

Shifting the Balance of Power in the NHS

The Impact on LMCS

The West Midlands Perspective

1. Scope and Purpose

- 1.1 This document considers the changes that the most recent NHS reforms as outlined in *Shifting the Balance of Power in the NHS* (STBOP) will have upon LMCs, and how LMCs in the West Midlands should react.
- 1.2 This document takes into account the views of LMCs in the West Midlands as discussed at the 2001 WMRLMC Nuts and Bolts Meeting and the January 2002 WMRLMC Seminar.
- 1.3 It is suggested for LMCs to use this document as a basis for discussion at LMC meetings and/or with their constituents so that the proposals for all the West Midlands can be discussed at the next WMRLMC Seminar on the 18th March 2002. **Please note: Although this document suggests some possible solutions these are not exhaustive, and also different solutions may be appropriate for different LMCs.**
- 1.4 This document also suggests actions for LMCs with appropriate dates.

2. Background

- 2.1 STBOP implements many changes, but most pertinently changes the form and function of Health Authorities and of Primary Care Trusts (PCTs).
- 2.2 The *NHS Reform and Healthcare Professions Bill* (RHP Bill) currently progressing through parliament amends the NHS 1977 Act and lays down the outline for legislation to enable the changes.
- 2.3 The main messages from STBOP and the RHP Bill are:
 - 2.3.1 Health Authorities will merge into larger Health Authorities and convert to Strategic Health Authorities (StHAs) once legislation is enacted.
 - 2.3.2 PCTs will take over most contractor functions from HAs.
 - 2.3.3 LMCs will continue as statutory committees, and the statutory levy will continue (for GMS principals only).
 - 2.3.4 The statutory requirements for LMCs to be consulted (by HAs and PCTs) will continue.
 - 2.3.5 LMCs may be coterminous with one or more PCTs.
 - 2.3.6 LMCs will need to seek recognition from their PCT(s).
- 2.4 **But** – these changes will not have legal status until the legislation is enacted (presently predicted to be October 2002).

RISK – DISCUSSION POINT

LMCs at present have to be coterminous with Health Authorities until the new regulations come into force in October 2002. All Health Authorities are merging into larger Health Authorities with effect from April 2002. Therefore, unless LMCs change to be coterminous with the merged Health Authorities, between April and October 2002 they will not be properly constituted under prevalent legislation. The Department of Health (DoH) recognise this issue, and in the latest document (STBOP – The Next Steps) recommend that in this interim period LMCs should continue in their current arrangements, but use this period to decide their future configuration. In effect the DoH are suggesting that current legislation is ignored during this period. The risk for LMCs is that during this period there will not be any statutory requirement for consultation, and LMCs will be relying upon PCOs/HAs complying with central guidance.

ACTION BOX 1**Actions before April 2002**

1. Seek agreement from the merged HA to continue with current structure during the interim period (from April 2002 to October 2002) in line with *STBOP – The Next Steps*.
2. Seek informal recognition from PCT(s) and agreement for the LMC to act as representative of all general practitioners.
3. Liaise with other LMCs in the same StHA area to agree framework for consultations with (and representations to) the StHA.

Actions between April and October 2002

1. Decide the boundary of the LMC identifying which PCTs it will be coterminous with.
2. Develop a new constitution and gain agreement from constituents, including
 - 2.1 Ensuring equal representation of PMS and Non-Principal general practitioners.
 - 2.2 Deciding level of levy for GMS, PMS and Non-Principal general practitioners.
3. Once a new constitution has been agreed, seek agreement from PCTs (and the StHA).

Action October 2002

1. Finalise formal recognition from PCTs.

3. Strategic Health Authorities in the West Midlands

- 3.1 The number and boundaries of the StHA in the West Midlands have been agreed and both Chief Executives and Chairmen appointed.

Merged Health Authority/ StHA area	Chief Executive	Chairman	Current Health Authorities
West Midlands North	Bernard Crump	Mr Michael Brereton	North Staffordshire South Staffordshire Shropshire
West Midlands Central	Geoff Scaife	Mrs Elisabeth Buggins	Birmingham Dudley Sandwell Solihull Walsall Wolverhampton
West Midlands South	Mike Marchment	Mr Charles Goody	Coventry Herefordshire Warwickshire Worcestershire

4. Functions and Structure of LMCs

- 4.1 LMCs will continue to have many functions, including:
- 4.1.1 Being consulted by PCTs and StHAs (statutory function).
 - 4.1.2 Representing general practitioners (GMS principals, PMS doctors and Non-Principals).
 - 4.1.3 Informing and developing GPC policy.
 - 4.1.4 Pastoral functions of helping and advising general practitioners.
 - 4.1.5 Promoting general practice.
- 4.2 In order to perform these functions, LMCs must have:
- 4.2.1 Advice from an experienced general practitioner (Medical Secretary).
 - 4.2.2 Secretarial/office support.
 - 4.2.3 Access to timely up to date information.
 - 4.2.4 Support for more complex problems, or in the event of a bullish PCT/StHA.

Advice from an experienced Medical Practitioner

- 4.3 The Medical Secretary has traditionally been a general practitioner working part time, but LMCs elsewhere have joined together to employ a full time (i.e. non-practising) secretary (sometimes called chief executive). Recent guidance from the GPC¹ recommends LMCs to consider the 'professional' full time model, but at the discussion at the 2001 Nuts and Bolts day and at the January 2002 WMRLMC Seminar representatives from LMCs in the West Midlands were of the view that they wish to continue with the traditional Medical Secretary Model. Reasons cited included the view that the effectiveness of the pastoral role and the benefit of local knowledge would be decreased with the 'chief executive' model.

