

## Statutory Sector Liaison Group

**Date:** 27/01/2011

**Time:** 15.30

**Location:** Ladywell Leisure Centre

**PRESENT:** Ed Knowles (LBL), Petula Peters (LBL), Yvette London (NHS Lewisham), Amanda Holland (UHL), Joy Ellery (UHL), Alice Glover (SLAM), Paul Connelly, Rylla Baker (NHS Lewisham), Mike Goverly (NHS Lewisham), Dr Richard Neal, Rosie Fooks, Martin Howie (Chair)

**APOLOGIES:** Graham Trice, Brian Fisher

**In attendance:** Miriam Long, Darren Morgan (Minutes)

		Action
<b>1</b>	<b>Minutes of 7 October 2010 and Matters Arising</b>	
	<p>UHL - A patients' version of the Quality Accounts has been published, along with information on the building works.</p> <p>Page 3, Para 5 - Petula asked what was meant by 'secret panel'.</p> <p><i>To clarify the item on Page 3, Para 5.</i></p>	DM
<b>2</b>	<b>Redistribution of Primary Care Resources (Rylla Baker, Deputy Director of Primary Care Commissioning)</b>	
	<p>The aim of Rylla's presentation was to update the group on NHS Lewisham's review of the existing GP Contracts, highlighting potential risks and benefits and responding to questions raised by GP's.</p> <p>There are currently 2 main types of contract - Personal Medical Services (PMS) and General Medical Services (GMS). GMS is implemented nationally, setting out rules by which a GP practice has to operate and the financial payments due. PMS incorporates all of the rules included in GMS but allows for local negotiation of additional payments or more flexible arrangements to respond to local needs.</p> <p>NHS Lewisham has been reviewing all Contracts, looking at public accountability for funds, equitable investment of resources, delivering an efficiency saving (in line with other parts of the health sector), developing core standards and improved outcomes. Objectives are to achieve a 'fair and transparent' funding allocation and 'clear and measurable' performance standards.</p> <p>At present, investment per patient ranges from £65 to £120 per annum. One of the challenges is to work out the factors affecting practices differently and identify what practices are delivering for the money so the differences can be measured. A standard rate of £80 per patient is proposed following a period of negotiation. In comparison to the original position £80/patient was the median value across all PMS Contracts. Supplementary payments may be made, providing outcomes are measurable and meet local needs.</p> <p>It is acknowledged that this rebalancing of funding will result in 'significant losers and gainers'. A range of practices have varying degrees of measurable outcomes (those with specialist services such as diabetes or larger than average cohorts of deprived</p>	

patients). A list of supplementary schemes is to be developed (ie; deprivation, need to use interpreters in consultations) which when set up will significantly reduce the financial losses for some practices, and gaining practices may gain more.

The change in allocation of money will be spread over 2 years - the lifetime of the PCT. GMS Practices can either remain with GMS or move to a PMS Contract. Practices with PMS Contracts are being asked to move to a Variation on the existing PMS Contract. The PCT will issue termination notices in relation to the existing PMS Contracts giving six months notice - if in the intervening period the practice decides to take up the variation then the notice will be rescinded. There is a potential risk that reductions in numbers of staff or GP capacity may follow. Another risk for practices is that supplementary payments are not guaranteed in the longer term (they could be taken away if work is not done or priorities change). As for potential benefits, patients should be able to access service to at least a consistent standard wherever they are registered. Funding will be allocated transparently, making it easy to change the formula and avoiding paying twice for the same services (ie; all practices will be expected to have nursing capacity available to avoid patients having to go to A&E). Overall the new contracts will provide a foundation for the consortia and avoid the 'historic inequity.' Efficiency savings of 1.2m pounds are expected.

It was noted that a GMS practice is closing in February - not related to the process, and released savings will go back into the pot of money.

Dr Richard Neal raised the following:

There is concern that the Cahill Formula has been applied - this reduces London-wide funding and particularly for those practices on GMS.

A move away from the Quality & Outcomes Framework (QOF) for patients was happening regardless of this process and should not be part of it.

Which part of the PCT budget does the 3% efficiency saving apply to?

Is a 'Lay Representative' a 'Community Representative'?

Rylla's response:

It was made clear in a meeting with GP's that Cahill was the only available formula that could be used (using 6 national indicators) at present. Cahill may be updated in the future, but it is the basic benchmark formula.

A 'Lay Representative' in this context is a person who works as an outside representative, not unaware of general practice working and bringing in an external view - very good at challenging the process.

Spreading risk over 2 years will help transition, not only for losers but also gainers. The new Contract starts in April so termination notices need to be issued.

It was agreed that practices receiving more per patient may currently be delivering a better service but there is no guarantee of this. The main thing is the need for transparency and equity.

