ANNUAL CONFERENCE OF LMCs 2017

THURSDAY 18 & FRIDAY 19 MAY

SHEFFIELD LMC REPS:	Alastair Bradley	Mark Durling	David Savage
SHEFFIELD LMC OBSERVERS:	Claire Clough	Margaret Wicks	

This 2 day Conference was held at the very impressive Edinburgh International Conference Centre. In future there will be a 1 day English LMCs Conference and a 1 day UK Conference.

SPEECHES

As is Conference tradition, Chaand Nagpaul, Chair of the General Practitioners Committee (GPC), opened with a well-received speech on the issues affecting General Practice and the latest GPC negotiations with NHS England and the Department of Health (DH). Chaand highlighted:

- the stagnation in development of health policy and investment created by the Brexit vote and the calling of a General Election, which was leading to lack of investment of the extra £300m per week promised.
- what he perceived to be the successors of the GPC negotiation of the Urgent Prescription for General Practice and, in particular, the 2017/18 contract negotiations ending Avoiding Unplanned Admissions, money going into core funding, delivering the full reimbursement of the Care Quality Commission (CQC) costs, negotiating payments for rises in indemnity fees, practice expenses being itemised as actual cost for the first time, the significant improvements in GP sickness cover and the increasing global sum at £85.35 per head.
- the current workforce crisis related to shambolic workforce planning a decade ago, resulting in hospital specialist numbers rising 3 times more than the rate of GPs.
- the only way for GPs to survive was to stop doing work that should be done in Secondary Care.
- that the General Practice Forward View (GPFV) would not solve the crisis in General Practice, but that the promised funding should not be squandered and he was charging the GPC to monitor NHS England's balance sheet and task LMCs with monitoring Clinical Commissioning Group (CCG) progress in rolling out this money to individual practices.
- the GPC's successes on GP Access and acknowledgement that 8 to 8 was no longer required at weekends, negotiating limits on workload with overspill to Locality Hubs (although no detail on how this would be rolled out nationally or locally).
- the adaptability, determination and resilience of GPs and the need for extra funding for Primary Care compared to European counterparts.

It was our impression that the speech was well received, but not with the usual rapturous standing ovation. Many problems were highlighted along with some achievements, but no real significant solutions.

MOTIONS

A number of motions were a rubber stamping exercise discussing issues such as inadequate core funding, the Carr Hill Formula, a woeful provision of Occupational Health Services for GPs, the increase in Indemnity costs and the concern about the refusal of renewal of indemnity for some GPs.

Core Contract: There was the usual debate with regards to defining a core contract and a definitive list of what is included, therefore, giving GPs the opportunity to decline extra work. As usual the proposal failed, with voices from the floor suggesting that a list of things that were not core contract was more important.

Re-certifying Letters of Competence in IUCD/SDI fitting/removal: Conference noted with alarm the 2016 revisions. This was carried.

Interface with A&E: The GPC was instructed to oppose placing GPs in A&E departments, as this was further destabilising Primary Care.

Capita: Not surprisingly there was a motion lambasting Capita for its appalling performance.

Premises: A motion on premises raised concerns with regard to last man standing issues with NHS Property Services and buildings.

Election of GPC Members: A proposal to amend the number of representatives, their terms of office and representations from the regions was lost in all parts.

GP Trainees and Training: A motion proposing greater investment in GP training and increased places for foundation training doctors in practice, together with lengthening the GP training scheme to 4 years (with at least 2 years in practice), was passed in all parts. A further motion proposing increasing investment in facilities and trainers, together with better support, reduced examination fees and practice based incentives to take trainees in FY1 and FY2 posts was carried.

Sustainability & Transformation Plans (STPs): There were a number of motions highlighting their significant shortcomings, particularly (i) the risk of developing a postcode lottery between areas, (ii) causing division between organisations rather than integration and (iii) an acknowledgement that there was a significant move to cut services in order to reach budgetary balance. Conference supported the principles that, as things stand, STPs are not democratically accountable to the public and nor are they adequately representative of General Practice. Further motions affirmed the need for STPs to have good LMC representation and consultation, together with real investment in General Practice and primary care more widely to stimulate potential savings in secondary care. Timescales and targets must be clinically led rather than financially or politically driven.

APMS: A motion was carried that mandates the General Practitioners Defence Fund (GPDF) to take expert legal opinion to challenge the notion that only APMS contracts may be awarded when procuring general medical services.

E-Referrals: A motion was carried that the notion of exclusive e-referrals is bad for patient safety, demanding that all queries from patients concerning e-referrals must be directed to the appropriate hospital rather than the GP.

Clinical Records: The proposal that all patient clinical information is held digitally in an approved NHS system was supported, along with the transfer of all clinical information digitally between practices and central storage of current paper records.

