Londonwide LMCs
The professional voice of London general practice

The M Word issue 5 - Dr Michelle Drage's latest personal briefing for practices on NHS reforms

Here's the latest update on what has and what has not been going on over the last few weeks, and what is likely to happen over the Autumn. I will cover:

Pathfinder Clinical Commissioning Groups (pCCGs) – previously pathfinder GP consortia
Grip and QIPP pressures diverting pCCGs away from commissioning of hospital and community services towards GP micromanagement
Worrying trend for pCCGs to emulate PCTs – letter to all GPs from the Chairman of the GPC

My best wishes

Dr Michelle Drage FRCGPCEO Londonwide LMCs

1. Pathfinder Clinical Commissioning Groups (pCCGs) – previously pathfinder GP consortia

Pathfinders are currently constituted as subcommittees of PCTs and so are governed by the PCTs. The PCTs have retained their own boards nominally, but have delegated over their functions to clusters of PCTs. To some this is confusing. It means that there are potentially 4 sets of bodies trying to organise the NHS locally.

The Cluster,
The PCT,
The Borough or Subcluster, and
The Pathfinder CCG.

All clear so far?

Now lest we forget, we must remind ourselves what pCCGs are being established to deliver.

pCCGs are supposed to be developed by their cluster, the current experts in commissioning, as we all know, to enable them to take over the commissioning of Non-Primary Medical Services (NonPrMS), ie Hospital and Community Health Services (HCHS) by 2013. As part of getting there they have to pass the 'Delegation' test set by the cluster, and ultimately the ‘Authorisation’ test, under the auspices of the National Health Service Commissioning Board (NHSCB), once that body has been legally established under legislation still working its way through parliament.

2. Grip and QIPP pressures diverting pCCGs away from commissioning of hospital and community services towards GP micromanagement

You'll recall I mentioned Grip in M Word 4. Grip is the term used to describe the NHS's central control to ensure that, wait for it, money isn't frittered away by GP commissioners doing commissioning.

So the delegation and authorisation tests operated by the clusters are part of Grip. Clever clusters enable the Grip to work in favour of GP

commissioning development. Others use it to slow that development down.

In the meantime, in order to pass the ‘Delegation’ test, pCCGs are required by the clusters, subclusters and boroughs to deliver QIPP. Now you know all about QIPP as I addressed it back in M Word 4. QIPP is the government's 'largescale transformational programme for the NHS' and stands for Quality, Innovation, Productivity and Prevention, designed to create £20 billion of savings to redirect to frontline care.

Details of QIPP are on the Department of Health's website, follow the lead to the primary care commissioning workstream if you dare.

As part of QIPP, pCCGs are being driven along the route of reducing demand on Hospital Services ostensibly to contain costs.

For example, for pCCGs QIPP essentially means referral control.

But there are no similar pressures on pCCGs to examine and inspect their suppliers, the hospitals themselves, to improve the services they provide to their customers, ie, pCCGs, GP practices and GP practices' patients, or for them to control the demand they place on our services accordingly.

Take discharge management for example.
Or prescription dumping.
Or DNA patients returned to their GPs.
Or poor hospital Dr - Patient communications leading to patients seeking consultations with us to explain what actually happened to them in hospital or outpatients without any knowledge of what actually happened at the time.
And all the associated unnecessary workload involved for GPs and staff leaving you and your practice teams to pick up the pieces, often out of your own pockets, and certainly out of your precious staff resources.
And the games trusts play with disease coding and consultant to consultant referrals.

So we must sympathise with the frustration of our pCCG lead GP colleagues who find themselves in the awkward situation of being unable to get on with proper commissioning, and having to mark time / be diverted/ make do with primary care QIPP, diversions such as constitutions (which by the way is unnecessary as there will be a national model constitution shortly) and not looking or behaving like a PCT whilst driving it.

But there is another worrying trend emerging. The trend for some pCCG GPs to emulate PCTs and with it the whole GP performance agenda.

3. Worrying trend for pCCGs to emulate PCTs – letter to all GPs from the Chairman of the GPC

I have therefore reproduced a letter sent to all GPs from the Chairman of the GPC, Dr Laurence Buckman. The letter makes clear our negotiators' concerns about this tendency to turn what was a laudable concept designed to place GPs in the position of leading and redesigning the commissioning of secondary and community care from a general practice perspective into yet another organisation focused on GP micromanagement, performance and productivity.

