SOMERSET LMC

LMC Conference, Thursday 18th May 2017
Morning Session

Chaand Nagpaul: NHS paralysis in funding with "savage austerity cuts" and a breakdown in relationships after the junior doctors' strike. Despite this GPC had achieved the end of the AUA, full reimbursement of CQC costs and expenses in rise to MDO fees, no more discretionary funding on sick cover and increase in Global Sum of £85 per patient, "still nowhere near enough."

But the avalanche of unfunded work transfer, the shambles of workforce planning means primary remains in crisis. The real solution will be a political one with increased funding and numbers of doctors. The NHS needs a larger share of national wealth with primary care requiring more of that quantum. If the 1:4 of needless appointments could be avoided, if precious appointments were not wasted, then there would be no need for fatuous targets like "5000 more GPs." Contractual changes for hospitals to bring about internal referrals and communication of test results and Fit Notes without recourse to GPs had been achieved. Next year prescribing changes would be negotiations to reduce "work load dumping" but the mindset of decades in hospitals would have to change: CCGs would have to be held to account by LMCs.
A 6% reduction in GP capacity would double A&E attendances so moving GPs into EDs utterly missed the point.

Self–care initiatives for patients were vital and the Quality First scheme had received 60,000 views.
NHSE would be held to account over the GPFYFV and its balance sheet was being scrutinised. Grassroots GPs would be brought into contact with senior NHSE managers to make sure they knew about the mismatch between national policy and local implementation.
CCGs faced with hospital deficits must show leadership: starving primary care would only make this worse.
The idea of 8–8 opening across seven days had been challenged and could be implemented flexibly and these hard–won changes must be used.

There were record practice closures, the domino–effect of partnership retirement could affect the most apparently stable practices. The OOH cooperative movement had saved GPs from the unstainable 24/7 responsibility and this collective mentality, from the grassroots upwards, drawing on the independent partnership model and unleashing entrepreneurial instincts.

Financial collapse due to PropCo service charges was a risk to some of the most vulnerable, caused by another part of the NHS.

Outsourcing to Capita had been a disaster with cost–cutting commercial practices leading to falls in quality which, if applied to a practice at only a fraction, would be punished by CQC.
Parity of esteem for all GPs was vital: patients did not care if their GP was a partner, salaried or sessional doctor.

Partners were under tremendous strain however but the collapse of the partnership model would sink the NHS. Working for commercial providers would mean having to accept very different standards.
The GPC had done well to raise the awareness of the crisis in general practice. The Prime Minister's attack on primary care in January had been a disgrace and had been robustly defended by the GPC.
He welcomed the formation of an English executive to recognise the reality of devolution but the representatives of the four nations remained in close contact. He particularly mentioned the plight of Northern Irish GPs and pledged undying support to loud applause.
GPC contacts to LMCs was "more important than ever before" was now "unprecedented" and needed "mutual respect" to go forward.

We had seen troubled times before, what we did for patients, despite constraints, trumped political promises. The general election outcome must deliver the £10b funding gap.
The speech was well–received with the traditional standing ovation although some observed this seemed to develop more slowly than in previous years and did not last as long.

Kent proposed that more funding into core practice budgets. Carr–Hill was a joke and was out of date in 2004. Practices did not need an "urgent prescription but resuscitation." Lincolnshire spoke against the motion but "because it didn't go far enough." More weighting to deprivation, isolation, and rurality was required. Another speaker spoke about the demands made by the proper care of the elderly with multiple problems. Carr–Hill did not reflect this. Hertfordshire spoke against the motion as failing to meet the problem which was the overall "size of the cake." Derbyshire supported motion saying that primary care needed half as much funding again to provide top quality care but added burdens had eroded this for the very best. We now needed double the money now, not in five years' time, and it needed future proofing. Gwent said funding had been a problem for 30 years but the 2004 contract had undermined Carr–Hill leaving the need for a MPIG. He thought that Carr–Hill was now working as it should, diverting care to those in greatest need, a new formula could be even worse. Hampshire and Isle of Wight supported the motion with particular reference to nursing home patients who, these days, tended to be in step–down beds often in brief stays for end of life care with expensive prescribing and dressing needs. Present funding did not reflect this.

Chaand Nagpaul pointed out that review of Carr–Hill was already underway in England. Both a bigger cake and a better formula, and one that took into account fixed practice costs, was what was required. Kent's proposer summed up in song (as is traditional) to massive applause. The motion was passed nem con.