CQC: A statement that Conference has no confidence in CQC was carried unanimously, along with a request to develop guidance to support and empower GP practices to challenge process and inspections, support through appeals processes, reduce bureaucracy and ensure inspections are evidence based.

EU Nationals: A motion that Conference believes EU nationals working in the NHS should be granted an immediate right of UK residence was carried.

UK Shortage Occupation List: The motion requiring the UK Visa Bureau to add general practitioners to this list was carried.

REPORT BY ZOE NORRIS, CHAIR OF THE GPC SESSIONAL SUB-COMMITTEE

This was one of the most well received parts of Conference. Zoe gave an impassioned delivery with regard to the role of women in General Practice and the need for Sessional and Locum GPs. She received a standing ovation.

REPORTS BY THE NATION CHAIRS

The plight of General Practice in Northern Ireland was notable, with the absence of a functioning devolved government and a significant number of failing practices who are on the brink of returning their contracts.

The GPC in Northern Ireland has gathered undated resignation letters from almost all of its practitioners, and is hoping for a resolution with the new government if this is successfully negotiated. There is a risk that GPs in Northern Ireland may leave the NHS, which will undoubtedly create an enormous crisis in the provision of care there, and will focus the wider British public's attention on to the funding deficiencies we all face.

THEMED DEBATES

Bridging the Gap (rationing)

Claire Clough attended this debate, which looked at how funding allocated to NHS services is insufficient to meet the needs and wants of the population, and how General Practice can manage within these funding constraints.

As you would expect, discussion was largely around the clinical vs financial priorities, with North Yorkshire LMC contributing vehemently, having submitted 7 of the 42 motions listed under this heading. Discussion included the following suggestions:

- Restricting access to certain services. This was an obvious choice although proposals for types of services could not be agreed upon, and fears were expressed over diluting the quality of care. Attendees questioned whether debate over potential services to be rationed should be held in the public domain and whether this should be locally or nationally.
- Use of the BMA document *Quality First: Managing workload to deliver safe patient care* to manage capacity as an alternative to restriction of services. Patient education would also be key.
- Negotiation for monies for services not currently funded.
- Encouraging patients to purchase over the counter medicines or to make more cost effective prescription choices. Some advocated making it clear that prescriptions were never 'free'.

The following motions were carried:

That conference believes NHS rationing is happening, and politicians will not discuss this due to the implications; conference demands that GPC shows some genuine leadership and engages the country in debate on what should be rationed.

That conference instructs the GPC to produce a discussion paper outlining alternative funding options for general practice, including co-payments.

Contractual status/risk/individual survival

Margaret Wicks attended this debate, which was exploring the reasons for many GPs not being keen on becoming partners despite the independent contractor model having long been the norm in General Practice. There was discussion around the increasing number of new GPs opting to either locum or be salaried, as well as a considerable number of partners taking early retirement or also opting to locum or be salaried. Many areas reported significant recruitment and retention problems, with partnerships folding and contracts being handed back because partners could not be appointed. Whilst acknowledging that workload is a contributing factor, attendees were asked to focus on other issues and factors as there was a separate workload themed debate. A number of themes were discussed, such as:

- Whether the independent contractor model has reached the "end of the road".
- The implications of a full salaried model.
- The importance of list based practice.
- Guarding against divide and rule.

The following motion was carried:

That conference asserts that the independent contractor status must be the basic model for general practice, and instructs the GPC to:

(i) ensure that all employment options are accessible to all GPs
(ii) develop a framework that would limit financial and employment risk for contractors
(iii) ensure that the contractors are incentivised and rewarded for making a commitment to the community
(iv) develop safeguards to prevent exploitation of different profession groups.

Working at Scale

Mark Durling attended this debate, which was informative. At the heart of the discussion was that GPs should remain within the NHS and that working at scale arrangements should necessarily be flexible. Conference acknowledged that working at scale may provide opportunities for improving practice resilience and sustainability, developing multidisciplinary arrangements and helping to shape integration of service. However, the registered list should remain at the core of patient care and continuity. Fragmentation should be avoided and methods of working at scale should be based around needs to shape local services that meet the needs of those populations rather than the prescriptive model. There were many examples given of practices working at scale from Super Partnerships with Executive Partners to looser associations of federations and less formal arrangements purely to share back office functions or sickness cover arrangements. There was acknowledgement that the size of these organisations does influence local negotiations for service design but, in the case of the Manchester model (the so called 'Devo Manc'), Tracey Vell, Chair of Manchester LMC, illustrated that their experience of working at scale in a wider collaborative citywide model, involving integration of health and social care together with redesign of pathways, meant that there had been, in effect, little change in the provision of core General Practice at practice level. Indeed, she highlighted that working at scale was anything we wished it to be. Their experience was that this did not threaten the continuity and the continuance of core practice provision.

