# LMC SECRETARIES CONFERENCE

## 'CELEBRATING/FUTURE-PROOFING LMCS'

## THURSDAY 19 OCTOBER 2017

**SHEFFIELD LMC ATTENDANCE**: David Savage Margaret Wicks

We had the opportunity at the start of the Conference to congratulate Richard Vautrey on his appointment as Chair of the General Practitioners Committee (GPC) UK and GPC England, and I expressed our view that it was excellent news to have a Chair from the North of England, particularly one who had made regular efforts to come and talk to Sheffield GPs.

### ADDRESS BY GPC UK AND ENGLAND CHAIR

The main points of note were as follows:

- There was recognition of the problems faced by general practice, both in the Government and NHS England (NHSE).
- One of the fundamental problems was that the UK did not raise enough Income Tax per capita for healthcare compared to comparative countries. Even with the £2.4b being invested by 2021 (a 14% uplift) this would still leave a £3.5b funding gap in general practice. The average General Medical Services (GMS) payment per patient after expenses was £142.63, which was insufficient to deal with the expectations of the general public in the 21st Century.
- The London Trainee Survey 2017 showed that only 4% of Trainees wish to become Partners. Although there had been an increase of 224 GPs between March and June 2017, the number of full time equivalent GPs fell by 1252 between March 2016 and March 2017. A number of schemes are in place to try and slow this diminution in workforce, such as the GP Retention Scheme and international recruitment initiatives.
- There had been 469 NHS GP Health Service consultations since the service was launched in January 2017, which showed the pressure of general practice.
- The GPC was working on "black alerts" in general practice, much as the "red alerts" in hospital, and were trying to negotiate safer working.
- An agreement on the Premises Costs Directions was anticipated in the near future, after years of negotiations with NHSE. It was hoped that this would include Last Partner Standing Protection and updated Rent Reviews.
- 93% of General Practice is rated as "good" or "outstanding" by the Care Quality Commission (CQC) compared to 71% of Acute Trusts and 74% of Mental Health Trusts.
- The point that Multi-speciality Community Providers (MCPs) are not the only game in town was highlighted, and Richard stressed the importance of practices not giving up their GMS contracts.
- Richard felt that a State-backed Indemnity Scheme was a positive outcome, although it could take 12-18 months to negotiate the detail and establish the scheme.
- It was highlighted that Clinical Peer Review is not mandatory.

### LMC SURVEY – WHAT CAN WE DO BETTER?

Rachel McMahon, Deputy Chair of LMC England Conference, presented the findings of a survey carried out in February 2016. Sheffield appeared to be around the average and the mean for most denominators, with 500 to 599 GPs being an average number of constituents, 82 practices being slightly below the mean of 123 (although the variance was huge, with some LMCs having over 1000 practices). It was of note that Sheffield LMC's running costs were low compared to the national average. The majority of LMCs have a Statutory Levy and a Voluntary Levy, although there are some that only have a Voluntary Levy. 30% of LMCs charge a locum levy. There was a general perception that LMCs did not have enough representation from sessional doctors, and that sessional doctors were more difficult to make contact with. The spread of lay staff and clinical staff at Sheffield LMC was around average. Rachel referred to standardisation across LMCs, but many felt this would be difficult because of the different nature of organisations and varying needs of constituents.

## SESSIONAL GPS UPDATE

Zoe Norris, Chair of GPC Sessional Subcommittee, highlighted the following:

- Much of the workforce is changing to portfolio medicine.
- Access to NHS emails for locums is vital.
- There were concerns around the vulnerability of some doctors who had worked for locum banks and e-consulting services who had found themselves reported to the General Medical Council (GMC).
- Negotiations were ongoing with Primary Care Support England (PCSE) on a number of issues.
- Out of hours doctors were vulnerable and experiencing a funding gap with in hours doctors.
- Model terms and conditions for locums were being produced, which would outline expected behaviour of locums and practices, in view of a number of cases where availability had changed or costs had been inflated at unacceptably short notice.
- The average age of locums was 51 (males) and 48 (females), suggesting that many more senior doctors are choosing not to become or remain as partners.
- The importance of sessional representation on Clinical Commissioning Group (CCG) Boards and Sustainability and Transformation Partnership (STP) Boards was highlighted.
- There would be a survey of sessional doctors to see if practices were using the BMA model contract or offering terms no less favourable, which was considered to be mandatory by the GPC and the BMA.

