



# 2011 Conference of Local Medical Committees

Over 350 GP Local Medical Committee (LMC) representatives from across the UK attended the annual two day June conference. Under the theme *General Practice – the centre of the NHS*, the excellent debates, ably chaired by Lanarkshire's Mary Church, covered current topical issues, ranging from the NHS reforms to GP contracts to Care Quality Commission registration.

This report summarises some of the Conference's key policy decisions and how these are being taken forward by the BMA's General Practitioners Committee (GPC).



Mary Church

## NHS reforms

In the lead up to the publication of the NHS Future Forum report and the government response, the GPC chairman, Laurence Buckman, set the Conference tone in his opening address, urging for changes not to be a 're-spray job'.

On the NHS Bill, Conference's significant concerns about the pace and scale of the changes included: fragmenting the NHS, compromising the health of the nation and endangering patients. Major worries were voiced opposing enforced competition and Monitor's role in promoting competition rather than cooperation.

A particular issue was the threat to the overriding duty of doctors to put the needs of their patient first and the effect this will have on patient trust. Dr Buckman condemned the idea of a quality premium that would directly link practice income to the financial balance and achieved targets of CCGs as 'utterly unethical'. This risked undermining patients' trust in their GP. Other delegates stressed that there must be no suggestion that GPs stand to gain financially by rationing care. The Bill must therefore be amended to remove any mechanism that appears to offer inducements to doctors to make financially motivated decisions about an individual patient's care.

More positively, it was felt that the reorganisation at last gives GPs the opportunity to bring clinical input to bear on health policy, although, crucially, amendment was necessary to avoid the risk of damage to healthcare from unfettered market influences.

While some of these points have been partially addressed in the government's response to the Future Forum and the re-committed NHS Bill amendments, they have also been covered in the BMA's briefings on the re-committed NHS Bill and will continue to be pursued.

## Commissioning

The commissioning debates covered plenty of detailed ground about the implications of this aspect of the NHS reforms, particularly for primary care and the way GPs work and care for their patients.

Inclusive working by clinical commissioning groups (CCGs) was considered a must by Conference, to ensure the active involvement of all GPs. GPC sessional GPs subcommittee chair, Vicky Weeks, was concerned that all sessional doctors were not being given the opportunity to be included as they

should be, despite having the talent and skills needed and she argued for them to be fully brought on board. Conference supported the need for input from secondary care and public health doctors and engagement with local authorities. GPC guidance on involving and working with all stakeholders was requested, and this will be prepared in the coming months taking account of further developments from the re-committed Bill.

On the democracy of CCGs, the view was that there should be a working majority of GPs on the board and that all board members should be elected, with all GPs in the area having an equal vote. The electorate should be able to hold the board to account and directors of bodies qualified to undertake NHS work other than primary medical services should not be able to be members of the board.

Other practical considerations included the need for CCGs to be large enough or work with other CCGs to be able to fulfil their statutory functions without becoming dependent on an external organisation. Protected time is needed for GPs involved in commissioning to undertake the work, with access to ongoing support and training; the work needs to be properly remunerated, including payments for audit and preparation time, and backfill for ongoing clinical commitments.

With the transition from PCTs, Conference's view was that CCGs should not inherit PCTs' historical overspends nor be burdened with the cost of managing staff inappropriately transferred from PCTs. Any action by outgoing PCTs to sign up to long term contracts that could tie CCGs into expensive and inappropriate agreements was deplored, and commissioning support units that are developed should be part of the NHS and not social enterprise or privately run organisations. The GPC was requested to campaign urgently for the necessary checks and balances on the powers of the NHS Commissioning Board in respect of powers to command and control CCGs, practices' GMS and PMS contracts and GPs' performance.

Conference expected the statutory role of LMCs to be enshrined in the Health and Social Care Bill, including a requirement on CCGs and the NHS Commissioning Board to consult LMCs on all matters relating to the regulation, resourcing and delivery of general practice.



Laurence Buckman

While there was regret that there is no form of clinical commissioning in Scotland, it was insisted that any form of commissioning developed in the future should be on a collaborative basis, rather than on an inefficient market driven model.

The GPC is continuing to seek to persuade Ministers and the Department of Health on these matters, working with the wider BMA as appropriate, including in lobbying and briefing on the re-committed Bill. Updated and new GPC commissioning guidance will help ensure GPs receive necessary advice and information.

