

THE WORK OF THE LOCAL MEDICAL COMMITTEE IN ENGLAND AND WALES

BACKGROUND

- 1.1 When the National Insurance Bill was first introduced in 1911 no provision was made for general practitioners to participate in the administration of the new state health insurance scheme. But the British Medical Association was determined that the profession should have a voice in its day-to-day running. It therefore ensured that locally elected committees of general practitioners (Local Medical Committees) were given statutory recognition in the 1911 National Insurance Act as the representative voice of the 'panel' doctors.
- 1.2 The 1911 Act required the Local Insurance Committee (the forerunner of the NHS Executive Council, the Family Practitioner Committee and latterly the Family Health Services Authority) to consult all general practitioners participating in the health insurance scheme on a wide range of matters via the LMC. After the LMCs had been set up, a national committee was established within the BMA to represent the interests of 'panel' doctors in negotiations with government. This national committee, the Insurance Acts Committee (the forerunner of the General Medical Services Committee), was recognised by government as the authoritative voice of general practitioners.
- 1.3 It was not surprising that the Liberal Government agreed to these arrangements for representing general practitioners. The success of the 1911 health insurance scheme depended on the willing co-operation of a large number of independent practitioners. The profession supported the introduction of a state medical scheme but was strongly opposed to a salaried service; it recognised that the loss of the independent contractor status would undermine the freedom of doctors to practice without state interference, and ultimately put patient care at risk. General practitioners feared that government would seek to direct them in their day-to-day treatment of patients. This commitment to the contractor status remains a guiding principle of the GMS. Indeed, had it not been for the tenacity of its forerunner - the National Insurance Acts Committee - on this crucial issue, general practitioners could have been drawn into a salaried service (as were their hospital colleagues in 1948). The well tested and proven value of the contract for service with the local insurance committees led to the preservation and extension of this type of contract when the NHS was established in 1948. The Local Insurance Committees - the predecessors of the FHSAs - knew that this contract worked successfully and were active in ensuring that it was preserved in the new NHS structure.

THE FORMAL ESTABLISHMENT OF AN LMC

- 2.1 In order to function and raise the funds necessary for its operation from its constituents, an LMC, under paragraph 12(4) of the NHS and Community Care Act 1990, must obtain formal recognition by the FHSAs. This involves submitting its proposed constitution to the FHSAs. If the authority is satisfied that the committee will be properly representative of the doctors concerned (this has both numerical and geographical implications) it will be recognised.
- 2.2 To assist LMCs in drafting their constitutions, the Department has produced a model constitution which was included in circular HSG (91) 14, Recognising Local Representative Committees, issued on 23 October 1991. The model does not preclude local variations, and several of these have been approved. If an LMC decides to alter its constitution, the amendment should (if prepared in accordance with that part

of the constitution dealing with amendments) be submitted to the FHSAs for approval to ensure that the committee continues to be recognised as the LMC.

2.3 When a committee is recognised by the FHSAs as representative of the general practitioners in an area it becomes the Local Medical Committee and thereby acquires certain statutory functions which it is required to perform.

2.4 The statutory recognition of the LMC has many parallels in other parts of the public sector. The legislation enacted during the 1940s to bring public utilities and major industries into state ownership made explicit provision for the recognition of trade unions and professional associations for the purposes of negotiation and consultation. A notable feature of the statutory recognition accorded to LMCs is that it was granted almost 40 years earlier by the National Health Insurance Act 1911. Indeed, it is the earliest example of statutory recognition being accorded to an organisation which is representative of those who work in a publicly funded service.

2.5 The statutory recognition and functions of the LMCs are presently defined in Sections 44 and 45 of the National Health Service Act 1977 (as amended by Schedules 3 and 5 of the Health and Social Security Act 1984). These were originally defined in the National Health Act 1946; the 1977 Act consolidated and the 1984 Act amended these provisions. They were further amended by the NHS and Community Care Act 1990 (Section 12(4)). The relevant references are:

- 44 - (1) Where a Family Health Service Authority is satisfied that a committee formed for the locality is representative - (a) of the Medical Practitioners providing General Medical or General Ophthalmic Services in that locality the Family Health Services Authority may recognise that committee; and any ... committee so recognised shall be called the Local Medical Committee for the locality concerned.
- (2) Any such committee may with the approval of the Family Health Services Authority delegate any of their functions, with or without restrictions or conditions, to subcommittees composed of members of that committee.

(References below to FPCs should be taken as references to FHSAs in accordance with Section 2(1)(b) of the NHS CommunityCare Act 1990.)

