



*North Staffordshire*  
LOCAL  
MEDICAL  
COMMITTEE

# Annual Conference of LMCs 2017 – Report for GP Practices

## Introduction

Three of our LMC officers and our practice liaison officer attended the annual conference of LMCs in Edinburgh last month. Below follows a brief report of discussions over the 2 days.

### Day 1

The GPC's chairman Dr Chaand Nagpaul gave an account of the work done by the GPC on behalf of GPs in the previous year. This included getting the government to recognise that General Practice is under unprecedented pressure, as a result of which they committed to additional investment in General Practice supported by the GP Forward View, a stable GMS contract agreement for 2017-18, multiple "Focus on.." documents (providing guidance for practices) and much more. Of course there was also a ready recognition that all this will not be sufficient to rescue practices under pressure, and that a significant shift of funding from secondary care to primary care, in particular General Practice, will be required to help colleagues survive.

Directly linked with this was the first motion at the conference highlighting the fact that the current funding formula for General Practice is unfit for purpose and that the Carr-Hill formula is to be reviewed and total GP funding to be increased.

The lack of reliable occupational health services for GPs and practice staff was condemned, and concern was raised about the conduct of Medical Indemnity Insurers who on occasions refuse to insure colleagues without reason. A government led national indemnity scheme was called for.

There was a request for disincentives for GPs to remain in the pension scheme to be removed and to allow GPs to superannuate less than 100% of their NHS earnings (where desirable). It is unlikely though that GPC can gain any concessions about this as it is part of national pension policy.

A big topic of discussion was the seemingly open-ended commitment GPs face in providing General Practice services to patients, as it is not defined in our contracts what we are, and what we are not responsible for. There was a motion asking for a definitive list to clarify what is included in GP responsibilities, but this motion was lost as many felt that it would be more helpful to focus on what we cannot be expected to do. The [GP Quality First document](#) already provides us with guidance on what we are not responsible for, but in addition a national list is being drawn up of all enhanced services commissioned in the country, which by definition determines that those commissioned activities are not part of our core contract.

In the afternoon of day 1 followed break-out sessions with themed debates. 4 of these debates were attended by your LMC representatives:

## 1. Contractual status:

There was overall strong agreement that the partnership model remained the best core option for the stability of general practice. However 3 main issues were developed which either support or undermine this – safety of the service (linked to indemnity), sustainability (linked to workload, especially admin) and succession (linked to leases and last man standing). This was making locum, then salaried then partner the diminishingly attractive option. Purely salaried services in Wales were costing an additional 64% premium to provide the same service. Most locums don't do admin. There was a general feeling that the total salaried option would not be viable as the numbers required would be unattainable. There was also recognition that skill-mixing can partially mitigate but GPs still remain responsible.

All this is being addressed differently in the devolved nations. A key theme was actual ownership of the service and care delivered to patients. If there isn't ownership, the service declines, but currently ownership itself has become increasingly toxic, which is perverse in a caring holistic system. This has to be addressed and actually it seems the system has failed beyond a critical point in many parts of the country, meaning that alternative and extreme measures will have to be taken.

STPs transferring unfunded or double accounted work onto a collapsing primary care is a recipe for complete disaster, but is also happening everywhere. However, some federations seem to be jumping for this completely and beyond the GPC guidance of level 1.

## 2. Working at Scale:

There was a brief summary of current models of working at scale to set the scene, and many in the audience shared their experiences, most of which was positive. Models highlighted were the 3 super partnerships in Birmingham (MMP - 70K patients - 12 sites - 1 contract - fully integrated, OHP - 350K patients - 44 sites, maximum autonomy - cost centre model - levy £2 pp/year, Modality - 150K patients - 4 sites - web based triage - more salaried GP model). Federations have more loose arrangements. We discussed MCPs, Hubs and the need for GPC to produce blueprints for successful models of working at scale to facilitate adoption/development by other practices across the country. North Staffs LMC is hoping to facilitate a coming together of practices later this year, should there be a demand for this.

CCGs are being asked to fund practices £1.50 pp for 2 years to help facilitate transformational change and working to scale, amongst others to try and improve practice resilience, allow flexible working arrangements for a multidisciplinary workforce and influence the shape of integrated services.

In amongst all this the conference was unanimous in their view that a registered list should remain at the core of General Practice service provision.

### 3. GPFV/urgent prescription for General Practice:

An open debate on GPFV was held on the first day of conference. The session was well attended and discussion was lively with the vast majority of the participants having very negative views about GPFV and what is actually being delivered at Practice level.

It was clear from the comments around the room that monies for the various elements of the GPFV have not been forthcoming from CCG's and many LMC's are struggling to have any dialogue with their CCG's about the funding.

It was felt that the GPFV is not addressing the main issue of workforce and that there have not been any positive changes over the last 12 months on this matter. Delegates in the room felt that the money in the GPFV should be paid directly to Practices in the global sum and it should then be up to Practices to spend this money appropriately.