Secretarial/Office Support

- 4.4 Most LMCs in the West Midlands have their own LMC office with part time secretarial support (with the exception of the North and South Staffordshire LMCs who share an office). The advantage to this traditional arrangement is that the secretaries are readily available close to the Medical Secretaries. The disadvantages are that the offices are therefore only manned for a few hours each week, possibly limiting access of constituents and support to LMCs.
- 4.5 Possible arrangements would be for more LMCs to share secretarial/office support. This may be across just two or three LMCs, across a whole StHA area, or across the whole West Midlands (i.e. by increasing the services provided by the WMRLMC) – or indeed a combination.

Access to timely up to date information

- 4.6 Currently, often several LMCs are separately trying to find out the same information. This includes identifying and downloading the same documents.
- 4.7 The ideal situation would be to have an aggressive information model, with a full time centre collating and producing definitive guidance on all aspects of LMC work. It is quite rightly considered that this should be a core role of the GPC (and one that it does not always carry out as timely as necessary). However, this will never be possible to fully implement because: the information is often not openly distributed (sometimes deliberately, sometimes inadvertently); the pertinence of a document or change to general practice is not always initially obvious; and that organisations (HAs, PCOs, Social Services etc) will sometimes come up with new 'innovative' schemes not covered by usual guidance.

¹ The NHS Reform and Healthcare Professions Bill and Local Medical Committees in England – Guidance for LMCs.
GPC:January 2002

- 4.8 At the WMRLMC seminar it was agreed that the regional website could be put to more effective use in this area. Already the WMRLMC website does include some documents pertinent to LMCs, and has disseminated good practice from Warwickshire LMC. This could be expanded into a library of information and guidance.

EXAMPLE: USING WMRLMC WEBSITE FOR IMPROVED INFORMATION NETWORKING

1. All the documents regarding the NHS Reforms are available to download from the WMRLMC website. This saves individual LMCs from searching for them on the DoH site, and the download time and success rate are increased.
2. In Warwickshire, the local Bus Company commenced a scheme requiring disabled passengers to have a form completed by their general practitioner. The Warwickshire Medical Secretary researched the problem, identified that this scheme was against Government advice, and was able to reverse this decision. Information regarding this including the governmental guidance was added to the Warwickshire LMC website (www.warkslmc.fsnet.co.uk), and this was highlighted in the 'WHATS NEW ON THIS SITE' section on the WMRLMC website.

- 4.9 Improved access to information for LMCs should also include ensuring that all LMC secretaries have ready access to email messaging. The GPC supports an email discussion list for LMC secretaries (GPC LMC List server²). At present this is often used only for chitchat, but should be used for LMCs to seek the advice from other LMCs when coming up against a new problem or opportunity (and for support).
- 4.10 At the WMRLMC Seminar Charles Zuckerman suggested that what was really needed is an 'Ask Jeeves' type service. For reasons explored above, this is unlikely to be achievable. However, the use of an expanding regional resource of information, combined with ready access to advice from other local Medical Secretaries through the WMRLMC network and LMCs nationally through the GPC list-server should come close to this.
- 4.11 LMCs should also consider how they could make up to date information available to their constituents. This can be achieved by a regular newsletter, posting information on a website (Local or Regional LMC), or by email messaging. This latter position is currently obfuscated due to the common NHS message format (see paragraph below).
- 4.12 The email service that the NHS provides for general practitioners current uses X400 format, which is incompatible with the usual 'SMTP' email systems. Long term the aim is for email messaging to migrate to the more standard SMTP format, and this will allow LMCs to email from outside the NHSnet to individual GPs (*Note: SMTP addresses are already supported within the NHSnet and practices can ask for this to be 'activated'*). The WMRLMC can provide advice to LMCs regarding websites, email messaging etc.
- Support for more complex problems, or in the event of a bullish PCT/StHA*
- 4.13 Most LMCs have found themselves in this position at some time. The BMA Industrial Relations Officers and the GPC National Office will continue to have important roles.
- 4.14 At the WMRLMC Seminar, it was also noted that LMC secretaries valued the role of the WMRLMC in encouraging networking between secretaries, providing mutual support, and providing a forum for problems to be brought up and discussed. It was further discussed whether the role of the WMRLMC secretary should be enhanced or increased.

² A List Server is a unique individual email address. When you send a message to this address it is automatically sent to everyone on the list.

ACTION BOX 2

1. Decide whether to continue with the same structure of medical secretary, or to share a medical secretary across more than one LMC, or to appoint a full time medical secretary (or chief executive) across several LMCs.
2. Discuss within and between LMCs how office and secretarial support could be best provided, considering providing adequate support to medical secretaries, best value for money, and level of access of the service to constituents.
3. Explore, in the event of shared appointments/facilities etc., how these are to be managed & funded.
4. Consider what information would improve the working of LMCs and how this could be best provided. Ensure that the LMC has ready access to the Internet, and the Medical Secretary is confident with email messaging and is able to participate in the GPC hosted LMC list server.
5. Consider how LMCs can provide constituents with timely information.
6. Consider how support for more complex problems should be provided.
7. Discuss the ongoing role of the WMRLMC, and what its roles and functions should be.

Note: There is no absolute time frame for these actions. Change will of necessity be evolutionary as well as revolutionary responding to the developing reforms (and may be affected by the new GMS contract).

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