## THE GENERAL PRACTICE FORWARD VIEW (GPFV): PROGRESS AND SHAPING THE FUTURE

Dr Arvind Madan, Director of Primary Care and Deputy Medical Director, NHSE was a GP who worked in practice and also worked for an out of hours service. He gave a very supportive speech with regard to NHSE's view that general practice is key to the NHS surviving and that he still saw the GP as the gatekeeper. He went on to describe the benefits and successes of the GPFV, whilst accepting that this was not enough. He acknowledged the fact that many LMCs felt that the GPFV was piecemeal, but felt that this was the only way that these sums of money could have been approved by the Treasury. The successes included an indemnity review by March 2019, full reimbursement of Care Quality Commission (CQC) costs and efforts to increase the workforce and make general practice attractive again. He highlighted the increase in training places and Medical School intakes, in particular in Medical Schools that have high GP output. Greater use of physios, mental health workers, pharmacists etc, such that GPs were not always the first point of contact was noted. He felt that workload and demand management was fundamental in reforming general practice, and that use of 111 and clinical triage was the way ahead. He accepted that there had been an unacceptable delay in sorting out an Estates and Technology Strategy, and pointed to an 18% increase in GP IT funding and moving towards online and phone triage and WiFi in all practices. He encouraged enrolment on the General Practice Development Programme, the Time for Care Programme and 9 month Active Learning Programme.

## CAN PRACTICES GET TOO BIG TO NEED LMCS?

Margaret attended this workshop which highlighted considerable variation in the services that LMCs provide and considered the relevance of those services to GPs that are part of new, larger organisations, such as GP Federations. Concerns were raised by some LMCs who did not have 100% sign up to their voluntary levy. It was noted that LMCs are unique in offering independent, trustworthy advice, as well as having a mandate to represent constituent GPs. LMCs understand the beliefs and values of general practice and have an important history and knowledge base in relation to day-to-day core general practice. It was suggested that there will inevitably be times when individual GPs wish to seek the advice and support of their LMC in relation to actions taken/decisions made by the new organisations that are forming. However, LMCs should not become complacent about the needs of their constituents, and should be reviewing their role, services, funding etc to ensure they remain relevant, responsive and value for money. As well as providing excellent services to individual constituents, LMCs can be invaluable to the new organisations that are forming, by virtue of their longevity and expertise. It was concluded that LMCs are adaptable, evolving and resilient to change and, as such, there was confidence that they will secure their role in general practice in the future.

## HOW CAN AN LMC HELP A GP TO SURVIVE

I attended this workshop which was a presentation by Michael Wright from Nottinghamshire LMC. He highlighted that they have 10 pastoral advisors, mostly retired GPs, who attend training updates and meet together quarterly to discuss cases anonymously. This service was established in 2001, funded by the LMC. Following a survey of 100 GPs in 2015, in which 73% of doctors reported that their mood was low and their workload unmanageable, they set up GP-S Mentoring. The LMC received funding from Health Education England and trained GP mentors through a private company (Egan Skilled Helper Model). The set up costs were in the region of £50k and there are ongoing costs. Each GP requesting mentoring receives 4 free sessions of 2 hours. Each mentor has at least 2 mentees. Feedback on the mentoring has been extremely positive, with many doctors stating that they now felt "that they were happy to get up again in the morning".

## FUTURE COMMISSIONING - WHERE DO FEDERATIONS FIT IN?

This workshop was chaired by Simon Poole from Cambridgeshire, discussing issues of working at scale. It was apparent that the pace of change across the country varied enormously, with some areas stating they had robust federations working successfully and other areas seeming to be way behind Sheffield, particularly in areas where there was more than one CCG per LMC. Some LMCs felt that there was no option other than an out of hospital model of care at scale involving Primary Care, with GPs and Practices as providers. There was debate as to CCGs consulting with federations, and it was felt that this was not legal, as only LMCs have this mandate. It was pointed out that federated practices had to be able to say no, and some suggested there was some advantage to "letting it fail". Northern Ireland was struggling as all of their practices are in federations and all have the right to say no. It was suggested that the federation's role was to respond to the demand of working at scale with limited liability vehicles. They should be set up to advise services at risk and with risk, but at the present time they were not a legal entity.

## HOW CAN LMCS COMMUNICATE BETTER WITH GPS AND THE GPC?

Margaret attended this workshop which addressed the above question, but also considered how the GPC can better communicate with LMCs. The main points of note were:

- LMCs are increasingly using Social Media to communicate with their constituents, but this does not resolve the issue of getting messages to GPs who do not have an online presence, do not access email regularly etc.
- There is always a difficult balance between filling GPs' In Boxes with lots of separate emails vs newsletters being too long.
- Some LMCs found that communicating with Practice Managers was an effective way of keeping abreast of the issues practices are facing, as well as conveying key information from the LMC.
- The GPC was asked to give greater priority to getting more positive messages about general practice in the media.
- Concerns were raised that LMCs are not always made aware of all BMA/GPC guidance or updates to existing guidance. In addition, guidance can be difficult to locate and it was suggested that a searchable index would be a vast improvement.
- Consideration was given to how the Regional GPC Election process could be improved, which led to concerns being raised about the difficulties of getting contact details for all constituents, particularly locums.

## Q&A

There was a Q&A session at the end of the Conference, during which Richard Vautrey stated clearly that there was no desire within the GPC to lose the Independent Contractor Status. It was also noted that priority was being given to negotiating insurance for a Last Man Standing Partnership.

**DR D SAVAGE**
**Secretary**