- 45- (1) The Family Practitioner Committee for a locality in respect of which committees are recognised under Section 44 above shall, in exercising their functions under this part of this Act, consult with those committees on such occasions and to such extent as may be prescribed; and those committees shall exercise such other functions as may be prescribed.
- (2) The Family Practitioner Committee may, on the request of any committee recognised under Section 44 for their locality, allot to that committee such sums for defraying the committee's administrative expenses (including travelling and subsistence allowances payable to its members) as may be determined by the Family Health Authority.
- (3) Any sums so allocated shall be out of the moneys available to the Family Health Authority for the remuneration of persons of whom the committee so recognised is representative and who provide general medical services as the case may be, under this Part of the Act. The amount of any such sums shall be deducted from the remuneration of those persons in such manner as may be determined by the Family Practitioner Committee.

FUNCTIONS AND DUTIES

- 3.1 The many functions and duties of the LMC that derive from its statutory recognition may be subdivided into three groupings:
- (i) those based on the 'partnership principle', originally established in 1911.
 - (ii) those concerned with the administration of the contract.
 - (iii) those concerned with the representation of general practitioners as a whole.
- 3.2 In many ways the partnership principle has been superseded by the advent of the 1990 contract. Formerly, successive governments had recognised the value of special arrangements for administration of GP contracts to take account of their independent contractor status. Before the 1990 contract 8 of the 30 members of the Family Practitioner Committee were LMC nominees. Now only one member of the much smaller 'executive' of the FHSAs is required to be a practising GP and the appointment of members lies entirely within the RHA's discretion, save for that of the general manager who is directly appointed by the Secretary of State.
- 3.3 However, LMCs perform many other services for their constituents, the pattern of which is established by local 'custom and practice'. They include the handling of ethical problems and the representation of GPs in relation with bodies and organisations outside the NHS and maintaining the standing of general practice in the media and among the public generally. Many LMCs have established close ties with MPs, local councillors, community health councils, and with other professional groups such as nurses, health visitors and social workers. LMCs might consider coopting a representative of trainee GPs to the committee. It would be beneficial if this group was represented as newer members of the profession would then become familiar with the work of the LMC at the beginning of their careers in general practice. LMCs may also have contacts with pressure groups. In short, the LMC has a major role in the provision of primary care. As a statutory, yet independent, body it occupies a unique position of influence within the NHS.

ADMINISTRATION OF THE CONTRACT

- 4.1 FHSAs are required by statute to consult LMCs on many issues; this is evident in the Regulations governing the provision of NHS general medical services, the terms of service for general practitioners and the statement of fees and allowances. The LMC also plays an important part in the complaints procedure and investigation of matters relating to professional conduct.
- 4.2 (i) General Medical Services Regulations

There are many references to LMCs in the NHS (GMS) Regulations 1992 (as amended) to be consulted: Reg

5(7) where a doctor has made an application for inclusion in the medical list.

7(4) prior to the removal of a doctor's name from the list who has personally never provided services or has ceased to provide services for the past six months.

- 11(5) about Regulation 5(1) and (2) and 11(1) and (2), i.e. on reports required by the Medical Practices Committee from the FHSA on the adequacy of medical services in the locality, and on the need to appoint a successor on the death, withdrawal or removal of a doctor.
- 24(8) on a proposed block transfer of excess patients from one doctor's list to another.
- 25(2) about temporary arrangements for carrying on a practice.
- 25(5) it appears that a doctor is incapable of providing general medical services because of his physical or mental condition. After such consultation with the LMC the FHSA may require where a doctor to be medically examined.

- 25(6) where it appears that a doctor's terms of service are not being adequately carried out in order to make arrangements for the temporary provision of general medical services for that doctor's patients which may consist of or include the appointment of one or more doctors to undertake the treatment of such patients.
- 25(7) where it appears that a doctor is fit to resume practice.
- 25(8) where a doctor is required to be medically examined before the FHSA vary or terminate any arrangements made under 25(6) above.
- 25(9) to appoint a doctor to undertake the medical examination, to consider the report of the examination and to report in writing to the FHSA as to the doctor's fitness to carry out his obligations under the terms of service.
- 30(5) where the FHSA considers medical advice necessary, on the application by a doctor for inclusion on the obstetric list.
- 36 on the determination of whether a substance is a drug.

(ii) **Terms of Service**

There are many references to LMCs in the terms of service, to be consulted: para

- 11(2) about the termination of the provision of maternity medical services.
- 22(3) before the FHSA refuses consent or imposes conditions on a doctor's use of a deputising service.
- 22(4) on the review of such consents or conditions.
- 24(2) before refusing or withdrawing consent to employ an assistant.
- 27(b) To inspect practice and premises.

