CONFERENCE OF ENGLAND LMC REPRESENTATIVES
FRIDAY 23 NOVEMBER 2018

SHEFFIELD LMC ATTENDANCE: Alastair Bradley Mark Durling David Savage

SPEECH BY RICHARD VAUTREY, CHAIR, GENERAL PRACTITIONERS COMMITTEE (GPC) ENGLAND

Richard's speech was based around the phrase "It's about time…" as used to advertise Dr Who. He highlighted some of the positive outcomes over the last 12 months:

- 96% of practices were rated "Good" or "Outstanding" by the Care Quality Commission (CQC);
- 5 New Medical Schools had been announced with a much greater emphasis on community training;
- GP trainee numbers had increased;
- Matt Hancock, Secretary of State for Health and Social Care has continued to express his support for the partnership review, state-backed indemnity scheme and primary care;
- £20b long-term funding settlement was welcome;
- £3.5b announced for primary care.

However, there were a number of caveats to these positive messages:

£20b was not enough to meet the needs of patients and was only just above the rate of healthcare inflation. There was no guarantee how much of this would go on patient care in primary care rather than propping up secondary care. The £3.5b was only enough to meet current demands and did not meet the demand of moving care out of hospital. Richard urged NHS England (NHSE) not to make this available in small pots of money that were difficult to access, eg General Practice Forward View (GPFV).

Richard highlighted the perverse consequences of annual allowances on pension tax relief and how this was discouraging senior doctors from staying in the NHS or taking on more work. Increasing clinical risk and liability held in primary care was also affecting retention of doctors.

There was genuine support for technological innovation but this had to support care for all, not be selective, like GP at Hand. Richard also called for the scrapping of "out of area registrations" which was aggravating the situation.

Richard also re-iterated that Integrated Care Provider (ICP) contracts were a threat to independent general practice.

<u>Note</u>: The necessity to be wary of Department of Health & Social Care (DoHSC) announcements became apparent through the day as it became clear the DoHSC wanted to fund the state-backed indemnity scheme by top-slicing core funding. The Secretary of State also tweeted how pleased he was the GP numbers were rising, only to retract the tweet when it was apparent the opposite was true!

<u>MORNING SESSION</u>

Motions passed that criticised the promotion of services such as GP at Hand, which were the only GP service that could "choose if the patient is right for them". There were concerns about not condemning some services, eg Alternative Provider Medical Services (APMS) contracts to care for the homeless under the same umbrella.

Particular concern was raised about GPs being encouraged to work beyond their clinical skills to fill commissioning gaps, particularly around transgender patients, eating disorders and substance misuse. Problems are created by the conflict between General Medical Council (GMC) "Good Clinical Practice" guidance and GMC specific advice around not caring for these patients if GPs refuse to prescribe. An Adolescent Child Psychiatrist agreed that these were beyond our competences.

Referral management schemes were condemned for blocking referrals and increasing the clinical risk held in general practice. Concerns were also raised about the mission creep of general practice being seen as an emergency service to plug gaps in other service short-comings.

THEMED DEBATE - PARTNERSHIP

Nigel Watson, Independent Chair of the GP Partnership Review gave an update to the Conference on "Revitalising the Partnership". The talk covered many of the topics raised in Richard's speech, such as pensions, indemnity and risk. There were calls to simplify out of hours and extended access provision. There should be more training for medical students in general practice with other speciality trainees spending some time in the speciality as well.

The review is exploring Limited Liability Partnerships (LLPs) and how GPs should be allowed to provide some services to their patients privately, that are not available on the NHS. There was also a call to invest more directly into the General Medical Services (GMS) / Personal Medical Services (PMS) contract.

The subsequent debate centred on the partner / salaried models. There were a number of horror stories of partnerships failing, but equally with the falling number of partners and rising number of locums the system would fail and nobody wanted a service salaried to a multi-national organisation. There should, therefore, be incentives to promote partnerships.

Working at scale was also discussed and whilst it can be beneficial to patients and practices, no practice should be mandated to work at scale if they did not wish to do so. There was support for maintaining primary care funding initiatives through individual practices.

Note: The GP Partnership Review Interim Report and our response can be found on the Facts & Information page of our website – www.sheffield-lmc.org.uk.

AFTERNOON SESSION

Regulation was discussed in terms of CQC practice regulation and individual performance regulation / Performance Advisory Group (PAG). There was support for reducing the frequency of CQC visits, giving a minimum notice of 14 days for an inspection and simplifying practice registration requirements. Concerns were raised about the subjectivity of investigations and undertakings recommended by PAGs. An independent oversight of the process was sought.

Core practice funding was debated, the sense being that it had been eroded over the years. However, a call to start negotiations on a new contract was defeated, partly because the GPC was concerned that they might end up with a worse deal!

The excessive workload was discussed, but a poorly worded motion meant little was agreed as sections of the motion would reduce GP funding either by reducing core hours or restricting GPs to 1500 patients per whole time equivalent (WTE). I am sure this will return better worded. GP retention was tackled through recommending incentive schemes to acknowledge expertise of senior doctors (however, pension considerations may frustrate this).

The most hotly debated motion was around co-payments with a dichotomy of views. Again the motion was poorly worded as there was discussion whether co-payment could be a small amount to make patients think twice about booking an appointment (nudge theory) or should contribute significantly to the payment of the NHS. The motion was lost, but the GPC was quite clear they did not wish to negotiate this policy anyway.

CONCLUSION

Overall it was a good Conference with a spread of motions that covered all the current pressure points. There was some frustration with the wording of some of the motions and that, on certain topics, the GPC did not want to engage in dialogue with a Conservative Government backing a policy of significant cuts to public services.

DR A BRADLEY
Chair