21st March 2019

See Distribution

NOTES FROM THE LMC UK CONFERENCE IN BELFAST 19/20 MARCH 2019

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Paragraph numbering below refers to the numbers of the relevant agenda items.

Note: If a motion is carried as written it becomes GPC negotiating policy. When a motion is taken 'as a reference' it means that the spirit of the motion is agreed as guidance to the GPC but the wording is too inappropriate, inaccurate or prescriptive to become policy.

Gloucestershire LMC was represented by Drs Bounds, Fielding, Lees and Yerburgh with Dr Penelope West attending as an observer.

DAY ONE – 19th MARCH – AFTERNOON SESSION

RETURN OF REPRESENTATIVES

1. THE CHAIR: That the return of representatives of LMCs be received. Chair Dr Mark Corcoran.

STANDING ORDERS

2. THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE). Standing orders were adopted..

REPORT OF THE AGENDA COMMITTEE

3. THE CHAIR (ON BEHALF OF THE AGENDA COMMITTEE). The report of the agenda committee was approved.

ANNUAL REPORT

4. THE CHAIR: Report by the chair of the GPC UK, Dr Richard Vautrey, who gave the keynote speech that "We have listened, acted and delivered." He gave a comprehensive report of the various areas of progress that had at last been made in all four nations but said there remained more to be done in several areas, including: premises; the rebuilding of Primary Healthcare Teams; Information Technology, which had to support general practice, rather than undermining it; reduction of demand; the over-medicalisation of society; and pensions. He received a partial standing ovation, led by the GPC.

REPORT BY THE CHAIR OF GPC NORTHERN IRELAND

5. RECEIVED: Report by the Chair of GPC Northern Ireland, Dr Alan Stout, who pointed out that areas of Belfast have the lowest life expectancy in Europe, there is no Health Minister in post in Northern Ireland, and one will be needed to sort out indemnity.

WORKFORCE

6. AGENDA COMMITTEE PROPOSED BY SUFFOLK: 'Conference, mindful of the appalling statistics and circumstances of doctor suicides, charged the GPC to raise the issue of GP suicide with all major stakeholders, lobby government to resource support systems, and press for NHS funded coaching and supervision.' Dr Lucy Henshall gave a heart-rending, double-length proposal that psychological support was essential to prevent the unacceptable occupational risk of suicide. Some 430 health workers (including 81 doctors) had committed suicide in the last 4 years and female doctors were far more likely to commit suicide than women in other professions. The request for a survey was carried only as a reference but otherwise conference was deeply in support of the motion, and a one-minute silence was held in memory of all those colleagues who had been driven to pay the ultimate price. Motion taken as a reference.

PUBLIC HEALTH

7. AGENDA COMMITTEE PROPOSED BY N. AND N.E. LINCOLNSHIRE: That 'health screening should not take place in the UK's national health services without the approval of the UK National Screening Committee, and if carried out privately, requires the screening provider to provide follow up appointments with patients to discuss abnormal results, and if GPs end up doing his work for them, they are empowered to invoice the company for their time.' The motion was carried. There was interesting additional discussion on the subject of genomic screening and the ways in which GPs may become embroiled.

INFORMATION GOVERNANCE

8. GATESHEAD AND SOUTH TYNESIDE: 'Conference believes that the role of data controller is no longer compatible with modern general practice because the time and financial resources taken up impede clinical care and pose a risk to practices who may inadvertently breach regulations.' This was carried, but the idea that the role would be better taken over by a dedicated team at NHS England was rejected.

GENERAL DATA PROTECTION REGULATION (GDPR)

9. AGENDA COMMITTEE PROPOSED BY MORGANNWG: Conference feels that the impact of GDPR on practice workload has been significant, and calls for extra workforce, the UK Government to ensure that inappropriate requests for reports masquerading as SARS be penalised, the GPC to take action against general practice being used as a resource for solicitors, and the GPC, NHS bodies, Information Commissioner's Office, Law Society and Association of British Insurers to develop guidelines on fair and proportionate use. Motion carried.

