to carry out a review following publication of the Francis Report into the breakdown of care at Mid Staffordshire Hospitals.

Following five months of work, his independent report – A promise to learn – a commitment to act: improving the safety of patients in England – was published in early August, recommending that NHS staff should be supported to learn from mistakes and patients and carers must be put above all else in an attempt to make the NHS a world leader in patient safety.

The report examines the lessons for NHS patient safety from healthcare and other industrial systems throughout the world. His four key findings are that:

1. The quality of patient care, especially patient safety, should be paramount;
2. Patients and carers must be empowered, engaged and heard;
3. Staff should be supported to develop themselves and improve what they do; and
4. There should be complete transparency of data to improve care.

Recommendations in the report include:

- **The NHS needs to adopt a culture of learning** - this cannot come from regulation, but from 'countless, consistent and repeated' messages to staff so that goals and incentives are clear and in patients' best interests;
- **Staffing levels must be adequate, based on evidence** - the report echoes the Keogh review in saying that staffing levels cannot be dictated from the centre, but that boards and local leaders should take responsibility for ensuring that clinical areas are adequately staffed;
- **Connecting with patients and the frontline** - leaders need first-hand knowledge of the reality of the system and the patient voice must be heard and heeded at all times;
- **Complaints systems need to be continuously reviewed and improved**;
- **Transparency must be complete, timely and unequivocal**;
- **There is no single measure for safety -** the NHS should continue to use mortality rate indicators to detect potentially severe problems. But these indicators remain a "smoke alarm" and should not be used to generate league tables;
- **Supervisory and regulatory systems should be clear** - an in-depth, independent review of the structures and the regulatory system should be completed by the end of 2017, once recent changes have been operational for three years; and
- **New criminal offences should be created** - around recklessness or wilful neglect or mistreatment by organisations or individuals and for healthcare organisations which withhold or obstruct relevant information. But the report emphasises that the use of criminal sanctions should be extremely rare and unintended errors must not be criminalised.

The report does not recommend that a statutory duty of candour for healthcare workers is introduced – instead it finds that this duty is adequately addressed in professional codes of conduct and guidance. Above all else, the report argues that cultural change is the most important factor in continuously reducing harm. In particular the report distinguishes clearly between mistakes and negligence and the need for a transparent culture where mistakes are reported and learnt from.

The solutions in the report are grouped under the following themes:

- Recognise the need for systemic change;
- Abandon blame as a tool – distinguish between errors and misconduct;
- Reassert the primacy of patients and carers;
- Use targets with caution – they have a role en-route to progress, but they should never become the end in itself;
- Recognise that transparency is essential;
- Ensure that responsibility for safety is clear and simple, with cooperation among the agencies involved;
- Give NHS staff career-long help to learn, master and apply modern methods of quality control; and
- Focus on pride and joy, not fear.

The group that has developed the report with Prof Berwick includes world-leading experts in all aspects of the culture and processes of minimising patient harm, from healthcare management and nursing to sociology and psychology.

NHS England

Complaints backlog

NHS England has apologised after the handling of thousands of complaints about GPs and dentists was delayed following the handover from PCTs to the organisation. For more than two months it failed to quickly process the large numbers of queries and complaints it received.

Savings plan shortfall forecast

HSJ has reported that NHS England is predicting it will fall short of its efficiency savings target by 13% this financial year. It is understood that NHS England is aiming to make savings of 1.4% through its QIPP programme, but at the end of June, it was 9.2% behind target with the shortfall forecast to rise to 12.9% (£48.1m) by the end of the year.

The main contributor to the gap is primary care, with NHS England predicting it will miss its primary care QIPP target by 19% (£22.5m).

Integrated customer service platform

The integrated customer service platform being developed by NHS England is expected to save the NHS more than £1bn by encouraging patients to get involved in online self-care. In a report presented to the Informatics Services Commissioning Group's July meeting it says 'The programme will deliver the most cost-effective health and care service (£0.11 per interaction) by catalysing digital first (reducing face-to-face and paper-based interactions), stimulating the health technology market, and increasing the percentage of the population who are informed, involved and engaged with their health. If online self-care advice could be used for 10% of GP appointments for minor ailments, savings of £830m would be realised.'