Londonwide LMCs under my direction is working hard to keep pCCG GPs supported in our joint wish to see CCGs achieve effective GP led commissioning of non- Primary Medical Services. We are also there to protect them and you and your practices from any unintended consequences associated with this new tendency through our strategy of securing the future of London's general practice.

Letter from Dr Laurence Buckman (7 October 2011)

Dear Colleague,
NHS Reforms

It is now only six months until Clinical Commissioning Groups (CCGs) are expected to be up and running in shadow form. While there are good things happening in some areas – GPs, supported by managers, are becoming more involved in the planning and delivery of healthcare and there is greater working with our consultant colleagues - I am becoming increasingly alarmed by the manner in which some CCGs are being established and are operating. There is a limited window of opportunity left for us, as your national representatives, and you, as practising GPs, to influence the development of CCGs, and that is why I am writing to you now.

The BMA continues to have major concerns about the Health and Social Care Bill, but we recognise that the changes set in motion simply by its proposition are already having a huge impact on the NHS. We are therefore trying, as far as possible, to influence this process so that GPs' interests are best represented. That is why the GPC has been involved in Department of Health groups developing policy on the new structures. However, I am very concerned by reports I am getting from GPs who do not feel engaged with the changes happening in their area, or feel they have not been given opportunity to be involved; it is vital in the early days of a new NHS in England that it is the many and not the few who influence important formative decisions.The changes to health services in your area are happening now, regardless of the Bill’s passage through parliament. I have set out our primary concerns below and would urge you to make sure your voice is heard locally, not just if you have concerns, but so you can help shape the future of healthcare in your area. More information about how you can do this is set out at the bottom of this email.

The GPC’s main areas of concern about the development of CCGs are:

In areas of good practice, board members are being properly nominated and elected, but we have heard of places where there has not been any adequate democratic opportunity or where not all GPs have been included in the process.
In some cases CCG board members have put in place untried and unacceptable measures to micro-manage practices, irrespective of the views of local GPs.
Local medical committees (LMCs) represent GPs and practices locally and they must be engaged with CCGs and primary care trusts (PCTs); where this is happening, positive developments are being made, but in some areas the LMC is being sidelined and ignored which is not acceptable. CCG authorisation requires the demonstration of engagement of local practices and the LMC is best placed to assist with this.
It is appearing increasingly likely that the authorisation process, while trying to ensure that these newly formed statutory bodies (CCGs) will be fit for purpose, will only authorise organisations that bear a remarkable resemblance to PCT. It means many GPs trying to build their groups will have wasted a lot of time, energy, and resources and are now having to reorganise for a second time.

In terms of government health policy and its impact on GPs:

The greater focus on competition, particularly through the enforced roll-out of the ‘any qualified provider’ policy, will make it harder for primary and secondary care providers to collaborate for the benefit of patients.
Although the government has amended its proposal to make clearer the link between any reward and commissioner performance in relation to quality and healthcare outcomes, we remain seriously concerned that potential incentives or financial reward associated with commissioning will adversely affect the doctor-patient relationship.

More detail about our many other concerns surrounding the Health and Social Care Bill and what the BMA is doing to address these can be found on the BMA website.

However, when it comes to the development of CCGs, we believe democratic accountability and collaborative working with constituent GP practices, including all sessional and salaried GPs, is vital. We must learn the lessons from Practice Based Commissioning: where there has been active engagement of grassroots GPs greater positive change has been achieved; where it has not it has failed to deliver and, in some cases, has damaged existing services.

Your LMC, working with the BMA, has a long history of representing GPs’ interests, having been in existence through 100 years of NHS reforms; its organisational memory and role, both statutory and none statutory, is even more important today than it has ever been. But it needs to know your views. More information about how to contact your LMC can be found on the BMA website.

No matter what happens with the Health and Social Care Bill, for our patients’ sake we need efficient and effective services. Vested interests need to be removed as do actions which do not improve patient outcomes. CCGs and PCTs need to work with LMCs, following the example we have seen in areas where there is constructive working. This is the only way that positive changes will be made.

Yours sincerely,Dr Laurence Buckman