The next motion concerned occupational health and was proposed by a sessional GP. She deplored the shameful, patchy coverage and the requirement for hard–pressed GPs to pay for parts of the service. The provision of care for doctors facing emotional burn–out in the FYFV should be unnecessary as proper OH services should be readily available. A City and Hackney speaker supported the motion asking where were the comprehensive OH services promised by Simon Stevens? Patient care would be improved by an equitably available service for all staff. Islington reiterated the message: as a portfolio doctor he was frustrated by the variation of care available. A Hampshire and Isle of Wight, who worked for a charity working to reduce suicide in the profession, spoke about the key interface between work, physical welfare and return to work needed expert advice. An emergency speaker from Tower Hamlet pointed out that the London scheme was now available across the country but, regrettably, only to GPs.
The final speaker from Lothian spoke of the disparities across the nations and commended the comprehensive OH scheme in Scotland.
The motion was passed unanimously.

Indemnity was the next topic with it being deplored that MDOs did not have to give a reason for turning down a doctor, calling for GPs to be allowed a "right of reply" and alternative "national indemnity scheme." A Devon speaker said that the rise in costs could soon be prohibitive for many. Scots GPs paid a third of what English colleagues paid. "Were they better doctors?" he asked naively. Mark Sanford–Wood answered for the GPC asking for support of the motion. He described work on peer review of cases on refusal and this motion would strengthen the GPC's hand. Conference duly obliged.

The next motion also concerned indemnity. The proposer spoke of the annual lottery of discovering how much one had to pay next year. She welcomed the progress made by GPC in England for the increase in fees for GMS–only work, not in new models of care. This was a start but a payment on the basis of list size was not fair given the variation in costs and wanted direct and full reimbursement across the UK. A speaker from Northern Ireland told how even the partial English improvements had been refused. Hampshire and Isle of Wight deplored the lack of mention of sessional GPs in NHSE's response to urgent care indemnity. The cost of clinical negligence would be massively increased after the recent Lord Chancellor's decision on

the discount rate could make indemnity unaffordable for all. If a solution for OOH could be found, why not for core work? Across Europe indemnity was either state–funded or amounted to 2–3% of income. One Portuguese colleague was reported to pay €90 a year (sic). A GPC speaker said the problem was clear and that "enough was enough" and urged GPs not to re–indemnify for OOH in August: it would not be a strike, would be legal and we had been propping up a broken system for too long. Another said that only a national reimbursement as per CQC would prevent surgeries from closing next year. The chairman of committee agreed and spoke of the "staggering and eye watering amounts of money" which would be needed to cover the rises which would result from the change in the discount rate.

The section of complaints was next and we heard some harrowing reports of the present, wasteful system and the tremendous strain on GPs as a consequence. Somerset's motion on combining the NHSE performers' list and the GMC GP register received a sympathetic hearing and a small amount of amusement at Capita's expense.

Motion 11 was about complaints and feedback and how anonymous online comments could amount to trolling and cyber–bullying. It was without dissent.

Questions to the chair of the sessional subcommittee followed. She made an ironic admission of her contribution to the NHS crisis being a woman, at the mercy of her ovaries, and a locum to boot. She pointed out that locums were nowadays often older, ex-partners and sometimes forced out of regular work by pressures in the system, usually working in a small range of practices. Adding demands upon them would force them out of the workforce altogether. Most salaried and locum doctors believed in general practice and did not "work in a bubble" removed from reality. Money–hungry doctors willing to take last minute bookings anywhere were rare. Some practices were entirely staffed by sessional doctors. Politicians needed to know that although many made a choice to work in sessional roles but many others had no choice but to protect their health by taking that route. GPC was pushing for up to date information from the Performers' List (cries of "good luck!") so that LMCs could represent all sessional doctors. Emailing practice managers was not a good way to contact sessional GPs to keep their pension contributions accurate. Protection for all GPs working in new models of care would be required to empower them to say "no" if needs be. She was as angry about a locum who failed to show up as she was to learn about a practice that cancelled a booking at short notice. The profession needed to stand together or would fail together. Derisive comments was about dividing and ruling whether it was sessional versus partners or hospitals against primary care. Speaking out over deficiencies was not "talking down the profession" and damaging recruitment.