	<p>Martin asked what would happen if some practices don't accept the new contract, citing the 15 that as yet have not. Rylla said there could be a detrimental impact if small practices try to deliver the outcomes. We should expect to see a fewer number in the future, perhaps from 48 to 30, this would achieve economies of scale and perhaps practices could work together. Cluster 4 has 7 practices, it could be better to take a bus to one of a decent calibre and open more local pharmacies.</p> <p>Specialist Services - Petula cited that Lewisham could lose out if practices offering the most sophisticated services lose more money. Rylla confirmed we 'don't want to lose something really good' and practices could become a cluster resource (ie; those who have developed a Diabetes 3 service, or with a large number of interpreters).</p> <p>Transparency - Joy asked whether commissioners and providers sitting on the same committees would result in a conflict of interest. Rylla said LMC are the negotiators and are separate. A way ahead might be for groups of GP's to become provider groups and move out of commissioning groups.</p> <p>Consultation - Martin acknowledged the financial considerations and that the system has to be fair from an administrative point of view, but there will be changes that patients have to deal with. Has there been a consultation with patient groups to get a view? When the changes come in, how will it be communicated so people know where to go to get the best service? Rylla confirmed there is a communications plan and she will send a summary. If terminating contracts there will be a formal 'change of service consultation', but hopefully this will not happen and is not the aim.</p>	
<b>3</b>	<b>Information from statutory sector partners: Overview of current work; changes to policy or practice</b>	
	<p><b>NHS Lewisham</b>  In light of the White Paper NHS Lewisham is restructuring, with some functions to be delivered at NHS SE London. It is hoped that the new structures will be in place by 1st April. There will be staff redundancies, estimated to be between 30 and 60. A budget update will be presented to the Overview &amp; Scrutiny Committee on 10th February and budget plans will be presented on 10th March, detailing £80M of savings over the financial year.</p> <p><b>Lewisham Healthcare NHS Trust (UHL)</b>  Joy presented Amanda Holland to the group, who has been appointed Head of Public and User Engagement, a role which will provide more capacity in patient engagement. There is much work on the foundation trust application and a meeting in March forms part of the formal consultation (public meetings are planned for 10th March at UHL and 12th April at Waldron Health Centre). Quality Accounts are being put together for this year (to be published in June) and the LINK will have an input.</p> <p><b>South London &amp; Maudsley NHS Foundation Trust (SLAM)</b>  A Mental Health and Wellbeing stakeholder day took place in March, hosted in partnership with the LINK. Restructuring in terms of CAGS is continuing, looking at involvement around care pathways. The Patient Experience Data Intelligence Centre (PEDIC) is being extended and will use part electronic/part paper surveys to capture systematic feedback, and through community teams it is hoped this feedback will be more consistent. Miriam pointed out that the LINK has not received service user feedback from SLAM, and has now requested this through freedom of information. Alice said SLAM will send feedback, but due to confidentiality this will not include verbal content.</p>	

	<p>Miriam expressed concern at the disinvestment in services in favour of primary care - will there be enough resources to support people, do we know how many people are using services and whether they are satisfied? Alice said it is hard to establish who is eligible for services and the components that go into supplementary funding. Someone with a mental health condition less likely to know where to go.</p> <p>Dr Richard Neal As part of ongoing efficiency savings there is a move towards primary care to make resources more efficient, but there should be more protection to ensure service stability. Martin said a discussion would be helpful, the LINK could scrutinize, raise questions and get answers.</p> <p>London Borough of Lewisham (LBL) Ed confirmed that NHS SE London will be a new cross borough PCT, taking on the functions of 6 and leaving 'Business Support Units' behind. The purpose is to aide the transition to consortia and there are many implications in terms of governance and partnership working. Policy – the Public Health White Paper was issued in November with the intent to separate Public Health from the NHS. This is already happening in Lewisham, with the transition of staff from the PCT to the LA. The Health White Paper has become the Health and Social Care Bill, and from the LA perspective the Health and Wellbeing Board will be the local partnership arrangement. Stakeholders are now working out how it will work locally. Cuts - LBL are to make £60M of savings over 3 years and will be required to save even more, so planned cuts will have to be deeper. LBL is proposing to charge for adult social care and is looking at social care pathways. In addition there will be further health and social care savings proposed in 2012. A Service User Satisfaction survey for Adult Social Care will be rolled out. Martin acknowledged the significance of the implications and proposed discussions in more detail.</p>	
<b>4</b>	<b>Lewisham LINK Outcomes and Transition</b>	
	<p>The LINK is caught up in a crossfire as to funding, which is no longer ringfenced. Negotiations with LBL are ongoing with a further meeting next week. Alternative ways of moving forward are being discussed, including joint working with other boroughs. There is a wish to maintain as much as possible - Lewisham LINK has a good reputation and it would be disappointing if this was damaged over the coming year in an exercise of 'shrinking and re-expanding'.</p>	
<b>5</b>	<b>AOB</b>	
	None.	
	The meeting ended at 17.00. Next meeting: 24 <sup>th</sup> March 2001	