The report goes on to say that the platform will 'harness the power of technology to create the 'front door' to transform the way the public engage with health, public health and social care services in England.'

The platform is expected to build on the existing NHS Choices website. A beta launch of the platform planned for November will include; a symptom checker; GP appointment booking; a health apps library; web chat; tools to find the nearest urgent care provider and GP; ratings of services; and online ordering of repeat prescriptions.

Future content will apparently include results from the Friends and Family Test, speciality hospital consultant data and information from NHS England's new patient feedback service Care Connect. There are also plans to include several apps, such as a real-time A&E waiting time app, personal health records, a safety thermometer, test results and a shared-decision making app.

A call to action for general practice

As part of NHS England's 10 year strategy to transform the NHS, it is reviewing the current primary care system and engaging with key partners, including frontline clinicians, to develop a long term, effective solution. This approach forms part of the wider The NHS belongs to the people: a call to action that NHS England launched on 11 July 2013.

To commence its work on the development of a primary care strategic framework, NHS England launched Improving general practice – a call to action in mid-August.

NHS England recognises that general practice and wider primary care services are facing increasing pressures, linked to an ageing population, increasing numbers of people with multiple long term conditions, declining patient satisfaction with access to services, and problems with recruitment and retention in some areas. General practice and Clinical Commissioning Groups (CCGs) are increasingly looking at how they can transform the way they provide services so that they can better meet these challenges.

NHS England says it wants general practice to play an even stronger role at the heart of more integrated out of hospital services that deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.

The main purpose of the call to action is to stimulate debate in local communities, among GP practices, CCGs, Area Teams, Health and Wellbeing Boards and other community partners, on the best way to develop general practice services. NHS England is also inviting comments about how it can best support local changes, for example through the way national contractual frameworks are developed.

NHS England is also developing its strategic approach to commissioning primary dental, pharmacy and eye care services and will carry out separate engagement exercises at a later stage.

GPs should form larger providers

Following the publication of Improving general practice – a call to action, NHS England's deputy medical director, Mike Bewick, has said in an interview with *HSJ* that GPs should form larger provider organisations or networks as part of a rapid development of out-of-hospital services.

He said "General practice is talking about the difficulty of sustaining the current model. A major reason for change is that quite a lot of the public in certain areas of the country are not very satisfied with [current GP] provision. People are bypassing primary care and going to accident and emergency or elsewhere. The scrum that occurs on Monday morning [to get appointments] is becoming increasingly difficult."

The engagement on the Call to action will explore a range of potentially controversial policy changes, including incentivising practices to merge or form networks, and introducing new providers to stimulate innovation and improve capacity.

Dr Bewick said there "must be some access to types of primary care throughout the weekend", and called for a debate about how services and the current workforce could meet that.

Urgent care

Prime Minister announces £500 million to relieve pressures on A&E

With over 1 million more people visiting A&E compared to 3 years ago, last year's harsh winter put exceptional pressure on urgent and emergency wards. In early August the Prime Minister announced the release of new funding for A&E departments identified as being under the most pressure, with £250m being released this year and a similar amount being made available next financial year. NHS England, Monitor and the NHS Trust Development Authority are working closely with the local NHS to identify those A&E departments that will benefit most from this extra funding.

It will be targeted at 'pinch points' in local services with the aim of patients being treated promptly, with fewer delays in A&E, and for other patients to get the care, prescriptions or advice they need without going to A&E.

Hospitals have already put forward proposals aimed at improving how their services work. These include improvements to both A&E and improvements to other services away from A&E so there are less unnecessary visits or longer stays in hospital. Some of the local initiatives could include:

- minimising A&E attendances and hospital admissions from care homes by appointing hospital specialists in charge of joining up services for the elderly;
- 7-day social work, increased hours at walk-in centres, increased intermediate care beds and extension to pharmacy services to ease pressures on A&E departments; and
- consultant reviews of all ambulance arrivals in A&E so that a senior level decision is taken on what care is needed at the earliest opportunity.

