

17 June 2009

All LMC Members

REPORT ON LMC CONFERENCE 11-12 JUNE 2009

Dr Laurence Buckman gave the keynote speech.

<http://www.pulsetoday.co.uk/section.asp?navcode=978&cid=lmcs061709#>

His main thrust was that the profession faced a number of challenges, both external and internal. Externally the government was determined to claw back as much as possible of the increase in remuneration given in 2004, and to demand ever-greater services for the remuneration they did give. He mentioned the intention to move away from MPIG as soon as possible, and the move to a fairer prevalence calculation in QoF. He felt that long questionnaires were unfair when given to patients months after the event without telling them the effect their responses would have on the income of the GP practices concerned. The move to revalidation and accreditation, both theoretically welcome in that they would reassure patients that GPs were up to the job, would have to be introduced carefully to ensure that the burden was proportionate and bearable. Internally the risk of division between principal and salaried GPs continued. The way the profession reacts to these challenges would be critical in shaping their future. He specifically avoided crowing at the peccadilloes of MPs' expenses claims, but did comment that GPs should continue to give their normal outstanding service to patients as the media attention could easily switch back again. The strength of General Practice lay in its focus on patient care, its knowledge and care of patients, and the trust which it enjoyed.

The debates which followed stressed that there were few generalists left in the NHS except GPs, and that they were in some sense specialist generalists, providing huge value for money, efficiency and cost-effectiveness. Patients regularly preferred quality over choice. Despite considerable dislike of it, World Class Commissioning had one or two redeeming features which needed to be preserved.

Revalidation.

- Professor Michael Pringle of the RCGP addressed revalidation on the first day. He stressed that it was being developed very much with the cooperation and input of the profession. The documentation on the website was continually developing to reflect continuing GP input, which he invited. (mike.pringle@nottingham.ac.uk) The scheme was currently being piloted and although the first volunteers would probably be revalidating in 2011, this could slip. He was very conscious of the need for revalidation to be suitable for all doctors, including sessional GPs and those in remote rural areas. He had taken the point about the complications of the proposed educational credits, and was now considering a scheme based on hours spent, but with an 'impact factor' possibly being added for special events. Appraisal development would happen, but it was not yet known how. The role of Responsible Officer was key, but as yet undefined. The whole scheme had to be properly resourced. He felt the BMA should lead but the RCGP would be in support. Dr John replied that hospital doctors were allowed time off for professional development which GPs did not get, to the detriment of their patients. Remediation was another key issue: who would be trained to do it; who would pay for it; and how would it be tested? He warned GPs at conference that it would be very time consuming; that 360 degree appraisals were an unknown quantity and would have to be tested carefully before being allowed to threaten a doctor's career. Above all, the system

should be kept simple. In closing, Professor Pringle gave a 'solid commitment' that there should be no disadvantage to those who were not RCGP members.

- On the second day the conference debated several motions on the subject. There was general agreement that revalidation was a good idea, but that the scheme should be realistic, relevant and practicable, should not detract from time devoted to patient care, should be fully funded and resourced by central government (including the cost of remediation should that prove necessary, and the costs of time to prepare), and that there should not be a consequent, disproportionate increase in GMC fees. Sessional GPs were a special case, and revalidation would have to be designed to fit them also. Appraisals were accepted as being a key part of revalidation, but, as always, it was important not to rush things through in an ill-considered fashion. In particular, 360° appraisal must not become part of revalidation until a validation method has been agreed with the GPC. There was also general suspicion of the proposed scheme of learning credits – too complex and too subjective – and a more reasonable scheme was needed. Lastly the conference stated that the costs should be the same for all GPs, whether or not they were members of the RCGP.

GP Education and Training. Despite strong arguments that there should be no more than one trainee to each trainer the conference voted that down, but did call for an increase in trainer numbers and an increase in the trainer's grant. They also felt that GP trainees required at least 5 years training post-foundation, and that half of that at least should be spent in a practice.

Funding. There was much discontent at the inequalities of pounds per patient across practices, and that these inequalities were being perpetuated by current changes. All agreed that the MPIG should only be got rid of if global sum payments increased by at least as much. They were also concerned that PCOs were not taking steps to cushion the blow to some practice incomes caused by abandonment of the square rooting formula this year and the 5% threshold next year. The importance of seniority payments was recognised.

Miscellaneous Motions.

