LMC SECRETARIES CONFERENCE 2011

THURSDAY 1 DECEMBER 2011

SHEFFIELD LMC REPRESENTATIVES: David Savage (Secretary) Margaret Wicks (Manager)

ADDRESS BY GPC CHAIRMAN

Conference opened with a key speech by Dr Laurence Buckman. He outlined the current state of play with contract negotiations, the Health and Social Care Bill and commissioning. The main points of note were as follows:

- The National Institute for Health and Clinical Excellence (NICE) has been keen to keep politics out of QOF negotiations, which was welcomed by the General Practitioners Committee (GPC).
- Commuters – there are 2 choice of practice pilots underway - the GPC model relies on patients being registered as temporary residents, whilst the Department of Health (DH) model relies on patients being registered with 2 practices. There are no planned changes to allocation arrangements, temporary residents or immediately necessary treatment arrangements.
- The British Medical Association (BMA) has opposed the Health & Social Care Bill in its entirety in view of concerns about Commissioning Support Organisations (CSOs). Despite this the GPC continues to support Clinical Commissioning Groups (CCGs) and their evolution, whilst lobbying for a number of amendments to the Bill. It was emphasised that LMCs should ensure democratic legitimacy to CCG appointments and should be involved in the process. It was noted that the Secretary of State for Health will retain ultimate responsibility for the NHS.
- It was stated that there was still a risk of large multinational companies taking over CSOs in 2016 and it was suggested that CCGs should be encouraged to commission NHS support services.
- General Medical Services (GMS) Contract Variation 2012/13 has been agreed. Overall income is protected and there is an expenses increase of 0.5%. Some QOF points will be retired and there will be 2 new indicators. In the Quality and Productivity (QP) part of QOF, the prescribing section is replaced with work to be done on A&E attenders.
- Care Quality Commission (CQC) Registration has been delayed until 2013. The GPC is working with the CQC to lessen requirements as it is widely acknowledged that practices are a low risk area for CQC. It is also acknowledged that the standards developed by CQC are mainly applicable to secondary care and, therefore, will require modification and scaling back.
- Revalidation is due to begin in late 2012 but the process is not yet finalised.
- It was highlighted that notional rent valuations can go down as well as up, although these should be challenged.

GPS AND PRACTICES HOLDING CCGS TO ACCOUNT – ROLE OF LMC

This was a useful and well attended workshop which painted Sheffield in a reasonably good position compared with many other areas.

- Clear and effective communication between CCGs and LMCs is essential. Many areas, like Sheffield, have secured non-voting, observer status on CCGs.
- LMCs have a fundamental role to play in contractual issues, particularly with regard to enhanced services, which appear to be at risk nationally. This should be defended and LMCs should be vigilant to ensure CCGs do not use incentive schemes when enhanced services would be more appropriate. Incentive schemes have no contractual basis, do not require LMC consultation and are not superannuable.
- A number of LMCs had made efforts to improve communications with their local practices with initiatives such as an annual survey, an open meeting on CCG performance and securing a place on the Local Authority approval process.
- It was felt strongly that LMCs should be opposing new work for practices without new resources.
- Some areas are having significant problems, from there being no agreed CCG to a situation described by the LMC as ‘open warfare’ between the LMC, PCTs and CCG.

- In some areas CCGs have been appointed with no election at all, whilst in others there were concerns about the appointed responsible officer being a previous PCT employee and undue pressure on CCGs to follow PCT policy.

WHAT NEW PROBLEMS WILL CCGS CAUSE FOR LMCS?

This workshop focussed on the continuation of LMCs and their role in the new structure.

- It was stressed that LMCs are the only mandated representative body of all GPs in an agreed area, whilst CCGs are commissioning bodies. This should be reiterated to organisations that are mistakenly assuming that they should consult CCGs on all issues relating to general practice.
- There were differing views as to how many PCTs/CCGs an LMC should relate to, with the suggestion that the Local Authority footprint was a better basis for the LMC's boundary.
- There were concerns that CCGs were focusing almost exclusively on the QIPP agenda, on the instruction of the PCTs. This was resulting in services being cut in some areas, instead of CCGs focusing on commissioning different, more cost effective services.
- Consideration needs to be given to how LMCs will be formally consulted by CCGs, rather than LMCs merely having a non-voting, observer status at CCG Boards.
- LMCs need to work constructively with CCGs, offering as much help and support as possible, whilst being able to oppose them when necessary.

ASK THE NEGOTIATORS

There followed an opportunity to question the GPC Negotiators, the following being the main points of interest:

- Care Quality Commission (CQC) inspections should be about practices and not individuals.
- There had been no discussions about negotiating a new, national contract.
- Work that is classed as a local incentive scheme that practices outsource is not within the NHS contract and, therefore, is not superannuable. Practices or LMCs should negotiate an increase of up to 35% to take into account superannuation payments.
- A number of LMCs had experience of GPs being referred to the NHS ombudsman, which can result in a fine of up to £10K, although this is not enforceable legally. There has been negotiation with the ombudsman and local areas should be trying to strengthen the second stage of complaints, which are thought to be generally weak. The ombudsman would not consider cases that need to go through a legal process.
- The GPC does not support charging NHS patients for services which have been decommissioned by CCGs or PCTs.
- The GPC feels the principle behind the 111 number is alright, but they strongly oppose 111 direct appointment booking. Feedback from the pilots has been mixed and further evaluation continues.

ADDRESS BY MIKE FARRAR, CHIEF EXECUTIVE, NHS CONFEDERATION

Mike gave a powerful speech outlining the challenges for primary care, particularly in view of George Osborne's speech.

