

13th June 2011

LMC Members

LMC CONFERENCE 2011

ADMINISTRATION

The Mermaid Centre was well organised but too small for the numbers wishing to attend, and about three quarters of an hour away from the usual hotels. The dinner in the recently and expensively re-vamped Savoy Hotel was enjoyed by those who attended it. The Liverpoolian cohort, for the fourth year in a row, gave an impassioned plea that the meeting move to Liverpool (not least because of the pressures which will be caused by the Olympics next year) and the meeting actually agreed. The GPC will now look into it.

KEYNOTE SPEECH BY DR LAWRENCE BUCKMAN

(which you can read at:

http://www.bma.org.uk/whats_on/branch_practice_conferences/lmcchairmanspeech.jsp)

The GPC Chairman gave his usual rousing speech, pulling no punches, and was rewarded by a standing ovation.

He would resist, for many reasons, the trend to have different health services in each of the 4 nations. For instance, he feared that the training of GPs to a single, United Kingdom standard would be threatened not only by divisions between the nations but also by the loss of SHAs (and thus potentially of the SHA-funded Deaneries). Foreign management companies could exploit these divisions. New and threatening powers for Monitor had to be faced. The true secret of success in the NHS should be collaboration, cooperation and coordination across the levels of care.

Funding should be balanced more effectively and fairly between secondary and primary care. The former currently absorbed over 80% of the budget.

He was sure that no legislation was needed to introduce clinical leadership into the existing PCT structures, and he welcomed some of the noises he was hearing from 10 Downing Street. He scorned the idea that GPs should be rewarded with a 'performance related bonus' for saving money by providing lower quality care.

Moreover, just because GPs were joining shadow consortia did not mean that they supported the Bill; they were merely trying to limit the damage. Taking to the lifeboats did not prove agreement with sinking the ship. He stressed that GPCCs should involve sessional GPs, of whom there were now many in the workforce. In the new era LMCs would have an ever-more-important role in fighting for GPs, and standing up to GPCCs where necessary.

He recognised that after 4 years in the doldrums GP practices' expenses had only increased, and that there was nothing left for them to cut.

He was concerned at the huge amount of extra work involved in CQC registration; it was burdensome, costly and of no benefit to GPs. He regarded it as a hidden tax, and too complex for its own good. Further discussions were needed, especially on the costs of registration.

The GPC would continue to push its alternative view of practice boundary reform; boundary abolition was not the best way to go.

He would also fight to prevent terminal damage to NHS pensions in the coming year.

NHS REFORMS: THE IMPACT ON PATIENTS AND CITIZENS

Dr Iona Heath, President of the RCGP, gave a keynote speech on this subject, which was followed by an open debate. You can download the text of her speech, which is thoughtful and worth reading, from:

http://www.bma.org.uk/whats_on/branch_practice_conferences/lmconf2011.jsp

GENERAL IMPRESSIONS TAKEN FROM THE CONFERENCE

There was, as usual, a strong degree of unanimity over most aspects of GP practice. The role of the LMC was seen as very important and worth preserving.

The strength of GP practices remained in the trusting relationship with its patients and its generalist medical knowledge.

Many threats to GP practices were discussed: CQC registration, pension changes, lack of recruitment, the drift away from partnership working, privatisation of the NHS, the impact of any willing/qualified provider, how to maintain a UK-wide training scheme etc.

The challenges for the next year included:

- The Health and Social Care Bill, which was seen as a major risk to healthcare rather than as an opportunity to improve it. However, the GPC was encouraged to work with the Government to make it better, and to fight it if that proved impossible.
- How to bring in GP Commissioning Consortia (if that was what had to happen) in such a way as to improve patient care, give greater stability to GP practices and provide the economies demanded by politicians.

GLOUCESTERSHIRE LMC PARTICIPATION

Although Gloucestershire LMC did not lead on any of the motions to Conference many of its proposed motions formed part of those that were debated. All three of our representatives spoke:

- Dr Yerburgh asked the Negotiators whether CRB checks had to be carried out on all practice staff as currently advised by the PCT.
- Dr Alvis raised a question to them about the inclusion of M class generics in the Drug Tariff, through which the DH had removed some profitability from pharmacy and dispensing contractors. Since then further raids of this money had been made and the pharmacy contractors, but not dispensing practices, had been given the opportunity to earn some of this back via enhanced services. The lead negotiator mentioned that this had come up in a recent plenary session along with the discount review enquiry. They planned to actively discuss the issue during forthcoming talks.
- Dr Bailey opposed maintaining funding for extended services *in their current form*, because of the risk of them being outsourced to private providers. The better the funding, the more attractive they would be to a private provider. She supported extended services in principle but sought guarantees that GPs would continue to be the providers. She successfully argued against a motion that nurse practitioners and other health practitioners working in general practice should be able to issue Med3s.