- Cross-border Issues. Conference drew the GPC's attention to their serious concerns that in many areas the health and social care service boundaries did not marry up, leading to some very strange and illogical treatment pathways for some patients.
- GPs' Doctors. They agreed that GPs choosing to register with their own practice did not thereby put their own patients at risk.
- Prisons. There was a serious failure of communication between practices and prisons and vice versa, making it difficult to take over health care of released prisoners.
- Patient Feedback. Local, well-targeted, relevant patient feedback was extremely helpful to practices. Ill-thought-out, consumer-style feedback websites would probably be highly damaging.

The GMS Contract. Conference was concerned that there was endemic, unresourced contract creep and strongly stated that the negotiators should return to the Conference before agreeing to any practice losing baseline income. Dr Jo Bayley successfully proposed a motion lamenting the government's treatment of GPs in the media and, as included in the motion by the agenda committee, congratulating the GPC on its public relations efforts on GPs' behalf, and urging GPs and practices to do likewise locally.

Sessional GPs. Concern was expressed many times during the conference that taking on salaried GPs rather than partners was a self-inflicted wound on general practice, which might prove mortal in a few years time. All motions to change the make-up of the GPC (e.g. that Sessional GPs should have their own separate branch of practice committee) were defeated on the grounds that the GPC represents all GPs of whatever type. However the conference felt that patients of PMS and APMS practices might be disadvantaged if Sessional GPs in those practices were hired on less advantageous terms than their colleagues in GMS practices. The BMA terms for salaried GPs were seen as one lever for practices to take on more partners rather than salaried GPs. The GPC was invited to find practical ways to encourage practices to take on more GPs as partners. Salaried GPs, where employed, should be given fair and favourable conditions of service.

Primary Care Teams. The conference urged a return to the primary care team where at least the community nurses, health visitors and community psychiatric nurses should be based on the practice.

Pensions. There had been talk in the Press of a review of public sector pensions – as being too high in comparison to the pensions available to workers for private firms. This was obviously a matter of grave concern, and tinkering with it, if suggested by Government, was to be regarded by the GPC as theft and breach of contract.

Commissioning. PbC was due for renewal, but would only work properly if PCTs supported it wholeheartedly, and if there were no fetters on the reinvestment in service development of freed up resources. Conference also remarked on the trend to increase both numbers of consultants at secondary care while at the same time sending more and more work of ever-increasing complexity to primary care, without adequate resources. There was also a need for much-improved communications between secondary care and general practice, which was critical for patient safety. The problems went far beyond late delivery of inadequate discharge notes (although those were mentioned!) There was also concern that concentration on 'care pathways' was all very well but should not be at the expense of the right of GPs to refer to appropriate consultants.

Procurement of General Practice. There was general rejection of the concept of competitive tendering and of GP-led Access Centres as being a waste of money and a threat to existing practices.

Future Organisation of General Practice. Dr Nigel Watson (Wessex LMCs) led off the debate. The current pattern was for single-GP or partnership practices of varying sizes, some quite small. Mounting pressures might mean that this pattern would have to change, whether by federation or amalgamation or by some mixture of the two. Change was inevitable and would have to be embraced. One solution would not fit all, but practices should build on their strengths (continuity, skill, training, flexibility, records, patient advocacy and signposting patients through the NHS system) and remain strongly focused on patients' needs. Being radical he wondered if perhaps the Department of Health actually did care about GPs, but the GPs could not see it. Many PCTs valued their LMCs. There were stressing factors. The government's obsession with private companies was destabilising. The increase in salaried GPs at the expense of numbers of partners was disturbing. Some practices did not provide the choice, access and quality which they should, and remediation would be needed in those cases. Some practices, of course, were victims of circumstance and needed help. Increased performance management by PCOs was inevitable and would have to be managed, while a degree of integration with social services was also likely. High quality practice managers were needed, and they should be encouraged to take a partnership stake in the business. Discussions afterwards reiterated many of these points but added nothing new.

Information Management & Technology (IM&T). Despite the GPC committee chairman, Dr Grant Ingrams, resolutely defending the National Programme for IT (NPFIT) and saying that in parts it was excellent (e.g. QMAS, GP2GP and GPSoC) conference condemned the whole project as a waste of huge sums of money. They also felt that practices should be allowed to select systems of choice and that where these were too slow or inadequate then local servers etc should be provided until such time as the systems had improved. As to Choose and Book, the GP fraternity would be ready to use it or any software system that was fit for purpose, but, among other aspects, C&B should never be used as a performance management measure.