The Department of Health and NHS England are working to relieve pressure on A&E in the longer term. Professor Sir Bruce Keogh is leading a review into the demands on urgent and emergency care and how the NHS should respond.

Trial of 7-day GP services

HSJ has reported that a 6 month trial in Radcliffe, Heywood and Middleton, Greater Manchester will see GP practices opening into the evening and on weekends in a bid to reduce the number of unnecessary A&E visits. The trial is due to commence at the end of October and the changes could be implemented across Greater Manchester if it is deemed a success.

Commissioning

Reform of the Payment by Results Tariff

The pressure to reform the Payment by Results Tariff which determines the payments received by hospitals for treatment of most patients is growing, as CCGs continue to find the Tariff is constraining their ability to reorganise healthcare provision and integrate services at a local level.

HSJ has reported that NHS England wants to investigate the scope for scrapping payment by results for some services as early as 2015-16. Its Director of Strategic Finance, Sam Higginson, said emergency care and the treatment of long-term conditions were two areas where NHS England wanted to consider the possibility of moving away from activity-based payments to "pay for performance".

This could for example mean that a hospital would no longer receive a set payment every time a patient with COPD is admitted, instead it may receive a payment based on the number of people with COPD in its catchment population, but could then earn a significant further payment for hitting performance and improvement targets.

Long-term conditions, emergency care, and treatment of the frail elderly are areas NHS England are understood to be looking at for potential reform.

Integrated care

In early August the Local Government Association and NHS England published their planning 'vision' for how the pooling of £3.8 billion of funding will ensure a transformation in integrated health and social care. The Integration Transformation Fund is a single pooled budget for health and social care services to work more closely together in local areas which will come into full effect in 2015-16.

Health and Wellbeing Boards will sign off local plans, which will have been agreed between the local authority and CCGs. CCGs will also have to draw up two-year service integration plans by the end of the current financial year. Of the £3.8bn fund, £1bn will be performance related. Half will be paid out on 1 April 2015, which is expected to be based on performance in the 2014-15; the rest will be paid in the second half of 2015-16, and could be based on in-year performance. Performance will be judged against a combination of nationally-agreed and locally-agreed indicators.

CCG propose 'prime contractor' deals

HSJ has reported that around thirty CCGs are developing contracts in which a lead provider receives an outcomes based payment to integrate an entire care pathway. It cites an example of Bedfordshire CCG naming Circle as its preferred bidder to be 'prime contractor' for an integrated musculoskeletal service. The CCG said this previously involved 20 contracts across primary, secondary and community services.

The prime contractor model involves a single organisation subcontracting work to other providers to integrate services across a pathway, generally with a proportion of payments being dependent on the achievement of specific outcomes.

Nine CCGs forecast overspends in first year

HSJ has reported that nine CCGs are forecasting multimillion pound deficits in their first year. Between them, the CCGs (Barnet; Croydon; Hillingdon; Harrow; Eastbourne, Hailsham and Seaford; Blackpool; Coastal West Sussex; East Surrey; North Hampshire) are forecasting a combined deficit of £86.7m.

Possible reasons for the deficits included the abolition of strategic health authorities which meant there was less scope for the NHS to move money around to plug financial gaps and the complexity involved in dividing up PCTs' budgets among the new commissioners, with adjustments to the specialised commissioning budget (held by NHS England) having caused particular issues.

Meanwhile NHS England has said there is little scope for any redistribution of funding levels between CCGs, to reflect the target resource levels set by a proposed new financial allocations formula, without real-terms cuts for some CCGs. This followed the release of figures revealing how much CCGs stood to win or lose under the proposed new formula for CCG allocations, which NHS England decided not to implement when setting the 2013/14 allocations last year. The formula, proposed by the government's independent Advisory Committee on Resource Allocation, would see the north of England and London losing funds relative to the rest of the country.