(iii) **Pharmaceutical Services Regulations**

- 9(3),(5) and (13) Determination of controlled locality
- 10(1)(c) and (2)
- 12(1)(a), 2(a), Appeals on applications to the (Committee) relating to rurality or an area

- (11)(a)(ii) Determination of FHSA of application to provide pharmaceutical services
- 13(11) Appeals to the Secretary of State from decision of FHSA on applications to provide pharmaceutical services
- 22(3) To receive a copy of the medical and pharmaceutical lists and amendments
- (iv) **Statement of Fees and Allowances (the 'Red Book') There are in excess of 30 references to LMCs:**
- para 14.8 To be consulted on difficulty in agreeing with a doctor the percentage of his patients resident in a designated area.
- 18.2/18.4 To be consulted on any proportionate reduction in the assistant's allowance.
- 24.7 To be consulted on the payment of a higher night visit fee.
- 31.7 To be consulted on sharing of maternity medical services fee.
- 31.19 To be consulted when FHSA disputes a claim for a full care fee.
- 32.10 To be consulted on advance payment for the treatment of temporary residents.
- 33.7 To be consulted on payment of a special fee for emergency treatment.
- 33.11 To be consulted on the recovery of an emergency treatment fee from the list of another practitioner.
- 41.9 To be consulted if the FHSA is proposing to adjust 'reckonable income' for the purposes of calculating type A and B allowances.
- 41.11 To be consulted on withholding payment of Inducement Practice Allowance if the FHSA is not satisfied that a genuine endeavour is being made to build up the practice.
- 41.12 To be consulted by the FHSA on whether an area should be designated a special area for purposes of payment of IPA type 2.
- 43.7 To be consulted on the determination of a doctor's main surgery for calculation of rural practice units.
- 44.3 [Schedule (3)] Dispensing doctors and provision of oxygen equipment.
- 44.7(b) To be consulted on a doctor's application to be exempted from the discount scale, or to

- 44.8 receive special payments for the supply of drugs and appliances.
- 48.10 To be consulted on variation of the normal requirements for payment of locum allowance during sickness or confinement, particularly in rural areas.
- 48.17 To be consulted on assessment of hours for full-time locum allowance.
- 50.8 To be consulted on consideration of normal hours for locum during prolonged study leave.
- 51.2 To be consulted on acceptance of premises for (3 and 7) rent and rates.
- 51.12 To be consulted before the abatement or cessation of reimbursement of rent and rates.
- 51.25 To be consulted on apportionment of gross value for rating in combined premises
- 51.34 Visits to premises in connection with rent and rates.
- 52.17 To be consulted on payment of delayed claims.
- 53.1 Financial arrangements for doctors practising at health centres.
- 62.2 To be consulted on entitlement of doctors providing maternity medical services only to direct payments under the rent and rates and ancillary staff schemes.
- 62.3 For doctors providing maternity medical services only, to be consulted about whether it is necessary for the purposes of additional payments during sickness or confinement for a practice to engage a locum or deputy from outside the practice who is on, or qualified to be on, the obstetric list.
- 63.2 To be consulted when the eligibility of a restricted principal with a limited list for payments under the rent and rates and practice staff schemes is in doubt.
- 68.2 To be consulted on the entitlement of contraceptive service only doctors on their entitlement to direct payments under the rent and rates and ancillary staff schemes.
- 68.3 To be consulted on the entitlement of contraceptive service only doctors, to additional payments during sickness.
- 69.2 To be consulted when the eligibility of a principal providing child health surveillance services only for payments under the rent and rates and practice staff schemes is in doubt.
- 69.3 For doctors providing child health surveillance only, to be consulted about whether it is necessary for the purposes of additional payments during sickness or confinement for a practice to engage a locum or deputy on the CHS list.

70.2 To be considered where the eligibility of a principal providing minor surgery only for payments under the rent and rates and practice staff scheme is in doubt.

75.1 To be consulted on dates for payment of 'other' fees and allowances.

(v) **The Complaints Procedure**

Each FHSA has a medical service committee consisting of a lay chairman and six other persons, three of whom are appointed by the FHSA and three by the LMC. It is sometimes forgotten that the purpose of the complaints procedure is to investigate alleged breaches of the contract between a practitioner and the FHSA and not to provide an alternative to the civil courts for a complainant.

There are several references to LMCs in the NHS (Service Committees and Tribunal) Regulations 1992 (as amended), which relate to the service committee procedure:

Schedule 2, para 1 Constitution of medical services committee: 3 members and 3 deputies to be appointed by LMC.