SOAPBOX SESSION

Various issues were aired, including:

a. Our Dr Ben Lees asked the GPC to arrange that perverse reductions in practice premises rent repayments do not, as in his practice's case, occur.

b. Public health: Matt Hancock announced that prevention is better than cure, but Public Health funding was then cut. A properly funded public health system is needed to stem the tide of patient demand. The cuts to public health funding have two adverse effects on GPs: services will not be commissioned from the GP practices, reducing funding, and those denied community services will now turn up at the practice, increasing workload.

c. Primary Care Networks: One speaker objected to being forced into a Primary Care Network. In area (such as Plymouth) where there is a severe shortfall of GPs the requirement to provide a Clinical Director for each PCN will in fact reduce services to patients.

d. Data and IM&T: Lack of internet speed anywhere is a threat to patient safety. Data sets are frequently out of date.

e. Other issues:

i. Once again, practices need a light bureaucratic touch.

ii. Co-payment was mentioned ("We have not gone away".)

iii. Clinical recommendations (e.g. new asthma diagnostic techniques) should be properly commissioned.

iv. It is unfair for CQC to penalise practices that make the effort to invite women in for smear tests but then do not attend their appointment.

v. The workforce crisis will continue until the number of whole-time equivalent principals increases, instead of plummeting as at present.

REPORT BY THE CHAIR OF SESSIONAL GPs SUBCOMMITTEE

11. RECEIVED: Report from Zoe Norris: GPC to recognise the plurality of roles. She asked whether conference works for all, represents all, and if motions will become actions? She received a standing ovation in recognition for her three years of hard work on behalf of GPs who are not principals.

GPs WORKING IN SESSIONAL ROLES

AGENDA COMMITTEE PROPOSED BY SESSIONAL GPs: That conference asks the GPC to recognise the plurality of roles taken up by GPs throughout the UK, ensure that employment rights are correctly negotiated, and that non-clinical roles b recognised by the GPC, who should negotiate model terms and conditions for this disparate group of GPs. Motion carried.

REPORT BY **THE CO-CHAIRS OF GP TRAINEES SUBCOMMITTEE**

13. RECEIVED: Report by the Co-Chairs of the GP Trainees Subcommittee (Dr Zoe Greaves and Dr Sandesh Gulhane). 19% of trainees currently consider partnership. Do we accept the status quo or try to change it?

EDUCATION AND TRAINING

14. THE GPC: The conference recognises that GP training is outdated. It was proposed that GP training should be radically overhauled, with more time spent in primary care, an overhaul of the e-portfolio, training in leadership, business and management through funded courses, and a fully-funded community placement for all F2 doctors. Clinical competence is currently covered, but the multitude of others is not. The most important part of the motion was carried, but only by 143 to 95 votes.

15. NORTH YORKSHIRE: Conference recognised that good numbers of GP Trainers are critical to recruitment and retention, and national minimum standards for trainers are needed so that prior experience is transferable to another geographical location. Onerous 'hoops' should be avoided. Motion carried.

PERFORMANCE

16. AGENDA COMMITTEE PROPOSED BY NOTTINGHAMSHIRE: On appraisal and revalidation. Conference calls upon GPC UK to work with the GMC and respective NHS Bodies to overhaul appraisal and revalidation, aiming for a formative process, practical support, and mentorship. This was carried, but suggestions of changing the length of the revalidation cycle were rejected.

17. KENT: the performance regulatory processes dealing with patient complaints anonymised the processes to try and remove bias, and aim to reduce the risk to doctors. Some groups of GPs are perceived to receive unfair treatment form the GMC, which is greatly feared.

DAY 2 – 20th MARCH – MORNING SESSION)

(BBC filming from 10 a.m.)

BREXIT

18. RECEIVED: Report by Paul Laffin, BMA Public Affairs Manager (European Union). The BMA has had offices in Brussels since the 1990s because of EU working time directives and the effect on doctors. Brexit will fundamentally alter both the UK and the EU, but must not be permitted to threaten Europe's health. 'Damage limitation can only be accomplished by working with the BMA.'

19. NORTHERN IRELAND CONFERENCE OF LMCs: 'Conference recognises the unique and devastating effect that Brexit may have on the delivery of healthcare in the UK and particularly the unique situation in Northern Ireland and calls on the UK Government to take immediate steps to mitigate this.'

a. Professional qualifications have to be recognised, (NI has a quarter of doctors trained in Eire. Ten percent of GPs in Great Britain were trained abroad and a third of them are aiming to go back).

b. Cross border services e.g. paediatric congenital heart services, may be disrupted, particularly in Northern Ireland.

c. Obtaining medication; 99.7% of insulin is imported from Europe, and many other medicines also. Delayed deliveries increase the cost of maintaining the cold-chain.

d. Movement of professionals across the border to make home visits or report to surgeries in the North. Health workers living in the south but working in Northern Ireland practices/hospitals.

e. Will the European Working Time Directive be overturned?

f. Movement of data between EU and non-EU countries.