The organisation is still reviewing the options for next year's allocations, including the split between NHS England's own budgets (specialised commissioning and primary care) and those of CCGs.

CCGs and CSUs

In July NHS England published Towards commissioning excellence: A strategy for commissioning support services which sets out how the organisation will support the development of a vibrant market for commissioning support services where CCGs can make an informed decision about the precise mix of support they need and from where to source this.

At present most CCGs obtain commissioning support from Commissioning Support Units (CSUs) which are hosted by NHS England. It has always been the plan that CSUs would eventually become standalone bodies autonomous of NHS England. This could involve CSUs becoming social enterprises, being taken over by GP co-operatives or private sector organisations. NHS England has recently suggested that CCGs could also take ownership of CSUs if that was deemed appropriate at a local level.

NHS England has also proposed that where CCGs wish to do so, they can extend their Service Level Agreements with CSUs until no later than April 2016. Previous guidance has required this re-procurement to be undertaken no later than September 2014.

Steve Field appointed chief inspector of general practice

At the end of August the Care Quality Commission (CQC) announced that former RCGP chair Prof Steve Field has been appointed the first chief inspector of general practice.

As Chief Inspector of General Practice, Professor Field will:

- champion the interests of people who use primary medical services;
- make judgments about the quality of care provided;
- ensure that health and adult social care services join up seamlessly; and
- introduce a ratings system for registered primary care providers (GP and Dental practices).

Shingles vaccine campaign commences

The start of September saw the commencement of the new Shingles vaccination campaign. GP practices will offer vaccination against varicella zoster virus to adults aged 70 to 79 across the UK – a patient cohort of approximately 800,000 individuals. This marks the start of a programme of routine vaccination of all 70-year-olds against Shingles.

Collaborative local commissioning

In an interview with GP, Dr David Geddes, Head of Primary Care Commissioning at NHS England has said "There is work to be done on how Area Teams and Clinical Commissioning Groups collaborate and co-commission, because funding will in future follow care pathways developed as primary care 'wraparound' services."

Referring to the workload capacity constraints being experienced by many general practices, Dr Geddes went on to say "That will also mean using those funds to commission alternative providers, such as pharmacists, to pick up some of that workload. Even with the funding, you've still got a capacity issue [in general practice]. So we need to make sure some of the work currently being delivered in primary care [general practice] can be distributed, if needs be through other contractors."

This suggestion fits well with the proposals for community pharmacy to support general practice management of patients with long term conditions recently described in PSNC's narrative on its Vision for community pharmacy.

Public health budget ring fence to continue

In his weekly 'Friday message' on 30th August Duncan Selbie, CEO of Public Health England noted that the ring fencing on the public health services grant to local authorities will remain in place for at least a third year (2015/16). The ring fencing means that the grants, worth £2.6bn this year, can only be used by local authorities to fund services that improve the health of the local population.

Six CSUs form partnership

Six commissioning support units (CSUs) have announced that they are forming a strategic alliance. North and East London, North of England, South West, Staffordshire and Lancashire, Cheshire and Merseyside, and South CSUs have agreed to work together to share ideas and innovation, potentially share resources flexibly and use their collective buying power.

More funding for secondary care IT

An extra £240m for the 'Safer Hospital, Safer Wards' fund was announced on 4th September. Hospitals will bid for money to upgrade their IT to allow staff access to shared records and to facilitate electronic prescribing on wards, as part of the Government's challenge to the NHS to go paperless by 2018. These local IT developments will hopefully improve discharge information provided to primary care professionals, including community pharmacists.

UK – the addiction capital of Europe

The think-tank, The Centre for Social Justice, has claimed in its latest report that the UK is the addiction capital of Europe, with some of its highest rates of opiate addiction and dependence on alcohol.

The report, No Quick Fix, says the UK has become a hub for websites selling dangerous 'legal highs' or 'club drugs' which are being ordered online and delivered across the country by mainstream postal services. It also identified websites offering the chance for people to buy Class A drugs.

Language checks for doctors?