Schedule 2, para 2 Constitution of ophthalmic services committee: 2 ophthalmic medical practitioners and 1 deputy to be appointed by LMC.

Schedule 2, para 5(5) Acceptability of replacement committee chairman and committee chairman.

Schedule 4 para 5(2)(c) Member or officer of the LMC is entitled to be present as an observer [and, under Schedule 4(6), entitled to receive all the documents in each case].

Schedule 7 (1) Procedures under regulation 18
(2) Failure of FHSA and LMC to agree

paragraph 9(3) LMC consulted on recommendation that limit be imposed on list size because doctor unable to give adequate treatment.

paragraph 15(3)(b) Nomination to FHSA professional committee to investigate excessive prescribing.

paragraph 15(11)(e) Member or officer of the LMC is entitled to be present as an observer.

paragraphs 16 and 17 Procedures investigating on financial withholding and record keeping.

(vi) **Professional Conduct**

Whereas the medical service committee investigates complaints which allege a breach of the terms of service, when certain aspects of professional conduct are called into question, other investigations are

undertaken by the LMC itself and the FHSA is not involved apart from being the referring body in some cases. These functions are prescribed in the following paragraphs of the National Health Service (Service Committees and Tribunal) Regulations 1992 (as amended):

Reg. 16	Certification - failure to exercise reasonable care in the issue of certificates.
17	Record keeping - so far as the recording of clinical data is concerned.
18	Decisions as to treatment for which fees may be charged.
20	To consider any complaint made to the LMC by any doctors against a doctor practising in the locality of the Committee involving any question of the efficiency of the general medical services.

On each matter (except under 20) the Secretary of State refers a specific case to the LMC to investigate and report; in practice, the reference to the LMC comes first from the FHSA. The LMC responds to the FHSA which then informs the Department of Health. In effect the FHSA is acting as the agent of the Secretary of State. Any subsequent action by the Secretary of State takes into account the LMC's views. On several of these matters, if the Secretary of State is not satisfied with the findings of the LMC, he may appoint other persons to determine the case in question.

Although an LMC may only rarely be called to exercise some of these functions, it is important that the investigation of professional conduct is thorough and fair to maintain confidence of both public and the profession.

4.3 On many of the matters above the LMC and FHSA jointly determine what action should be taken, and in this sense 'consultation' also means 'partnership'. This local recognition and representation ensures the efficient provision of general medical services, enabling FHSAs to draw upon the goodwill and experience of the medical profession locally. The process of consultation also ensures that the terms of service, which are negotiated centrally by the GMSC and DoH, are fairly and reasonably applied locally. Again, this process is analogous to the procedures which apply to many groups of employees where there is some discretion in implementing nationally negotiated terms of service at local level.

REPRESENTATION OF THE PROFESSION

5.1 The LMC is consulted by the FHSA and other bodies when the views of general practice as a whole are required. The LMC also has a vital part to play in the Conference of LMCs, and the LMC/GMSC medico-political axis. It elects representatives to both the Conference of LMCs and the GMSC.

5.2 Health Department Circulars

The Department, under the auspices of the 'NHS Management Executive' issues advice to FHSAs in the form of health circulars. Some circulars introduce amendments to the terms of service, whereas others give revised guidance to FHSAs on how to implement existing arrangements. Normally this advice is in the form of a health circular, [formerly HC(FP)], but now

FHSL] which FHSAs should copy to the LMC. If the advice affects individual doctors, a corresponding FHSAs notice (FHSN) may be sent to each doctor on the list.

Some of these health circulars may require the FHSAs to consult the LMC on particular matters. The circular on medical audit in the FPS for instance, (HC(FP)(90)8), requires the LMC to nominate members of MAAGs, and the FHSAs is required to seek to agree the membership with the LMC.

5.3 **Other Health Service Bodies**

The LMC serves as the point of reference for other NHS bodies seeking the views of general practitioners. A perusal of LMC minutes (the GMSC secretariat is sent copies of the minutes of many LMCs) shows that this is a large component of LMCs' work. Although general practitioners are no longer represented, as of right, on RHAs or DHAs, some continue to serve on these bodies and some serve on unit management groups (UMGs) as unit medical representatives (UMRs). In some areas, LMCs appoint doctors to serve on regional medical advisory committees, regional advisory subcommittees in general practice, purchasing advisory bodies, district medical advisory committees (where these are established), and alternatively, on variously named district medical liaison committees and district medical executive committees, regional general practice subcommittees for postgraduate medical education, together with various ad hoc committees, and working groups both clinical and administrative at regional, district and unit levels. The LMC is consulted when general practitioners are appointed to many of these offices and posts, and it plays an active part in advising health authorities on a wide range of policy matters. In short, it has a continuing dialogue with other branches of the NHS. The LMC also becomes involved in many other issues affecting general practitioners locally: examples include, clinical assistant posts, HPG posts, GP hospitals and units, GP beds, access to diagnostic facilities.