Motion unanimously passed.

PRESCRIBING

20. GLASGOW: 'Conference is concerned that the impact of short supply of medication on good patient care and GP workload, and demands that health departments across the UK address this ongoing and increasingly problematic issue. Dr Tom Yerburgh spoke movingly in support of the motion, passed unanimously.

Conference was informed that the Medicines Act has been amended in the last few days to allow pharmacists to make minor changes to medication when an item is unavailable without referring back to the GP.

DISPENSING

21. AGENDA COMMITTEE PROPOSED BY GLOUCESTERSHIRE, DR ROZ BOUNDS

'Conference recognises the importance of dispensing to rural general practices and demands that GPC UK seek to support greater practice resilience, by seeking i)a fair dispensing fee, ii)reduction or elimination of clawback, iii)full funding for EPS for dispensing doctors, iv)a change to the regulation which prevents some rural patients in merged practices from receiving dispensing services from their GPs even after they have changed their home address, v)accountability for the lack of planning by NHS bodies for the implementation of the Falsified Medicines Directive in general practice.

Motion carried, with iv) taken as a reference.

CONTRACT NEGOTIATION

22. TOWER HAMLETS: 'Conference notes that it is GPC policy that GPs should not do the work of the Home Office by checking immigration status of patients.' The context is a xenophobic political atmosphere. Motion carried.

PARTNERSHIPS

23. AGENDA COMMITTEE PROPOSED BY HERTFORSHIRE: 'Conference reaffirms its support for the GP partnership model, which represents value for money unparalleled anywhere else in the NHS and calls upon the GPC to i) negotiate uplift to core funding ii) reduce financial risks of partnerships, iii) work with RCGO to make partnership teaching part of the curriculum iv) reduce administrative burden v) Support partnerships as PCNs become functional.'

Conference wants to keep the partnership model and notes there is a decrease in newly qualified GPs wanting to take up partnerships. Motion carried.

REPORT BY THE CHAIR OF THE GPDF

RECEIVED: Dr Douglas Möderle-Lumb, who said that the GPDF aims to provide value for money, whilst retaining 'firepower,' and will be launching a new GPDF website. There was a discussion about the BMA/GPDF relationship.

GPC/GPDF:

25. AGENDA COMMITTEE PROPOSED BY CLEVELAND: That 'conference is concerned about the transfer of funding for GPC work to the BMA from the GPDF' and i) is concerned that this has led to lack of clarity of payment of honoraria for work done ii) believes that this is likely to deter representation on committees by grassroots GPs iii) demands any future scheme is equitable to all GPs undertaking work with the GPC regardless of contractual status iv) any future scheme pays for all approved meetings v) demands any future scheme pays for approved electronic work undertaken on behalf of the GPC.

This is a complex situation, no briefing paper was provided, and conference was not altogether clear what motion 25 was about! It was pointed out that opinions should be left aside, and delegates should vote on the motion as stated.

It was then explained that GPDF now pays BMA a grant of £1.4M for this year for maintenance of the status quo. Thus, any failure to maintain the status quo must lie with the BMA, not with GPDF. It had taken a long time to come to this agreement and any problems with the system would be addressed very quickly Motion carried.

LMCs

26. AVON: Conference believes that the very survival of LMCs is under threat by new models of care: Debate and vote **postponed to 16:40 pm.** Where is the LMC in the modern world of general practice? To be credible, LMCs must support and represent all GPs. Contractual arrangements must guarantee levy payments. Motion passed unanimously.

GMC

27. SHROPSHIRE: 'Conference acknowledges the legal hurdles to creating a single professional register but demands that the GMC now makes a public statement recognising that GPs are Specialists in Family Medicine and starts the process necessary to change the current regulations.' There was disagreement about wording and terminology, though there was support for the notion. Motion carried.