## NHS funding

With the current financial realities, it was considered inevitable that there will be a detrimental effect on patient care. Conference felt that there should be an open and honest debate about rationing in the NHS, with rationing done at national level, to avoid any postcode lottery and compromise of the doctor-patient relationship. One delegate wondered if the government had taken out a 'super-injunction' to prevent the use of the word rationing.



## Practice boundaries

Feelings also ran high on the proposed abolition of practice boundaries, calling for the GPC staunchly to resist proposals, because of their threat to locality based, personalised holistic general practice, along with the potential for damaging continuity of care. Other detrimental implications were the possible increased risk for children in need of protection, the integration of health and social services, and the education of doctors in training. In proposing the motion, Julian Bradley drew a parallel with the police and that it is not possible to call in a police officer from elsewhere, simply because you do not like your local 'bobby on the beat'. GPC deputy chairman, Richard Vautrey, agreed this will be a major battleground for the GPC in the coming year and it will need all the help it could get in fighting the changes by highlighting how the policy could lead to serious risks to patient care.

## GP education and training

The future of GP training was considered to be at risk with the proposed NHS reforms, and Conference insisted that education and training must be provided by central funding and subject to central oversight and monitoring. Proposals to abolish deaneries were condemned and the GPC was asked to work to maintain the current deanery model, in which deaneries should be independent from CCGs and teaching hospital foundation trusts.

The use of IT in GP training and assessment should, it was felt, facilitate the training process. The e-portfolio was regarded as too complex, time-consuming and having a detrimental effect on GP training, with speakers highlighting examples of it being overly bureaucratic and a box-ticking exercise. Conference demanded that the RCGP replaces the e-portfolio with a system more responsive to the needs of GP trainees.

The rising disparity in the quality of GP training schemes was a cause for concern, as was the quality of training received by some GP trainees in their hospital training posts. Deaneries should intervene to ensure the high standards of GP training are maintained and rectify any deficiencies highlighted in training. GP trainees should be trained to be properly equipped with the skills and understanding to be effective commissioners.

The GPC Education, Training and Workforce Subcommittee is working with the GP Trainees Subcommittee in taking these matters forward.



### **Sessional GPs**

Professional isolationism was felt to have detrimental effects on locum GPs and a number of measures were put forward to seek to address the problem. Jessica Harris, proposing the motion, observed that sessional GPs often lost out on opportunities to network and the support this provided. The GPC should facilitate networking between local and regional sessional GP groups, facilitate the sharing of good practice around the creation and running of such groups, and develop a toolkit for the creation of local sessional GP groups. The Sessional GPs Subcommittee will be working on this over the coming months.

Conference also called for the re-introduction of a nationally funded scheme that allows GPs who have taken a career break to re-enter general practice and provides supervision, support and a salary for those GPs.

### **Primary and secondary care interface**

The shift of work from secondary to primary care without a corresponding shift in resources to allow GPs to undertake the responsibilities adequately was once again condemned by Conference. Without transferred resources, it was argued, primary care cannot invest in the staff and infrastructure required. This concern will be considered further by the GPC negotiators, particularly in preparing for 2012/13 contract negotiations.

On referrals and care pathways, decisions must be based on a patient's clinical need, not influenced by financial inducements. No border within the UK should create a barrier to patients receiving the most appropriate and accessible care. Audits of referrals should include GP views, preferably supported by LMCs.

### **Paediatrics in general practice**

In the face of proposals to create specialist children's GPs, Conference took a firm line of opposition, stressing that paediatrics is an essential part of core general practice. This position was subsequently endorsed by the BMA's Annual Representative Meeting.

### **Care Quality Commission**

Major reservations were widely felt about the requirements for GP practices to register with the CQC. Standards set for general practice needed to be proportionate to the potential risk to patients in a primary care setting. Practices should not be penalised for failing to meet standards outside the control of the practice. Application of a registration fee to each GP provider location was deplored and all costs relating to these measures should be met by the government.

The government has since announced its proposals to delay CQC registration for practices by a year. In the meantime, the GPC will continue to work with the CQC and the Department of Health and press for further modification.

Broader dissatisfaction was raised further to the Panorama programme *Undercover Care: the Abuse Exposed*, in the light of which Conference felt the CQC, having admitted its failings, should be abolished.