The Department of Health has issued a consultation document which proposes changes to the Medical Act 1983 to give the General Medical Council (GMC) more power to take action where concerns arise about a doctor's English language capability. The powers would allow the GMC to carry out assessments of language skills before an overseas doctor is allowed to treat patients.

NHS England to publish 'never events' listing

NHS England has announced that it will publish a list of the 'never events' – preventable patient safety incidents – that have occurred on a quarterly basis. The list will break down the data to an individual trust level so patients are able to see how individual hospitals are performing on patient safety.

Continuing healthcare claims a threat to CCG budgets

The Health Service Journal has reported that Clinical Commissioning Groups (CCGs) have inherited unfunded liabilities for hundreds of millions of pounds worth of continuing healthcare claims. Claims for continuing healthcare costs are made to cover the full cost of a person's out-of-hospital care, for example in a care home, where the primary need for that care is a health need (rather than a social care need). PCTs received a large number of retrospective claims following the setting of a deadline for anybody wishing to claim back the costs of care between 2004 and 2012. CCG leaders are now reporting that settling the claims could severely affect their finances.

PHE highlights new data and knowledge gateway

Public Health England has highlighted the range of information and tools available on its new Data and Knowledge Gateway. The website gives direct access to analysis tools and resources for public health professionals from one single portal.

Over 100 tools are available through the gateway. They cover a wide range of public health areas, including:

- specific health conditions – such as cancer, mental health, cardiovascular disease;
- lifestyle risk factors – such as smoking, alcohol, obesity;
- wider determinants of health – such as environment, housing and deprivation;
- health protection, and differences between population groups, including adults, older people and children;

The tools serve a range of public health information needs, including the commissioning and planning of services, joint strategic needs assessment, health surveillance, understanding inequalities and variation, research and evidence.

Secretary of State - NHS must fundamentally change to solve A&E problems

In early September, Jeremy Hunt, Secretary of State for Health, set out proposals to fundamentally tackle increasing pressures on A&E services in the long-term – starting with care for vulnerable older people with complex health problems.

He said fundamental changes mean joined-up care - spanning GPs, social care, and A&E departments - overseen by a named GP. Many vulnerable older people end up in A&E simply because they cannot get the care and support they need anywhere else.

Overall, the number of people going to A&E departments in England has risen by 32 per cent in the past decade, and by one million each year since 2010. The over-65s represent 17 per cent of the population, but 68 per cent of NHS emergency bed use. They also represent some of the NHS's most vulnerable patients, and those most at risk from failures to provide seamless care.

To support the NHS in the short term, the Government previously announced that they would make available an extra £500 million funding over the next two years. In the announcement the Health Secretary set out how £250 million would be used by 53 NHS Trusts this winter.

Of the £250 million:

- Around £62 million for additional capacity in hospitals – for example extra consultant A&E cover over the weekend so patients with complex needs will continue to get high-quality care;
- Around £57 million for community services – for example better community end of life care and hospices;
- Around £51 million for improving the urgent care services - for example for patients with long-term conditions;
- Around £25 million for primary care services – for example district nursing, to provide care for patients in their home, preventing them from being admitted to A&E;
- Around £16 million for social care – for example integrating health and social care teams to help discharge elderly patients earlier and prevent readmission and;
- Around £9 million for other measures – for example to help the ambulance service and hospitals work better together.

Secretary of State - the future of out of hospital care

In a speech to a King's Fund event on 12th September Jeremy Hunt described how he wanted to see the provision of 'out of hospital care' services develop.

He set out the challenges being faced by the NHS and on the question of future affordability, he said "We can afford good quality care for everyone – but only if we undertake a bold and radical transformation in the way out of hospital care is delivered."

The scale of changes necessary are significant and it is likely to take a four-year process to achieve change. This change should be based on the four groups of people the NHS has to look after:

1. Vulnerable older people;
2. Other people with long-term conditions who need help to manage their condition;
3. Mothers and young children; and
4. those people who are normally healthy and well and need the NHS to help them stay that way.