FUNDING

28. AGENDA COMMITTEE PROPOSED BY MID MERSEY: 'Conference demands that payments in any GP contract should i) reflect number of patient contacts as well as list size ii) ensure that practices receive payment for registered patients who die before the end of the quarter. Motion i) lost ii) carried

COLLECTIVE WORKING PLENARY SESSION

The Agenda Committee decided to use some time to allow guest speakers from each nation to discuss models of collective working.

a. **Dr Tracey Vell, Greater Manchester, for England**. Experience of Greater Manchester Health and Social Care Partnership was given as an example. It has taken 4 years, with the first year of talking culminating in a provider vote. Primary Care is necessarily the core of the system. Needed to create space to make leaders, examine data. Not privatisation but the system coming together. Previously the system was, "Make them well and send them back to the environment that made them unwell." This is changing.

b. **Dr Iain Kennedy, Highlands of Scotland.** Scotland doesn't work at scale. The clusters are unofficial and not necessarily geographical. However, there is some success in the Highlands. Cromarty (25 miles NE of the Riverside practice), Riverside (Inverness) and Foyers (20 Miles SW of Riverside) have joined with a lead GP Partner, a salaried GP and a nurse practitioner in each practice. Benefits: one culture and one strategy; stability for two rural communities; easier to recruit because of the variety; retention improved by variety; more attractive to trainees. Challenges: business case; dealing with the Health Board; outgoing GPs playing hard ball; increased travel costs. Recommendation: embrace working at scale.

c. **Dr Peter Horvath-Howard South Powys, Wales** Cluster in South Powys taken as an example. GPs have developed bottom-up their multi-disciplinary teams – Community Interest Company set up (Red Kite Health Solutions) to improve the length of appointments etc. those who need us rather than those who want us.

d. **Dr David Ross, Northern Ireland** It took 5 years but all practices are now members of federation and each federation is established, or being established, on the same principles where a representative GP from each practice sits on their Federation Board and each Federation has a Federation Support Unit. The organisation costs about £1 a patient.

BREAKOUT SESSIONS

Conference members were given the opportunity to join one of three groups, to concentrate on issues of Representation, Nuts and Bolts, and Continuity vs Access.

Report from attendees:

a. Continuity v Access. Dr Ben Lees reports that his break-out session was on continuity vs access. Essentially, there was resounding support from GPs of all paths that continuity is incredibly important, truly affects outcomes and is sadly being sacrificed for cost or for access to the detriment of patient care.

b. Representation. Dr Roz Bounds attended a group which were looking at how you improve and maximise engagement of the LMCs with PCNs and at how you build some control over outside agency pressure. Suggestion at the outset that the question be turned around to ask why there are difficulties in working together.

There is a degree of mistrust within the profession about the process of the setting up PCNs and the danger of allowing CCGs to completely take control of the process. From the start we need to set the right ambition. The aim would be to keep high levels of communication but to argue within the room and have a single voice outside it. Remembering always that the overwhelming goal relates to live outcomes for patients.

It is important as we learn to work at scale that we overcome historic rifts between practices and find a way to negotiate within clusters. Clinical directors from different areas need to also have a platform for communication. There was a suggestion that eventually we should move towards clinical directors being LMC representatives. Remember that PCNs are not meant to be management arms of health boards, we must vigorously maintain a GP led service, bringing in resources to individual practices with fairness and inclusivity.

The situation in NI was highlighted where the GPs demanded £16m out of the prescribing budget to put pharmacists in every practice. Convergence brings power. Negotiation for instance can bring break clauses with secondary care contracts

c. 'Nuts and Bolts'. Drs Yerburgh and Fielding attended the breakout group addressing the financial and contractual issues of working at scale and interoperability of IT systems.

The views of the rather large group were varied and contradictory, as was the final summing up by the GPC panel. They seemed to suggest that expert legal advice should be centralised and given to LMCs but then said that LMCs/networks should individually take legal advice, especially regarding issues of data sharing and contractual risk.

The main summary point for IT interoperability was that we will be waiting forever to get a perfect solution and so to go with what is local on the ground at the moment and wait for the IT to catch up.

DAY 2 – AFTERNOON SESSION

CHARITIES

Dain Fund

29. RECEIVED: Report by Chair of the Fund Dr Bill Strange. Funds for doctors, or families of, in distress.
(See more detail of this fund at https://www.bma.org.uk/about-us/who-we-are/bma-charities)

Claire Wand Fund

30. RECEIVED: Report from Trustee of Fund Dr Russell Walshaw. Provided funds for GP research projects and memorial essay prizes.
(For applications see http://www.clairewand.org/application-process)

Cameron Fund Annual General Meeting

31. RECEIVED: Report by Chair of Fund, Dr Gary Calver. Helps colleagues in need. >£3000 obtained from collection at dinner last night.
(For more detail see http://www.cameronfund.org.uk/content/about-us)

CONTINUITY OF CARE

32. CONFERENCE OF ENGLAND LMCs: That conference instructs that policy makers should prioritise GP continuity of care over extended access, as there is mounting evidence that this is cost effective, improves mortality rates and patient satisfaction and reduces A&E admission. Motion carried.