Public Health and Pandemic Flu. The recent bout of swab taking requested of GPs by the Department of Health to track the development of swine flu in UK had raised interesting issues. The general feeling was that a consistent and unified approach to implementing these programmes was needed in future, with the workload and funding being defined and resourced (probably by a DES) in advance, and that the campaign should not be publicised until all these details had been agreed.

Clinical and Prescribing. 'Just in case' boxes of drugs for terminally ill patients came in for some criticism – although they were agreed to be a good thing there were difficulties, especially if the patient's condition changed or an unforeseen problem arose, particularly out of hours.

Essential, Additional and Enhanced Services. Borders LMC successfully moved that unscheduled care is a vital part of in-hours primary care, without which GPs would be come deskilled and undervalued. Much scorn was poured on the 5 new clinical DESs introduced in 2008/09 but implemented so late in the year, and conference passed unanimously a motion instructing the GPC to ensure that the money intended to come to primary care through those DESs should not be lost, and that in future DESs should be ready for implementation from the beginning of the financial year. Conference did not approve the idea of having Hepatitis B immunisation or HIV testing as DESs. Dr Steve Alvis led on a motion that extended opening hours were, and should remain, optional, should only be provided with adequate support services, should not be used as quality markers, should be distinguished from out-of-hours services and should be flexible to reflect local needs. This was carried as a reference, meaning that it would guide the GPC negotiators but would not be absolutely binding on them.

Out of Hours. Conference had no wish to take on Out of Hours responsibility, but recognised that the Conservatives intended GPs to take it on again. If it were forced upon the profession then there should be a minimum set of criteria that should apply, and the funding would have to be adequate.

Quality and Outcomes Framework (QoF). The conference fully supported QoF as it raised standards of care for patients, but strongly opposed the notion that it was a 'pump priming' scheme; once an activity under QoF had become embedded in GP practice the funding should not cease. As with new DESs, changes should be properly resourced, nationally agreed and brought into effect from the beginning of the financial year. The conference unanimously stated grave concerns regarding the role of NICE in the QoF process, but given that it was happening insisted that NICE should work with the GPC in managing the development and implementation of QoF. They were perturbed, though, at the emphasis on data collection at the occasional expense of time spent in consultation with the patient.

Patient Surveys. The conference supported the idea of patient surveys in general, especially those that were local, that asked unbiased questions and that employed statistical rigour. There was general dissatisfaction at the PE7 and PE8 survey results because they

did not meet those standards. There was real concern that patient surveys were being used to affect the amount of money a practice was paid, since a poor survey result would actually remove the money needed to provide a better service!

Regulation, Monitoring and Performance Management.

- Paperwork. What, the conference wondered, had happened to the 'light touch, high trust' basis of the GMS contract? They unanimously charged the GPC to intervene to reverse the trend by which PCOs were demanding ever more paperwork from practices, to the detriment of their main task which was to care for patients. In many areas 'balanced scorecards' were being introduced, probably as a result of the World Class Commissioning scheme (about which some cynicism was expressed). Such scorecards if used inappropriately, for instance to threaten closure or amalgamation of practices, were dangerous and wrong. Only evidence-based quality markers should be included and LMCs should agree to them before they are introduced.
- Suspension. There was strong concern over the use of suspension of a GP by the GMC pending a determination; the result was a loss of the ability to earn for as long as the process took – perhaps a year – and a severe blow to professional standing. If the charges were not proved then financial compensation should follow.
- Upgrade Training and Certification. There was an unwelcome trend to get GPs to re-certify in sub-areas of general practice, which should be resisted. GPs have huge experience and long training and that should be recognised.

Premises. There was general concern that practice premises were often inadequate, especially to support the increased amount of work being passed across from secondary care, and that not enough was being done to upgrade or replace inadequate premises.

Collaborative Arrangements. Conference passed a motion asking the GPC to publish an annual list of those collaborative arrangements for which GPs should be helping local authorities etc. It was agreed that the fees for that work would have to be set by individual practices and notified by them to local authorities, i.e. 'no change.'

Liverpool. The Liverpoolian delegation enlivened the meeting:

- By offering to host the next conference in Liverpool, with the added attraction for certain people of 'free bungee-jumping – a genuine offer; no strings attached.'
- By suggesting that the GPC should globally negotiate for Christmas to be moved to the first Monday after the second full moon following the autumnal equinox – or some such measure. This was taken as a reference since the Chairman of the GPC was 'on the old contract.'

M J D FORSTER
Lay Secretary