From April 2014, vulnerable older people will be the primary focus for the following 12 months. This group may only be a small proportion of the population, but they represent a significant cost to the NHS.

The underlying principles that will be applied are:

1. Prevention is better than cure;
2. Clinical leadership is key;
3. Accountability – one person needs to be responsible for the overall care of each vulnerable older person, with the power to make things happen quickly;
4. Any changes must be true to the founding principles of the NHS – the highest quality care and treatment for all, no matter who you are.

For the care of vulnerable older people, this means a move to proactive primary care, with a named GP for all patients in the cohort. The named GP will take responsibility for ensuring these patients have proper care plans and are supported to look after themselves. They should have time to contact their patients proactively, be able to decide how best out of hours care should be managed in their local area and be able to decide what support their most vulnerable patients get from district nurses.

The Secretary of State said he had asked Health Education England to recruit an additional 1000 GPs and increase the proportion of new doctors entering general practice to 50%. He also signalled the need for a dramatic simplification of the targets and incentives imposed on GP practices, to give them back the professional discretion to spend more time with the patients who need it the most.

He went on to describe the progress being made on the £3.8bn Integration Transformation Fund for health and social care which will be implemented in 2015-16. He announced that local integration plans that will need to be agreed by CCGs and local authorities will have to be put in place by April 2014 rather than the original planned date of April 2015.

The final element of the plans he described was the need for electronic health records to be available anywhere in the health and care system whenever a patient gives consent for them to be viewed by professionals.

RCP proposes reconfiguration of hospital services

A Royal College of Physicians commission on the future of hospital services has suggested that hospitals need to move to provision of full services seven days a week. This proposal supports similar proposals that are emerging from NHS England's review of urgent and emergency care.

NHS England delays publication of choice and competition guidance

A report to the September Board meeting of NHS England has revealed that it has had to delay publication of guidance for CCGs on how to use choice and competition as levers to improve standards of care. NHS England is continuing to work with Monitor on the guidance, but it is understood that the lack of evidence base for the benefit to patients is hampering its development.

Cross-party talks need on the future of the NHS

Liberal Democrat health minister Norman Lamb has told party conference representatives that the financial pressures on the NHS mean that a national conversation is needed on the long-term future of the service. He believes cross-party talks are required to consider how the long-term sustainability of the NHS can be guaranteed.

Mr Lamb also indicated that the Government would take forward the recommendation in the Francis Report to allow healthcare providers to be prosecuted for poor care and neglect.

GPs reporting high stress levels

The latest Department of Health funded survey of GPs' job satisfaction, stressors, hours of work and intentions to quit, undertaken by the University of Manchester has found that GPs are reporting the highest stress levels for 15 years.

13% of respondents had a formal role at a CCG and a further 15% said that they were their practice's commissioning lead. The majority of respondents agreed that GPs added value to pathway/service design, needs assessment, improving relationships with providers and contract negotiations/monitoring. However, respondents were divided on whether commissioning was part of their role as a GP.

Respondents expressed concerns about the impact that CCG introduction had had on their personal workloads, the time that they could spend on direct patient care and continuity of care. Respondents also reported that the introduction of CCGs had led to decreases in referrals and practice prescribing, and increased integration between primary and secondary care. 68% of respondents thought that practice income should not be related at all to CCG performance.

The level of overall job satisfaction reported by GPs in 2012 was lower than in all surveys undertaken since 2001. On a seven-point scale, average satisfaction had declined from 4.9 points in 2010 to 4.5 points in 2012 in both the cross-sectional and longitudinal samples. The largest decreases in job satisfaction between 2010 and 2012 were in the domains relating to 'hours of work' and 'remuneration'.

In 2012, as in 2010, GPs reported most stress due to 'increasing workloads' and 'paperwork'; reported levels of stress increased between 2010 and 2012 on all 14 stressors. Reported levels of stress increased between 2010 and 2012 on all 14 stressors.