- The increased cost of healthcare in developed countries is not sustainable and there has to be a change in delivery of healthcare. Mike's theory is that in the last 10 years the majority of funding has gone to the supply side (secondary care). In the next decade investment should be in the platform of primary care. He believes that the only way that this can be achieved is by decreased commissioning in secondary care and moving resources to primary care commissioning.
- Consolidation is required, which could be done by reconfiguring services.
- Political honesty about the financial situation is essential.
- Adequate dialogue with the public is required to get a mandate for planned changes, thereby avoiding unplanned cuts.
- Work needs to be done looking at the unit costs of labour, whilst providing some job security, thereby improving morale and productivity.

- Further exploration and embracing of new technologies should be considered to streamline workloads, reduce costs and change patients' perceptions of service availability and how to access them.
- The quality agenda needs to be supported over the next 10 years, ensuring that commissioning succeeds, as a failure would be detrimental to patients rather than GPs.
- The tariff based system is flawed and not fit for purpose. Mike's vision is for negotiations to take place between primary and secondary care, with a view to sharing costs and budgets.
- Smaller CCGs would be allowed but would be encouraged to federate with other small CCGs. Larger CCGs would need to ensure that they maintain contact with individual practices.
- Mike concluded by stating that GPs are in a powerful position, but they should use their power wisely and work with the new management structures to inspire the profession to move forward, as the changes will not go away.

DEALING WITH CONFLICT OF INTEREST AND OTHER GOVERNANCE ISSUES IN CCGS/LMCS

Again, this was a well-attended and interesting debate.

- There was a general, but by no means unanimous, feeling that there was a conflict of interest if paid LMC officers are also paid CCG officers. There was a strong feeling that the roles were incompatible and there were particular concerns around issues such as contract and performance management of levy paying constituents. However, the picture was mixed across the country and most LMCs had LMC members on the CCGs and CCG members on the LMC.
- Some LMCs felt that LMC officers could fulfil roles on CCGs provided they declared any conflicts of interest on a regular basis and that this would be beneficial because LMC officers could monitor CCG activity. However, examples were quoted where officers had seemed unable to recognise when there was a conflict of interest, which had put them in dispute with their colleagues.
- It was suggested that the workload involved in being a GP and having a paid role on an LMC and a CCG would prove impractical for most GPs.
- It was acknowledged that in the shadow CCG Boards it was important to have LMC involvement, although this would be more difficult and complex when they became live Boards in 2013. Even now, areas were making commissioning decisions that affect GP income and discussing contractual issues, which would appear to be a conflict of interest.

HOW CAN LMCS IMPROVE THEIR PERFORMANCE AND PROVIDE A BETTER SERVICE TO THEIR CONSTITUENTS?

This workshop focussed on the problems LMCs currently have in representing constituents and how these issues can be overcome.

- Communications with sessional GPs continue to cause concern for many LMCs.
- A few LMCs do not charge locum GPs, but the majority of LMCs present charge between £25 and £100 per annum.
- Regardless of whether or not LMCs charge, all LMCs struggled to engage with locum doctors. Suggestions of closer working with locum groups, more targeted communications and wider publicity of the work LMCs can do for locums were discussed.
- Some PCTs do not routinely inform LMCs when doctors join/leave the Medical Performers List and some PCTs refuse to pass on any information. As a result, LMCs were struggling to find out who was working in their area.
- Similarly, few LMCs have an arrangement with the local General Practice Specialty Training Programme to ensure that they are made aware of new GP Trainees.
- Closer working with General Practice Speciality Training Programme organisers was recommended, with LMC officers being able to speak at their events.
- There were widely differing methods of communication. Although all LMCs produce newsletters or bulletins, the frequency and method of distribution (hard copy vs electronic) varied considerably.
- There was a distinct lack of enthusiasm for the suggestion that LMCs could use Twitter or Facebook.

ADDRESS BY SIR DAVID NICHOLSON, NHS CHIEF EXECUTIVE

Conference ended with Sir David Nicholson's speech. Laurence Buckman warned delegates in the morning that David had slight paranoia about his relationship with LMCs and he certainly appeared very prickly when a number of fairly hostile questions were posed.

- Sir David outlined the current changes to the NHS but acknowledged how difficult it was to balance demographic change, medical technology and patient demand with financial pressure.
- The profession needed to focus on purpose and that purpose should be 'to improve quality and outcome for patients'. An example of a dementia patient was given, which was a little idealistic, involving early diagnostics and multiple community clinics, services and support.
- Commissioning is seen as the answer to such problems, with clinicians having the ability to plan, organise and deliver services.
- GP practices are seen as the building blocks of clinical commissioning - every practice should be involved.
- The size of CCGs is for individual CCGs to decide, although small CCGs will need to demonstrate that they utilise the benefits of economies of scale and large CCGs will need to demonstrate local sensitivity.
- All CCGs had been RAG rated for risk, with 93% being given an amber or green status.
- CSOs could be bought locally and it was up to commissioners where they wished to buy these.
- There was an acknowledgement (I felt rather begrudgingly) that LMCs would necessarily help shape the reorganisations.
- There had been no contractual agreement as to whether CCGs should be performance managing practices, although some CCGs seemed to be interested in this area. This should not go ahead without negotiation with LMCs.
- It appears likely that the PCT clusters will develop into the local branches of the NHS Commissioning Board (perhaps you could call these Health Authorities).
- An overhaul of tariffs is underway, with a proposal for a 'year of care' tariff which would be a shared tariff between primary and secondary care, taking on responsibility for the follow up of a patient after an acute medical episode.