INTEGRATED CARE AND WORKING AT SCALE

33. AGENDA COMMITTEE PROPOSED BY LEICESTER, LEICESTERSHIRE, AND RUTLAND 'Conference believes that the development of primary care networks will not improve general practice, and will undermine the autonomy of GPs.' Submissions for the motion were prior to negotiations for the new contract. Motion defeated.

PRIMARY/SECONDARY CARE INTERFACE

34. AGENDA COMMITTEE PROPOSED BY OXFORDSHIRE: Conference is concerned by the lack of consent of GP of work transfer. ('Work dumping'). GPs are being encouraged to work beyond their competencies. No GP should be pressurised into prescribing medication outside their competence. GPC UK should influence commissioning organisations to ensure appropriate discussion and funding. Motion carried.

ON LINE GP SERVICES

35. AGENDA COMMITTEE PROPOSED BY HULL AND EAST YORKSHIRE: Conference is concerned about the emergence of various IT solutions that are non-evidenced based, untested and poorly regulated. There is concern re on-line GP consultation apps such as 'GP at Hand, 'chat bot', and who bears legal responsibility for these services. Motion carried.

COMMISSIONING AND SERVICE DEVELOPMENT

36. AGENDA COMMITTEE PROPOSED BY BEDFORDSHIRE: That conference, with regard to the commissioning of urgent care services, calls for government to address the problems, of ambulance delays, GP services should not be 'urgent care, and NHS 111 and equivalent should not mis-direct patients. Calls for an ambulance to attend a GP surgery should not be de-prioritised. Motion carried.

REPORT BY THE CHAIR OF GPC SCOTLAND

37. RECEIVED: Report by the Chair of GPC Scotland, Dr Andrew Buist. The new contract is a foundation, not a 'quick fix', and will require serious hard work if it is to succeed, especially in rural areas.

REPORT BY THE CHAIR OF GPC WALES

38. RECEIVED: Report by the Chair of GPC Wales, Dr Charlotte Jones: Health Boards have been unwilling to release control over primary care, and many doctors and PHC teams feel disengaged. They look with interest at N.I. Federation model. Succession planning in GPC Wales has fallen down. She recounted her experience of being 'trolled' because of her role. She is standing down from GPC Wales, and received a standing ovation.

QUESTION THE UK CHAIRS:

a. Support on collaborative payment arrangements? GPC still working on it to achieve agreement between NHSE and Local Authorities Association

b. Employers superannuation rate: will Scotland also provide cover for increases? Working on it targeted to practices that actually need it. Northern Ireland has no solution yet. The payments to practices need to be reviewed as the current system is a disincentive to recruitment. Note that the increase is related to the discount rate. Wales are also hoping for a positive announcement shortly.

c. What can GPC do to more proportionally represent GP population percentages? To be discussed tomorrow at GPC UK meeting.

d. Any plans to future proof the role of the LMC in England? Since PCNs are practice contract based it places LMCs with an opportunity to engage with practices in their area.

e. Trolling – what can be done? Basically, ignore it, but the police will sometimes intervene, officially or unofficially, if the troll can be identified. However, please report specific examples to the GPC.

PENSIONS

39. AGENDA COMMITTEE PROPOSED BY DEVON: That conference notes the inflexibility of the NHS pension scheme and the problems of the recent HMRC changes in annual allowance are causing, and asks the GPC to negotiate for GPs to be able to adjust their contributions on an annual basis, avoid 'stop start' contributions, help PCSE manage the scheme better, help to retain older GPs, and ensure sessional doctors have the same benefits as the rest of the workforce. Motion carried, with i) taken as a reference, because it referred to percentage contributions on an annual basis rather than, as had probably been intended, the percentage of hours worked on an annual basis.

Motion 375 from supplementary agenda: Conference concerned about Government's proposals setting an annualised rate of pay when working out pension contributions. This is unfair and discriminatory, and provides a disincentive to do locum work. Motion carried unanimously.

REGULATION

40. HIGHLAND: That conference deplores bullying as an abuse of power that does not belong in our healthcare culture. In some areas, NHS England attempt to interpret the GP contract in contradictory ways to bully GPs into changing their provision of services. Motion carried overwhelmingly.

41. DEVON: That conference would like to ask the new Secretary of State for Health and Social Care for more precise details for his IT solutions to the GP recruitment crisis and asks him to distribute these via '# the missing 5000'. Motion carried unanimously.

CLOSE 16:30

Dr Penelope West
Medical Secretary