The proportion of GPs expecting to quit direct patient care in the next five years had increased from 6.4% in 2010 to 8.9% in 2012 amongst GPs under 50 years-old and from 41.7% in 2010 to 54.1% in 2012 amongst GPs aged 50 years and over.

GPs starting to rationalise workload

Pulse has reported that many GP practices have stopped providing the older GMS contract Directed Enhanced Services (DES) that were rolled over from the previous year. This change in service provision is understood to be related to workload increases under the contract changes implemented in April.

Data obtained by Pulse from NHS England suggests that take-up of the patient participation, alcohol and extended hours DES rolled over from 2012 has fallen by one-fifth year on year.

The patient participation DES saw the biggest drop in take-up, attracting 83% of practices in 2012/13, but just 58% this year. The extended hours DES fell in popularity from 73% to 61%, health checks for patients with learning disabilities saw sign-up reduce from 78% to 63% and the alcohol DES saw 67% of the practices signing up this year, compared with 78% last year.

GP contract negotiations split four ways

Pulse has reported that from 2014 the GP contract will no longer be negotiated on a UK-wide basis. For the first time NHS Employers will not conduct UK-wide negotiations with the General Practitioners Committee of the BMA, and will instead only negotiate terms for English GPs, as well as QOF terms for GPs in Wales. Entirely separate deals will be negotiated for Scottish and Northern Irish GPs.

CCG Board members' conflicts of interest

An investigation using the Freedom of Information Act conducted by Pulse has revealed that one in five GPs sitting on CCG boards have a financial interest in a healthcare provider which currently provides services to their own CCG. CCGs reported that procedures to safeguard against conflicts of interest are being fully followed.

Labour on General Practice

Speaking at the party's annual conference in Brighton, Lord Hunt, Labour's spokesman in the Lords, has said a Labour government should reform the GP contract and scrap GP-led commissioning and the purchaser-provider divide. Speaking at a fringe meeting he said the current GP contract may not be able to change sufficiently to meet the need for 24-hour services to reduce pressure on urgent and emergency care services. The comments followed Ed Miliband's reiteration of the party's policy on repealing the Health and Social Care Act.

Speaking at the Health Hotel question time event at the Labour party conference, Andy Burnham, shadow Secretary of State for Health said he opposed GP control and domination of commissioning via CCGs because it is not accountable and compromises the public interest. He went on to say that his plans for modifying the commissioning system were not another reorganisation and nor were they a local government takeover.

Pay rises linked to seven-day working

The Health Service Journal has reported that NHS Employers are arguing for the pay for the NHS workforce, covered by the Agenda for Change payment system, to be frozen for the second year running. It is also understood that they will argue that future pay increases should be linked to changes to working practices to help support more seven-day working.

Gradual fall in GP income continues

Figures from the Health and Social Care Information Centre (HSCIC) show a continuation of the gradual fall in contractor GP incomes from their peak at £110,000 in 2005/06. The average income before tax of contractor GPs was £103,000 in 2011/12, a drop of 1.1 per cent on 2010/11.

GP Earnings and Expenses 2011/12 provides figures on the earnings and expenses of full and part-time GPs across the UK and covers both their NHS and private income.