5.4 **Medico-political Functions**

The LMC is an independent self-financing body with statutory functions (as distinct from a state funded statutory body). Its independent status allows it to exercise medico-political functions in addition to statutory functions. This duality of function is unique and contributes to the power of the LMC. The statutory functions are concerned mostly with the interests of the individual general practitioner in relation to his contract with the FHSAs and the continuing dialogue between the LMC and FHSAs. On the other hand, the medico-political functions are primarily concerned with the collective interests of general practitioners as a group, and these operate through a quite separate channel consisting of

LMC to the GMSC and vice versa.

In some areas, regional committees of LMCs have existed for some time, as a forum for discussing supra-district problems and exchanging ideas. Now that the old FPCs have been reconstituted as FHSAs under the control of RHAs, it makes sense for LMCs to seek to act collectively via a regional committee in formulating policy on a regional basis. The Department has now delegated to RHAs the responsibility for resolving most of the day to day problems raised by FHSAs. In these circumstances a regional committee of LMCs could increasingly become the focal point of consultation with and representations to RHAs. The future for regional committees of LMCs is, therefore, very important for NHS general practice.

5.5 **General Medical Services Committee**

The GMSC is the standing committee of the BMA with full authority to deal with all matters affecting NHS general practitioners. It is the only body which represents all general practitioners (whether or not they are BMA members) and is recognised by the Department of Health as NHS GPs' sole negotiating body. The GMSC is responsible for determining what advice should be given, and what representations should be made, to the Secretary of State and DoH officials. Although the GMSC is responsible ultimately for policy, it cannot, and would not, formulate its policies in a vacuum. It therefore convenes annually (and on other special occasions) a conference of representatives of LMCs. For each conference the GMSC prepares a report, a copy of which is sent to every general practitioner, who then has the opportunity of expressing a view through his elected representative on the LMC, or at a meeting of all general practitioners held in the LMC's locality.

Whatever procedure is adopted, it is for the LMC to submit motions for inclusion on the agenda of the conference. Such motions, if carried, are referred to the GMSC and provide a firm basis for formulating policy. It is this democratic process which gives meaning and strength to the GMSC in its day-to-day representation of the interests of family doctors in the NHS.

This outline of the LMC Conference/GMSC structure shows how general practitioners have chosen to exercise 'self-government' through their elected LMCs. Every part of the United Kingdom has at least one spokesman on the GMSC, a doctor in active practice, to present its views and problems, as they affect negotiations for general practitioners as a whole, or, on occasion, individual practitioners.

5.6 **General Medical Services Defence Fund**

The profession has chosen this representative system and it involves considerable expenditure of time and money. The Defence Fund, which was first established in 1913, is the main source of finance for running this democratic process. The term 'defence' may appear to be a misnomer if you take a narrow definition which merely applies to some form of direct action against government, e.g. the collection of undated resignations from the NHS. However, the work of the GMSC, and its various subcommittees, and working parties, is for the purpose of defending the interests of general practitioners in relation to their terms and conditions of service, even though the profession may not be involved in a confrontation with government on some specific issue. All this activity costs money (members of the GMSC are reimbursed their expenses) and the NHS benefits directly. It could be said this is the necessary price the profession has to pay for 'self-government'.

5.7 **Statutory Levy**

The statutory levy is quite distinct from the voluntary levies which GPs are asked to pay as a contribution to the 'defence fund' and to defray LMCs' exceptional costs. As defined in health service legislation the statutory levy may be used only "for defraying the administrative expenses of the LMC, including travelling and subsistence allowances payable to members of the LMC'. The legislation enables an LMC to make a compulsory statutory levy on every general practitioner to meet these specified expenses (but no more) and these are open to external scrutiny. The administrative expenses of an LMC are the only expenses that may be collected by statutory levy and they are deducted by the FHSA from doctors' NHS remuneration and paid over to the LMC.

CONCLUSION

6. This summary of the work of the LMC does not claim to be comprehensive as the work is complex and covers so many areas. It is recognised that the roles and functions of the LMC are rapidly changing to promote the development of general practice in a period of financial stringency and organisational change.

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