For a detailed discussion of the debates held and decisions taken by the Conference, see Annex A.

Mike Forster
Lay Secretary

Annex A - Subjects covered during the Conference.

SUBJECTS COVERED DURING THE CONFERENCE

THE NHS

The conference did not agree that the NHS in its current form was unaffordable but said that any decisions on the rationing of treatment should be done at the highest possible level to avoid 'postcode lottery' accusations and damage to the relationship with patients. They doubted that the changes should be taking place now, at a time when funding was being so severely cut.

The Conference supported Gloucestershire's motion that the scale and pace of change proposed in the White Paper endangered patients. The GPC was given a firm steer that this potential damage should be fought against. Although funding limitations were inevitable, good care was essential.

One potential advantage of the reforms was that clinicians in general, and GPs in particular, would be able to bring clinical input to bear on health policy. Perhaps they would be able to re-introduce strong, well-supported, practice-based primary health care teams again?

COMMISSIONING OF CARE

A distinction was drawn between Shadow (interim, PCT-based) GPCCs and the real thing. LMCs should ensure that when GPCCs take over from PCTs their members are not only capable but also democratically elected, and genuinely accountable to their electorate, and that there will be a working majority of GPs on the Board. Sessional GPs should be able to be involved.

The statutory role of the LMC should be defined in the Bill.

GPCCs should not inherit historical overspends, un-needed PCT staff, ill-advised long term contracts etc from the current PCTs.

The powers of the new NHS Commissioning Board needed checks and balances – especially as the removal of a practice from a consortium currently threatened to remove the practice's contract and income.

COMPETITION

Conference unanimously opposed the privatisation of the NHS, and felt that the Secretary of State must retain responsibility for providing the overall service. They also unanimously agreed that Monitor should be promoting cooperation rather than competition.

INEQUALITIES

Conference felt that the Bill provided an opportunity to iron out inequalities in financial provision between practices, where for historical reasons practices do not currently receive equal funding for equal activity, and to target areas of deprivation where the clinical need is greater. Paradoxically market forces tended towards inverse care: the less you can afford medical care the more you need it.

In this connection Conference agreed that abolition of practice boundaries was a bad thing, in that (for instance) it would make it less easy to spot abuse of children.

GP EDUCATION AND TRAINING

Conference wanted the existing Deaneries to be preserved, with central funding, oversight and monitoring, and kept independent from GPCCs and teaching hospital foundation trusts.

There was a lot of argument about the e-portfolio used in training, but the general agreement was that it needed improvement.

Interestingly, by a fairly narrow (87:60) margin, Conference voted that GP trainees should be equipped with the skills and understanding to be effective commissioners.

SESSIONAL GPs

The sessional GPs sub-committee of the GPC had suggested that the professional isolation of locum GPs might be eased by the creation of local and regional sessional GP groups. Conference agreed, but LMCs generally reported being hamstrung by not having the contact details for the freelance GPs in their areas, and asked the GPC to encourage those GPs to share that detail with the LMC for their area.

PRIMARY CARE WORKFORCE

Conference recognised that a large number of senior GPs might be tempted to retire early, and that many more GPs would be needed to replace them because of the trend towards part-time working. There was a further impact caused by the increasing length of GP registrar training. It was important that there were enough GPs to handle the work, but not so many that their value was depreciated.

'SOAPBOX' SESSION

See Appendix 1.

CARE PATHWAYS AND THE RELATIONSHIP WITH SECONDARY CARE

On the principle that work expands to fill the available capacity, Conference was concerned at the number of extra consultant posts being created in secondary care. Narrowly (87:69) Conference dismissed the suggestion that Choose and Book should continue to be developed. However there was unanimity:

- That GP referrals should be based on clinical need, and that if they needed to be reviewed that review should be by GPs (aided by the LMC) not by secondary care.
- That internal UK borders should not stand in the way of patients receiving the most appropriate and accessible care.
- That responsibilities shifted from secondary care to GPs must be accompanied by an appropriate shift of resources.

PRIVATE FEES FOR NON-NHS WORK

Gloucestershire LMC was one of 7 LMCs who had suggested that practices should be able to charge their patients for non-NHS work. Conference agreed to shelve this as there was the risk of conflicts of interest and anyway, in a time of financial stringency, suggesting that well-paid GPs should be able to charge their patients would be politically insensitive. There was still Schedule V of the Act which allowed charging in certain limited circumstances.

CARE QUALITY COMMISSION

Conference felt that General Practice did not need CQC as GPs were already amply regulated, that the level of work involved in proving compliance with CQC standards was excessive and could adversely affect patient care. Most especially they felt that the CQC might not be up to the job it had been set, as evidenced by a care home that had proved to be CQC compliant, but was abusing its patients without the CQC finding out about it until the situation was exposed by BBC's Panorama programme. A boycott of CQC registration was, however, illegal. The GPC was urged to negotiate minimal impact on practices.