## Quality care

While the Conference congratulated the GPC negotiating team for the removal of the PE7 and PE8 Quality and Outcomes Framework (QOF) indicators, considerable concerns were aired about the contract changes attributed to Quality, Innovation, Productivity and Prevention (QIPP). QIPP changes, seen by Conference as a front for introducing rationing, were felt to attack the already excellent, cost effective and efficient service provided by GPs, making it unsustainable.

Several QOF principles were reinforced, namely there should be an evidence base for indicators rather than political whim, and they should not be used for wider public health aims that are outside the scope of general practice to deliver. Increased practice list turnover should be recognised as a barrier to achieving public health and QOF targets. Changes with respect to prevalence were welcomed.

The GPC negotiators are giving careful consideration to these issues as they prepare for the forthcoming annual contract negotiating round.

## Clinical and prescribing

Conference remained of the opinion that decisions about whether the NHS can afford high cost drugs or treatments should continue to be made by a national body.

Patient Reported Outcome Measures (PROMs) in primary care were regarded as of unproven value, unjustifiably expensive in the current financial climate, unsuitable in the current financial climate, unsuitable for performance management and unsuitable for using to allocate resources.

## Out of hours

In turning down a proposal that GPs should take back responsibility for out of hours cover, Conference noted with alarm the underfunding of out of hours contracts, believing this has degraded the out of hours service nationally, and demanded that the government sets a realistic minimum out of hours contract price per head, to which commissioners must adhere. Such a minimum price would need to reflect rural costs and the burdens generated by extra bank holidays. The government was called on to level the playing field by making it a requirement of all out of hours tenders to account for contingencies within the tendered budget, to reduce the disadvantage to GP collectives.

## Regulation, monitoring and performance management

A call to put revalidation on hold on the grounds that it was a cumbersome and expensive method of managing performance designed in times of plenty was turned down by Conference. Conference was advised that the GPC had been successful in making revalidation simpler.

The increasing tendency for GPs' work to be split into component parts with separate qualifications was rejected. In proposing the motion, Andrew Green urged delegates to be proud of being generalists, explaining that the role had never been more important as hospital care became increasingly specialised. A particular bugbear was an insistence by the Faculty of Sexual and Reproductive Healthcare that GPs had letters of competence for the fitting of long acting reversible contraceptives and this will be raised by GPC with them. Organisations responsible for managing performance of individuals and contractors on behalf of the NHS Commissioning Board will need to

work in a consistent and structured manner. They will also need to be independent of CCGs, work in collaboration with representative committees, and be properly resourced and individuals adequately trained for the work they undertake. These points will be pursued in responding to the re-committed Health Bill and the subsequent regulations.

### **Information management and technology**

Concerns were expressed that although GP System of Choice would continue for a further year, there were no guarantees of continued funding beyond that date and this may signal an attempt to transfer responsibility for IT back to GPs, but without a commensurate transfer of funding. A further issue was that GPs were being pressurised into choosing particular systems not of their choosing and this may be exacerbated if responsibility and funding for IT is transferred to CCGs. Moreover Conference felt that the system is no longer fit for purpose and GP IT systems need to reflect the need for interoperability between practices within CCGs.

### **Contract negotiations**

The GPC was congratulated on negotiating an inflationary uplift to practice expenses, despite the Doctors' and Dentists' Review Body not being asked to report, and was asked to demand that the government recognise the independent expertise of the DDRB in future contract negotiations. The DDRB was asked not to report for two years for all doctors, the second of which will be 2012, so this will need to be a longer term exercise.

In debating a proposal on the conditions for moving to a new single contract model for primary medical services, Conference believed that it must be a UK contract and ensure that the rights of GMS contractors to a permanent contract, without any end date, are enshrined in any agreement. Additionally, neither MPIG nor seniority payments should be undermined, reduced or lost, and the rights and needs of PMS and APMS as well as GMS contractors need to be considered. It should also be a product of proper and adequate consultation of the profession prior to any agreement.

Great concern was voiced about the erosion of locum payments for sickness and maternity leave and, particularly because of the consequences for female recruitment to general practice, it was demanded that the GPC seeks protection of these funding streams.

GPC was also urged to do all it can to ensure enhanced services funding is maintained.

### **Flu**

UK GP practices were congratulated on their successful efforts to protect large numbers of patients through the annual flu vaccination campaign. However, the Department of Health inertia in advertising the campaign was deplored and Conference demanded that the Department fund a public campaign to encourage uptake later this year. GPC was called upon to resist any attempt to introduce central procurement of vaccines in England and Wales and the committee's flu leads will continue to reinforce this position.