PSNC Regions, LPCs and Regional Representatives

	PSNC REGION	
1	North Eastern	Mark Burdon
		County Durham and Darlington LPC, Cumbria LPC, Gateshead & South Tyneside LPC, North of Tyne LPC, Sunderland LPC, Tees LPC,
2	Yorkshire and the Humber	David Broome
		Community Pharmacy Humber LPC, Community Pharmacy West Yorkshire LPC, North Yorkshire LPC
3	East Midlands and South Yorkshire	Garry Myers
		Barnsley LPC, Derbyshire LPC, Doncaster LPC, Leicestershire LPC, Lincolnshire LPC, Nottinghamshire LPC, Rotherham LPC, Sheffield LPC
4	East Anglia	Dhiren Bhatt
		Cambridgeshire and Peterborough LPC, Norfolk LPC, Suffolk and Great Yarmouth LPC,
5	East	Bharat Patel
		Bedfordshire LPC, Essex LPC, Hertfordshire LPC, Northamptonshire LPC,
6	London N Thames	Elisabeth Hopkins
		Barnet, Enfield & Haringey LPC, Brent & Harrow LPC, Camden & Islington LPC, City and Hackney LPC, Ealing, Hammersmith & Hounslow LPC, Hillingdon LPC, Kensington, Chelsea & Westminster LPC, North East London LPC
7	London S Thames	Indrajit Patel
		Bexley, Bromley & Greenwich LPC, Croydon LPC, Kingston, Richmond & Twickenham LPC, Lambeth, Southwark & Lewisham LPC, Sutton, Merton & Wandsworth LPC
8	South East Coast	Alan Robinson
		East Sussex LPC, Kent LPC, Surrey LPC, West Sussex LPC
9	South Central	Gary Warner
		Berkshire LPC, Buckinghamshire LPC, Dorset LPC, Hampshire & Isle of Wight LPC, Oxfordshire LPC
10	South Western	Andrew Lane
		Avon LPC, Cornwall & Isles of Scilly LPC, Devon LPC, Gloucestershire LPC, Somerset LPC, Swindon and Wiltshire LPC
11	West Midlands	Rajesh Morjaria
		Birmingham LPC, Coventry LPC, Dudley LPC, Herefordshire LPC, North Staffordshire LPC, Sandwell LPC, Shropshire LPC, Solihull LPC, South Staffordshire LPC, Walsall LPC, Warwickshire LPC, Wolverhampton City LPC, Worcestershire LPC
12	Mersey	Ian Cubbin

	PSNC REGION	
		Cheshire LPC, Halton, St Helens and Knowsley LPC, Liverpool LPC, Sefton LPC, Wirral LPC
13	North West	Mark Collins
		Ashton, Leigh & Wigan LPC, Bolton LPC, Bury & Rochdale LPC, Central Lancashire LPC, East Lancashire LPC, Manchester LPC, Oldham, Tameside & Glossop LPC, Salford & Trafford LPC, Stockport LPC

Deleted: STRATEGIC HEALTH AUTHORITY (as constituted on 14 October 2009) & LPC

Deleted: NORTH EAST STRATEGIC HA

Comment [SJL1]: Region change

Deleted: Cleveland

Comment [SJL2]: Name change, on merger with Northumberland LPC effective 1 October 2013

Comment [SJL3]: LPC name change

Deleted: Northumberland LPC,

Deleted: YORKSHIRE AND THE HUMBER STRATEGIC HA

Comment [SJL4]: Name change Humber LPC effective 1 October, includes merger Humber and East Riding and Hull LPCs

Comment [SJL5]: Merger of West Yorkshire LPCs into one LPC

Deleted: Bradford LPC, Calderdale & Kirklees LPC, East Riding & Hull LPC, Leeds LPC, South

Deleted: Wakefield LPC

Deleted: YORKSHIRE AND THE HUMBER STRATEGIC HA & EAST MIDLANDS STRATEGIC HA

Deleted: Northamptonshire LPC,

Deleted: EAST OF ENGLAND STRATEGIC HA

Deleted: EAST OF ENGLAND STRATEGIC HA

Comment [SJL6]: Region change

Deleted: LONDON STRATEGIC HA

Deleted: LONDON STRATEGIC HA

Deleted: SOUTH EAST COAST STRATEGIC HA

Deleted: SOUTH CENTRAL STRATEGIC HA

Comment [SJL7]: Region change

Deleted: SOUTH WEST STRATEGIC HA

Deleted: Dorset LPC,

Deleted: WEST MIDLANDS STRATEGIC HA

Deleted: NORTH WEST STRATEGIC HA

Deleted: STRATEGIC HEALTH AUTHORITY (as constituted on 14 October 2009) & LPC

Comment [SJL8]: merger

Comment [SJL9]: name change

Deleted: North Cheshire,

Deleted: South Cheshire LPC,

Deleted: NORTH WEST STRATEGIC HA

Deleted: Cumbria LPC,