QUALITY AND OUTCOMES FRAMEWORK (QOF)

Conference unanimously approved the removal of PE7 and PE8 indicators and said that all indicators should be evidence based, and should not be targeted at wider public health aims. They suggested that increased list turnover should be recognised as a barrier to reaching QOF targets (some parts of London have a 30% - 40% turnover each year). In particular they agreed that two letters to call patients for QOF assessments should be sufficient. The GPC will try to negotiate for that.

QUALITY, INNOVATION PRODUCTIVITY AND PREVENTION (QIPP)

Conference agreed with Dr Corcoran from Avon that since GPs provided 86% of treatments within the NHS for only 23% of the budget QIPP as applied to primary care was merely a front for rationing, and threatened to make their excellent service unsustainable. What about the high consumption of resources in secondary care?

CLINICAL AND PRESCRIBING

Conference was concerned at the logical inconsistencies under which GPs were forced to work: screen more but refer less; follow care guidelines but reduce the cost of drugs used when following them; being criticised for using expensive, but efficacious, medicines whose price the NHS had agreed with the manufacturer. They felt that decisions on affordability should be made at national level. They also doubted that patient-reported outcome measures were a fair or affordable measure of anything significant.

OOH

There was great concern that the OOH service was inadequately funded, and especially so in rural areas, and took no account of extra bank holidays. The GPC was asked to press for a realistic minimum contract price.

REGULATION

The table was again thumped – that once you were a qualified GP then you should need no other qualification, or certification, to provide services that you had been trained to provide, that the standards to be met by GPs should be set by GPs, and that a GP's ability and performance should be measured by appraisals from other GPs.

REVALIDATION

Conference dismissed Ayrshire and Arran LMC's motion that in the light of funding restrictions Revalidation should be put on hold. It had been needed for 20 years, had already about £156M of sunk costs and if GPs were to be responsible for the use of an NHS budget of £90B there was a need to ensure that they would act responsibly.

PATIENT REGISTRATION

While agreeing that practice lists should only include those registered patients who are genuinely still living within the practice boundary, Conference unanimously deplored PCT attempts to clean lists in an obvious attempt to save money since this could disadvantage the most vulnerable and put practices at risk. The GPC would seek a fair national policy for list revalidation including obtaining back-payments for practices where patients had been erroneously deducted.

Conference emphasised that at general practice level the issue of whether to accept and treat a person was largely a human one, 'Does this person need help?' It was not up to practices to be the gatekeepers of NHS care for overseas visitors.

IM&T

The future funding for IT support to practices was uncertain, but Conference was certain that it was needed, and that practices should be able to exercise freedom of choice in selecting a practice clinical IT system that suited them, provided it gave a suitable service.

There was agreement that the N3 connectivity was unsatisfactory; a recent national survey had shown that 29% of practices were 'extremely unsatisfied' with it.

The key to success would be compatibility for exchange of patient data between systems. Better links were also needed between consultants and GPs.

ACCESS

Conference ran out of time to discuss the motions under this heading.

QUESTIONS TO THE GPC NEGOTIATORS

Not a very informative session, frankly:

- *They could not advise how to hold onto worthwhile PCT staff.*
- *The future GP Contract was not yet being discussed, and the issue of APMS contracts was still open to question.*
- *Postgraduate training no longer includes the practical obstetric challenges that it used to, so perhaps new GPs are less skilled in paediatrics and obstetrics.*
- *Pensions are a BMA rather than GPC matter, so there was no answer to the question, 'what are the big guns in relation to pensions, and when will they be brought out?'*
- *Every coroner makes his own rules, so the new coronial regulations have been ditched. No progress yet.*
- *Even if a lack of recruitment of GPs is an **issue** now, which may later rise to the status of a **problem**, and ultimately to that of a **crisis**, there is no funding for a recruitment programme.*

CONTRACT NEGOTIATIONS

Conference set various 'drop-dead' lines for negotiators to follow when negotiating for a new GP contract:

- It must be UK-wide, covering GMS, PMS and APMS contractors, and at least maintain the rights of existing GMS contractors to a contract without an end-date.

- Additions from MPIG and seniority payments must not be undermined, reduced or lost.
- The profession must be properly and adequately consulted beforehand.

FUNDING

Conference thanked the GPC for negotiating a small inflationary uplift last year towards practice expenses, but urged them to demand that the DDRB be included in future negotiations.

