15th March 2018

All LMC Members and LMC staff

NOTES FROM THE LMC UK CONFERENCE 9TH MARCH 2018

Attendance. This LMC was represented by Drs Fielding, Hodges and Skene, with your Secretary attending as an observer. Your Chairman was present in his capacity as a GPC area representative.

Keynote speech. Dr Richard Vautrey, UK GPC Chair, gave the keynote speech covering:

- GPs' dedication should not be exploited or scapegoated. To do otherwise is unsafe and dangerous.
- Openness is essential to learn from system mistakes.
- To stop medicine errors there should be a fully funded pharmacist in every practice.
- The resourcing of mental health access for patients has to improve.
- Practice teams should be rebuilt, perhaps at cluster level.
- About indemnity, GPs should have equity with hospital colleagues to address the "tax on pay" that exists currently.
- A fundamental review of premises arrangements is necessary, with the NHS sharing the risks in order to stabilise practices.
- The independent contractor model needs re-invigorating.
- The registered patient list must not be 'cherry-picked'.
- The 10 years of underfunding must be corrected – "Enough is enough!"

Common Theme – "Make it real; put it in the contract" (where 'it' refers to funding). This phrase was stated over and over again by many speakers, taking the lead from the new Scottish contract which sets GPs up as expert medical generalists with a much-simplified contract, and with more money in their contract also. The Scottish GPC put their success in arranging this contract down to the mutual trust which had been, over three years, cultivated between the Scottish Government and the GPs. The general theme was that it would be much easier to have the GMS better reimbursed than to make practices chase minor enhanced service payments. The difficulty would be that in England there was no such trust.

Themed debate – workload.

- The culmination of this debate was an impassioned, and tearful, plea from one young GP, who had several times gone to the brink of breakdown through workload stress, crying out, "Change the environment so that I don't have to become more resilient!" This won a well-deserved standing ovation.
- Other points raised in the debate:
    - The contract requires GPs to meet the reasonable needs of patients in a manner decided by the practice. Several speakers suggested that practices therefore have it in their power to set the number and length of appointments without reference to others, so long as what they are providing falls within the terms of their contract.

- Norms in other countries averaged at 1,250 registered patients per GP, no more than 25 appointments in a working day (with more than 35 being deemed unsafe), appointments lasting 20 to 30 minutes and a strict 8-hour day.
- Proper data collection was needed to prove assertions of overload etc.
- Dr Yerburgh suggested that what really should be studied, and data gathered to support it, was the underlying causes of excessive demand, as the UK has consultation rates 2-3 times higher than comparable EU countries.

- The BMA's '*Workload Control in General Practice'* pamphlet was issued to all attenders and a series of electronic votes was held to discover what support it had, as under:

	Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
Agree the principles outlined in the paper and work with other organisations to promote its introduction	15	11	13	40	63	123
Undertake further work to specify precise safe limits to workload in practice settings	12	6	8	19	43	200
Produce resources for practices and locality groups with examples of how this model of working can be introduced	16	16	12	32	50	159
Endorse a locality approach which supports groups of practices or LMCs in setting their own safe limits	66	31	23	33	44	99
Collect and publish examples of hub-based working and workload control from around the UK	40	11	24	34	44	135

The GPC is now seeking positive examples of how to control workload. Do we have some?

GP Defence Fund. GPDF's aim was to increase support to GPs while ensuring adequate national representation.

- The voluntary levy for this year would remain at 6p per patient, unchanged now for three years. The new Board, composed of LMC representatives, would decide any future rate of the voluntary levy.
- The GPDF's financial disputes with the BMA had been settled.
- The GPDF were keen to have direct engagement with LMCs and to implement this would be surveying them about what the needs of LMCs were that might need GPDF support.

Questions to the Executive. There was general concern that although the Conference might pass motions requiring the GPC to achieve something the GPC lacked the leverage to do it, as had been proved many times over the last few years. There was also concern that different practices providing the same service were rewarded very differently, largely by historical patterns being perpetuated; what was needed was equal pay for equal work.

Sessional GPs Sub-Committee Report. The vast majority of LMCs had sessional GPs on their committees; nearly three quarters of LMCs had dedicated seats for sessional GPs. The difficulty was

to fill them, and to find the contact details for locum GPs. The Gloucestershire example of a significantly increased contact list for locum GPs after abandoning the £25 nominal levy was quoted.

Trainee Sub-Committee report. For the first time a report was heard from the Trainee Sub-Committee, which was well received. There was a new LMC/trainee guidebook and the value of creating links with trainees was stressed.

Soap-Box session. This gives a chance to briefly raise items that are not on the agenda. Points raised included:

- All GPs leaving the profession prematurely should have exit interviews with the LMC, not so much to urge them to stay but to identify what motivated them to leave.
- GPs generally should be positive in expressing their views on general practice. How otherwise will potential GPs be encouraged to commit to that career?
- Partnerships can keep their GMS contract when converting to being a limited company. Not straightforward, but it is possible.
- Placing sexual health with Public Health authorities was a backdoor cut in NHS funding.
- Dr Hodges pointed out that NHS 111 is a political vanity project that wastes resources, sometimes at an order of magnitude from the normal.
- The performers list regulations should be amended to allow doctors coming from abroad to work more easily in general practice.
- The standard of proof at GMC investigations should be the criminal rather than civil standard – 'beyond reasonable doubt' rather than 'on a balance of probabilities'.
- The 1.6 mile radius round a pharmacy rule is unfair to patients and limits patient choice.

Other debates. As usual, the motions provided for debate by the Agenda Committee were largely unexceptionable and usually were voted in by huge majorities. You can read these in the agenda on-line now and in due course the GPC will be publishing a full list. Where the outcome was less clear an electronic vote was held, which usually proved in favour of the motion. Three motions, in particular, need to be brought to your attention:

- Conference was concerned at the scapegoating of individuals when the health and social care system as whole was inadequate or at fault. With an overwhelming majority conference passed a vote of no confidence in the GMC as a regulatory body. This is the biggest shift in policy for many years. The full motion read:
  'That conference, following the recent case of Dr Bawa-Garba:
  - *(i) Has no confidence in the GMC as a regulatory body.*
  - *(ii) Directs GPC to advise GPs [to] disengage from written reflection in both appraisal and revalidation until adequate safeguards are in place.*
  - *(iii) Request the Health Select Committee [to] review the GMC's conduct regarding this case.*
  - *(iv) Mandates GPC to urgently implement a system whereby GPs can make collective statements of concern regarding unsafe care.'*

- Hertfordshire LMC proposed the following controversial motion: *'That conference believes the survival of the profession should take precedence over the survival of the NHS.'* (This LMC had proposed a motion with similar effect but it was not debated.) Some years ago such

an idea would have been soundly defeated, had it been debated at all, but this conference passed it by 92 votes to 61. Note that the intent was not to make light of the value of the NHS but merely that, as the bedrock of the NHS, general practice must be preserved as a first step.

- A call for two-day UK LMC Conferences to be reinstated was lost (it failed to gain a 2/3rds majority vote.) Similarly, a suggestion that national one-day conferences should all be held the day before the UK Conference at a location rotating between the 4 nations was narrowly defeated by 68 votes to 61. However, a vote to move the UK Conference to May was carried.

M J D FORSTER
Lay Secretary