The following motions were taken as references:

That conference mandates GPC to develop working at scale blueprints, taking into account the development of a national contract for sessional GPs, the development of a national contract for core services, local flexibility, organising at scale groupings appropriate to local geography to maintain influences and development of pathways of care with appropriate feedback as to function.

That conference affirms that General Practitioners wish to remain within the NHS ensuring that:
(i) the registered list remains at the core of continuity
(ii) further fragmentation is avoided
(iii) GPs continue to find ways to shape the future of primary care services that meet the needs of their local populations

That conference believes that working at scale offers opportunities to:
(i) improve practice resilience and sustainability
(ii) flexible working arrangements for a multidisciplinary workforce
(iii) influence the shape of integrated services

GP Forward View/Urgent Prescription for General Practice

Alastair Bradley attended this debate, which was opened by Chaand Nagpaul giving a briefing on the development and delivery of the "Urgent prescription for General Practice". This had led to some significant benefits for general practice such as the full re-imbursement of Care Quality Commission (CQC) fees and the addition of the Avoiding Unplanned Admissions money into the core contract. Debate was then opened to the floor on experiences of delivery of the GPFV. There was consensus amongst all representatives that delivery of monies from the GPFV was not directed towards practices, regardless of whether practice delivery of services had been proven to be more cost effective. There was some evidence of better engagement with delivery of GPFV monies in Lancashire, but other regions reported little money coming directly to practices.

The following motions were carried:

That conference demands that GPFV funding be allocated directly to individual practices to have a tangible effect at the individual practice level.

That conference believes that the GPFV is failing to deliver the resources necessary to sustain general practice and demands that GPC ballot GPs as to whether they would be prepared to collectively close their lists in response to this crisis.

The following Chosen Motion was carried:

That conference has no confidence in the GPFV as it has:
(i) failed to make any impact into the recruitment and retention crisis facing general practice
(ii) failed to make any inroad in to the unmanageable daily workload within general practice.

Workload

David Savage attended this useful debate with around 50 to 60 people discussing whether the profession should define the amount of work that they are able to do from the point of view of safety, both for the patients and doctors, and whether it was possible to define a consultation and length time per consultation and the number of patients to be seen in a day. There were a number of initial presentations stating that GPC feedback was that 8 out of 10 GPs felt that they had no time for safe care and 27% of consultations were avoidable. This accounted to 15m GP appointments a year. Bob Morley, GPC Contracts and Regulation Subcommittee Chair discussed limiting list size and informal suspension of registrations, although accepted that NHS England opinion varied from the GPC opinion. However, the GPC had agreed that they would support practices that shut their lists from the legal perspective. He suggested reviewing non-core work and looking as to whether Enhanced Services were cost effective. David pointed out the contractual issues of managing delivery of core work and addressing only the reasonable needs of patients, including onward referrals. David spoke with regards to the definition of what a consultation is – whether this is face to face, online, telephone or home visit, and that the profession should propose a minimum consultation time of 15 minutes with a defined length in working day face to face with patients.

It appeared that the Scottish Government is more sympathetic to the health service and, therefore, significant benefits had been negotiated in Scotland, including the end of the Quality and Outcomes Framework (QOF), child immunisations being performed in local clinics and not in GP Surgeries and GPs working as expert medical generalists. In Northern Ireland they have negotiated a fully funded pharmacist in every practice. In Wales they negotiated a huge reduction in QOF and a national Phlebotomy Service.

A general discussion was around whether it would be possible to have a motion restricting the number of appointments per day to 25 and they felt that this was too prescriptive. There were a number of useful suggestions, including a speech from Rotherham on re-establishing the Collaborative Arrangements which defined what GPs should and should not do and associated fees. In particular, there was a strong view in the room that GPs should stop doing work requested of them by other organisations such as the Police, Councils, the DVLA and Insurance Companies. There was also a discussion about holding CCGs and Hospitals Trusts to account with regard to the 2017/18 contract changes, insisting that contractual levers are used to implement the changes.

The following motions were carried:

That conference recognises that "workload pressures" is not a defence in law for any resulting mistakes and instructs GPC:

(i) to negotiate a maximum safe limit to the number of patient and other contacts a GP undertakes in a day.

(ii) to negotiate clear legal parameters for where a GPs' duty of care ceases so that a GP is not responsible for omissions of other parts of the NHS.

That conference applauds the achievements that the quality first agenda has made so far and asks GPC:

(i) to develop a warning system to alert the wider NHS when patient safety will be at risk due to excessive workload

(ii) to support, empower and encourage GPs to feel confident to say 'No' when work is inappropriately transferred to primary care.

DR M DURLING	DR A BRADLEY	DR D SAVAGE	MRS M WICKS	MRS C CLOUGH
Chair	**Vice Chair**	**Secretary**	**Manager**	**Administrator**