Locum payments for sickness and maternity leave were discussed, with particular reference to the adverse impact which the reduction in such payments might have on recruitment of female GPs. Conference unanimously agreed that such funding streams should be protected, clearly funded at national level, and carried on by the NHS Commissioning Board, and that the SFE should be amended to allow any GP (not just the part-time sessional GPs proposed by Gloucestershire LMC) to cross-cover for a colleague on maternity or sickness leave, or under suspension.

SEASONAL/PANDEMIC FLU

Conference unanimously condemned the idea of central procurement of vaccines in England and Wales. The current system was flexible, well-organised and responsive, but would do even better if backed by a timely advertising of the scheme by central government.

ENHANCED SERVICES

None voted against the motion that locally enhanced services drove up quality in clinical care and that funding for such services should be maintained.

PENSIONS

Conference gave the GPC their strong support in opposing any further changes to the NHS pension scheme, warning that the threatened loss of existing benefits might trigger a rush by senior GPs to retire, but did not agree to strike action.

There was also unanimous support for a motion from Cleveland LMC that GPs who have provided NHS services to NHS patients following procurement exercises must have their income considered as pensionable within the NHS scheme.

PREMISES

The combination of PCT overspends and the impact of the White Paper had produced widespread blight on the building programme. Conference voted unanimously in support of Gloucestershire LMC's motion that investment in GP premises should be substantially increased, equitable and ring-fenced, and also that we needed clarity on who will be responsible for planning premises, making the strategy within which that planning will work. Conference requested the GPC to negotiate a development and management strategy for primary care premises.

Conference also felt that, at least in some areas, the money spent on Darzi centres would be better spent on primary care services.

MEDICAL CERTIFICATES AND REPORTS

Conference unanimously requested the GPC to negotiate with the Secretary of State for Health to set a reasonable rate for coroners to remunerate GPs for the provision of reports regarding deceased patients (since the power to do so by the coroners themselves had not been exercised.)

MISCELLANEOUS

Smaller practices need protection from forced merger with larger practices; small practices provide a valuable service.

'Choose Well' is a good thing and should be supported, but patients should be taught the differences between urgent care, unscheduled care, emergency care and out-of-hours care.

Outsourcing. Conference deplored outsourcing GP support services. (This motion was basically aimed at NHS SBS but also included the new 111 support services in its sights.)

Children's GP. The very idea that a GP would have to specialise to deal with children was anathema.

Prisons. Primary care for those in police custody should be arranged by the NHS not the Ministry of Justice.

Animal Farm. Likening (one would hope unfairly) the GPs in the GP Commissioning Consortia to the pigs in the novel 'Animal Farm', Conference warned possible Napoleons that this time Boxer will not meekly go to the glue factory.

Appendix 1: Soap Box Session

APPENDIX 1 TO
ANNEX A TO
GLOS LMC NOTES ON THE
2011 LMC CONFERENCE
DATED 13TH JUNE 2011

SOAP BOX SESSION

(In these sessions GPs are allowed one minute to voice any issue of concern. No vote is taken but sometimes they are applauded. The points raised are noted by the GPC but do not form part of Conference policy.)

Non-availability of drugs. This is an increasing problem, and sometimes there are no alternative drugs. This can be serious for patients. It is wrong that pharmaceutical companies can put profit from foreign sales before meeting the needs of UK citizens.

UK Retainer Scheme. Surely this should be retained?

GPCCs and the Contract. If a practice is fulfilling its contract it should not be liable to action by its GPCC.

Sessional GPs in PMS practices. PMS practices should be under the same obligation as GMS practices to offer terms of service as least as favourable as the BMA model contract.

Pharmacists. What evidence is there that MURs, homeopathy etc are clinically helpful?

Public Accounting. Budgeting annually, which all government departments are subjected to, makes little sense when you are trying to run a business.

PCTs. The speaker expressed thanks for what PCTs have been doing, and felt that GPCCs would not have the freedom of action which some might think they will enjoy.

DNAs. Could the GPC initiate a campaign to reduce the incidence of those who do not attend booked appointments, and thus wasted scarce NHS resources?

SCRs. The GPC should negotiate that GPs should not be held personally responsible for the consequences of any lack of data on the SCR.

OOHs. Could some use of the OOHs organisations be used in day-time to avoid the need for practice boundaries to be abolished?

MMR. The MMR vaccine should be available to all travellers, not just those under the age of 16.

Job-Share Partnerships. One female GP wondered whether practices could improve workforce planning for female part-time GPs by offering job-share (not just part-time) partnerships?

Sexual Health. There is a Sexual Diseases incidence database which cannot be accessed by the GP, even with the patient's consent. Can this be sorted out?

NHS Logo. The patient recognises, and values, the NHS logo. The Department should be careful to whom it grants permission to use it.

Local Medical Society. The speaker urged that all clinically qualified people in a given area had common ground, and that they should be mutually supportive of each other.