ANNUAL CONFERENCE OF LMCs 2015

21 & 22 MAY 2015

SHEFFIELD LMC REPS:	Mark Durling	David Savage	Helen Story
SHEFFIELD LMC OBSERVERS:	Claire Clough	Margaret Wicks	

SPEECHES

The Conference opened with a speech from Dr Chaand Nagpaul, Chairman of the General Practitioners Committee (GPC), which received a lengthy standing ovation.

The speech:

- highlighted many of the issues that all of us feel are priorities at present;
- demanded that the government address the issue of workload, capacity, recruitment and retention;
- noted that rather than driving expectation with demands for a 7 day service, the government should concentrate on providing enough doctors to cover the hours required by the core contract;
- outlined that although the government were promising 5,000 GPs by 2020 this would not even replace the doctors who currently intend to retire;
- pointed out the salient fact that it now takes 3 medical students to be trained to fulfil the commitments of one full time doctor;
- highlighted concerns with Care Quality Commission (CQC) inspections and the fact that they place unnecessary stress on an already demoralised primary care workforce with little evidential benefit;
- celebrated the fact that the government had promised an extra £1b per year for the next 5 years.

The speech covered the majority of the key issues on the Conference agenda and Chaand's statement of intent in negotiation with the government was welcome. However, I think it would be fair to state that he did not suggest a huge number of solutions.

MOTIONS

Demand, Supply and Patient Safety

A motion stating that politicians irresponsibly fuel unrealistic public expectation of the NHS for their own political ends was debated and a demand to end the political interference in NHS structures was passed.

Sheffield's motion supporting a policy of non-politicisation of the NHS and demanding that political parties stop using it as a weapon of manifesto was included in this section, but we did not get a chance to speak.

Primary Care Workforce

There followed a section on primary care workforce, recruitment and retention which obviously had a significant number of speakers. It confirmed to us that this is a national problem and that some other areas, particularly in the North, had even greater recruitment problems than Sheffield.

The offer of golden handshakes was welcomed, although it was pointed out that these were financially inadequate to attract GPs to stay in the profession or even retrain in the profession, as they were totally inadequate compared to the commitment required.

A motion to support the creation of an intermediate grade qualification for GPs, similar to staff grades in hospitals, was defeated. I think this was the correct decision, although there were reports of a number of GP Trainees who had completed 3 years training and were not moving in to the primary care workforce because of failing the MRCGP. This appeared to be a huge waste of time and money, both for the GP Trainees and the NHS. It was agreed unanimously to try and find a way to help these doctors in to primary care.

Patient Safety

Numerous motions on patient safety, particularly in relation to maximum list size, were debated and passed, supporting the right for practices to close their list when they decide it is not safe to take on more patients.

GP Education and Training

A number of GP Trainees spoke eloquently and perhaps most interestingly expressed the view that although trained in primary care medicine they did not feel they had adequate training in management and leadership skills. In many cases, new GP partners felt they had no experience of finance and business management skills. A motion proposing that the GP training curriculum should encompass commissioning, management, clinical leadership skills, finance, business management, business skills, IT, health and justice and resilience was passed, although there was some discussion as to whether extra training would require an extension of the Trainee status to 4 years.

New Models of Care

This included integration of health and social care and federated working.

GP Partnerships

A motion proposing that allowing GP partners access to goodwill in their practices would be the most effective way to enable general medical practice to evolve to meet the challenge of the future was defeated.

Regulation, Monitoring and Performance Management

There were a number of motions criticising the current appraisal system, stating that it is no longer a formative experience for most GPs and that it is becoming inappropriate and bureaucratic. These were passed.

The CQC was heavily criticised, with Conference stating that inspections should focus on relevant clinical outcomes and should not demoralise the workforce or draw resources away from delivering healthcare. There was also a demand that CQC should only be able to see anonymised patient records.

Funding for General Practice

Much to Mark Durling's delight (as he has been trying to pass a similar motion for the last 3 years) the following motion was passed:

KENT: That conference believes that the current formula based core contract is unfit for purpose:
(i) in that it fails to recognise the ever increasing demand for access and complex care associated with model 21st century general practice
(ii) in that it fails to incentivise the expansion of primary care needed to cope with the vision set out in the NHS Five Year Forward View
(iii) and should be replaced by a payment by activity contract which directly links workload to resource.

This will obviously have significant implications for the GPC Executive Team (formerly known as GPC Negotiators) in their discussions with NHS England.

Unforutnately, although we had both prepared speeches, we were not called to speak.

The Prime Minister's Challenge Fund was discussed in this section. In general, it was felt that there was a risk of undermining GP out of hours services and stretching an already overstretched workforce and service.

SOAPBOX

This is where members of the auditorium can voice their concerns.

One GP gave an impassioned speech, welcoming the BMA's support of lesbian and gay doctors, but also criticised the GPC's choice of the Dorchester Hotel for the Conference dinner, as it is owned by the Sultan of Brunei.

PRESENTATION BY DR ALAN MCDEVITT, CHAIRMAN OF THE SCOTTISH GPC

This presentation was one of the most well received of the Conference. The Scottish GPC has conducted a programme of significant consultation with the Scottish Government in its approach to developing general practice. This was a distillation of their discussions and their proposals which seek to use general practice as the central focus in delivering community health care with team members aligned around practices, working under the direction of GPs. Its aim was to broaden the scope of activity of allied health professionals and encourage them to take on more of the routine tasks that GPs are currently overwhelmed with. It was a good presentation and focussed on potential solutions to the current capacity and workforce issues that we face.

BREAKOUT GROUPS

There was a breakout session where we were all divided into small groups to discuss:

(i) What should LMCs be delivering for GPs over the next few years?
(ii) What should the GPC/GPDF be delivering for GPs and LMCs over the next few years?
(iii) What should Conference be delivering for GPs, LMCs and the GPC over the next few years?

This highlighted the difference in LMC roles across the country.

ASK THE EXECUTIVE TEAM

During the feedback session to the GPC Executive Team it was abundantly clear that LMC representatives felt unhappy about the lack of solutions being discussed at Conference. The Executive Team were given a fairly clear message that Conference required them to focus on negotiations and solutions as a matter of urgency. This feedback was generally well received and acknowledged by the Executive Team, who committed to reflect upon these feelings and try to amend the structure of future conferences to provide more opportunity for discussion similar to the breakout groups.

DR D SAVAGE	**DR M DURLING**
Secretary	**Chair**