The outcome from the debate was 2 additional motions for presentation on day 2 to all conference delegates:

1. That conference demands that GPFV funding be allocated directly to individual practices so that it will have a tangible effect at the individual practice level. (Carried)
2. That conference believes that the GP forward view is failing to deliver the resources necessary to sustain general practice and demands that GPC ballot GPs as to whether they would be prepared to collectively close their lists in response to this crisis. (Carried)

Note in 2 above that conference has mandated the GPC to ballot GP's on the issue of collectively closing their lists due to the workload pressures, workforce issues and transference of work from the acute sector.

### 4. Workload

This was a discussion about the ever-increasing workload pressures facing us. 4.5% of GP appointments nationally are taken up by patients regarding booking or rearranging their hospital appointments or to chase up results from hospital investigations. This equates to 15 million GP consultations per year.

Nationally LMC's reported good uptake of the BMA Quality First templates which included the contractual requirements secondary care trusts should comply with in reducing the burden of inappropriate transfer of work regarding fit notes, chasing hospital investigations and appointments. The success of this is also dependent on the CCG enforcing any breach of contract. Template letters can be accessed on the BMA website [here](#) along with downloadable versions to integrate into your clinical system.

### **Management of list size**

While formal list closure requires liaison and agreement with NHS England, practices do have the option of informal suspension of registration if there are 'reasonable and nondiscriminatory grounds for doing so', (such as protecting the quality of patient services.) Further details can be found [here](#)

### **Reducing non-core work**

It was encouraged for practices to review the enhanced services they offer and look at the overall profitability and the bottom line figure in relation to the workload resources they involve to decide whether they should continue to provide these services.

### **Home visits**

A reminder that home visits are not a requirement and so should only be undertaken if in your opinion, the medical condition requires it; it is not at the whim of patients to demand a visit, rather the decision of the practice and GP to provide care in the appropriate setting within a reasonable time frame. Link back to our [North Staffs LMC Visiting guidelines](#) (page 5 provides an at a glance summary).

### **Safe working limit**

Members debated the motion of capping the number of GP consultations to ensure provision of safe care and reduce decision fatigue. South Staffordshire LMC proposed that this should be capped at 25 contacts per day in line with colleagues across Europe.

While the actual number may be contentious, there was consensus that like industries such as aviation and transport where mandatory rest periods are required, we should define what a safe working limit is. So where are our safe limits? In a recent [BMJ article](#) James Badenoch QC warned that workload pressure would not be a defense against clinical negligence. Conference passed motion 509 to define a maximum safe working limit.

## **Other Motions discussed**

Amongst other motions discussed and unanimously supported that afternoon was a motion to request that criteria for categorisation of violent patients be expanded, to include unacceptable behavior outside the practice, as currently only patients who have perpetrated a violent act inside the practice can be referred to the violent patient scheme.

As the issue of premises funding and costs looms large in our area we were very pleased to see an urgent call for GPC to address the significant threats practices are facing in relation to their premises. A more detailed 5 point motion submitted by North Staffs LMC on this subject was not heard as we ran out of debating time!

The LMC has had extensive discussions with other LMCs facing difficulties with NHSPS and CHP premises payments in their area and we are made to understand that a national solution is expected to be brokered in the next 1-2 months. In the interim we are planning to issue practices locally with further guidance whilst discussions with the local area NHSE team continue.

## Day 2

Day 2 of the conference again saw a wide variety of motions being discussed. This ranged from the way in which GPC representatives are selected to a debate on the proposals which arose from the break-out groups on day 1 (themed debates).

It was proposed and agreed that all foundation programmes must include a dedicated General Practice placement, and that GP training should be extended to 4 years, with a minimum of 24 months spent within General Practice.

The chairs of GPC of the 3 devolved nations gave their report to conference, and the Scottish plans for a new GP contract in particular drew ample attention and admiration. Although they will be expected to work in larger groups, they will retain their personal lists. They will no longer be providing vaccinations and will receive a number of support services, including a repeat prescribing service. Your secretary is considering his options should Brexit negotiations force him to leave England...

In further debates Sustainability and Transformation Plans (STPs) were considered undemocratic, fundamentally flawed and causing division between services with inevitable cuts in services.

In the soap box session many differing General Practice issues were highlighted. Concerns were raised about clinical records, e-referrals and the CQC, whilst a discussion on EU nationals resulted in the agreement to campaign for an early and positive decision by the government on the right of EU nationals working in General Practice and in the wider to remain in the UK.

The themed debates concluded the day, from which it was agreed that (amongst other things):

1. The GPC is to show leadership and engage the country in debate on what (if anything) should be rationed in the NHS
2. The GPC is to produce a discussion paper outlining alternative funding options for General Practice, including co-payments
3. The independent contractor status must be the basic model of for General Practice
4. All employment options should be open to all GPs
5. The GPC is to develop a framework that would limit the financial and employment risk for contractors, and incentivise the partnership model
6. The GPC negotiates a safe maximum number of patient contacts per day
7. The GPC negotiates clear legal parameters for where a GP's duty ceases, in case of omissions by other parts of the NHS

Somewhat more controversial was the debate on the GPFV and Urgent Prescription for General Practice. It was felt and agreed by a majority that the GPFV is failing to deliver and that the GPC should ballot GPs as to whether they would be prepared to collectively close their lists in response to the crisis in General Practice.

Full details of the Conference Agenda and video links can be found [here](#) and a summary of the outcomes can be found [here](#)