Questions included how LMCs could best communicate with sessional GPs given Capita's shortcomings? Zoe Norris directed us to advice on the website but would continue to press the private provider. How would the GPC protect the choice to be freelance in the era of superpartnerships. The monopolies created would try to dictate ways of working and it was necessary for GPC to drive the process before it was imposed. How could LMCs collect a levy from sessional GPs? Dr Norris thought that the provision of services and good engagement would help to achieve this. IR35 still caused anxiety in practices employing even short term, ad hoc single trader locums who were manifestly not covered by its provisions. Who would fund LMC representation for large scale all–employed organisations.

A young locum of six years' standing spoke of his isolation "hidden in plain sight" but had created his own support network. Now he found himself in a larger group as more GPs gave up partnership. Locums needed to be able to fill gaps to keep the system going: NHSE had to take them into account. It was acknowledged that locums were allowing representatives to attend today. A speaker against the motion spoke of the lack of interest in partnerships in Northamptonshire. GP partners needed support and so allowing locum fees to rise inexorably was not an answer, no matter how much we needed to avoid collusion with dividing and ruling.

John O'Dowd opened the debate pensions for Somerset. He made a good joke about actuaries being people who found accountancy too exciting. New models of care providers could not always offer NHS pensions as GPs were considered subcontractors. He spoke knowledgably about the tax disadvantages which could arise from the new limits in pension contributions which were encouraging older GPs to reduce sessions or retire. On the other hand flexibility in contributions could be attractive to younger GPs. Tongue firmly in cheek, he called for a "deep dive" into pension reform. The chairman of subcommittee pointed out that negotiating with HM Treasury on universal tax law was not likely to be useful. Regrettably getting a single form for locum superannuation was unlikely. Variable contributions could be dangerous. Voting in parts carried the first three easily but the fourth part on variable contributions was narrowly carried by 148 to 122 on an electronic vote.

Motion 14 was another attempt to define a core contract to protect the provision of important services to patients currently under pressure from unfunded transfers of work and political hobbyhorses. Cambridgeshire opposed the motion cautioned against temptation of retreat into a fixed level service when times were hard. In fact it risked the essential holistic role of GPs as the last generalists. Constraining what we do could be a slippery slope: we needed to define what we did not do. Another speaker felt that micromanagement on a scale to make CQC look like a picnic could result from a defined core contract. There was, as it were, some safety in vagueness. Richard Vautrey told conference that the Conservative Party election manifesto, published that morning, spoke of a new GP contract. The motion was defeated comprehensively.

The morning concluded with charity reports and the AGM of the Cameron Fund.

Themed Debate 1

Your correspondent attended the "Bridging the gap" (rationing) themed debate after lunch.
The GPC lead introduction to set the scene talked about co–payments for non NHS services, encouraging self–care. Should "plan Bs" be made public by doctors? GPs all too often tried to bridge the gap between wants and needs. We were shown a wartime poster extolling the merits of rationing and fairness. The Quality First project was a form of rationing practice time. Patient education might not be the place to invest scarce resources. Guidelines often were a source of conflict with local constraints on what was provided. Public debates were always called for but where would these best take place? GDP proportion of health spend could be deceptive with an economic crash appearing to increase health spending. At the top end of the league table of public spending there was poor correlation with improved health outcomes. Comparative spending could be deceptive too as continental spending figures often included private funding elements. If purely public spending was counted the UK was much higher in the tables.
The discussion was thrown open to the floor and the concept of blackmail was explored: for a commissioner rationing could mean finding someone stupid enough to provide a service for less, or in the case of GPs, nothing. Monitoring of eating disorder patients in primary care was a good example. At this point a member of the audience asked cautiously if there were any members of the press present. There were none. A CCG GP said his group was looking at "health optimisation" for smokers or patients with a high BMI having to delay referral for six months. A Kent doctor was all for patient education but felt regulation could help giving the example of how demand for home visits had been reduced in this way. The likelihood of politicians telling the electorate what they were not going to get was unlikely especially before an election. A speaker recommended that a flat charge on all visits to practices, stated that existing legislation (from the 1950s Labour government) allowed for this. Such a charge would protect practices in low income areas most, he argued, counter–intuitively. A Yorkshire GP asked when rationing measures became discriminatory? An overweight patient who lost weight, but not the obligatory 10%, could be denied surgery whereas a smoker who kept on smoking for six months remained listed. A Newcastle GP introduced the concept of the macro–economic benefits of the return on health spending in a healthier population. On the micro–economic level of co–payments which had really started with e.g. prescription

charges. He was convinced, from experience in New Zealand, that extending co–payments with “a fight with every seventh patient” and consequent increase in health inequalities. An Avon GP spoke of the likelihood of a Conservative victory in June and so a need to live within our means. It was paradoxical that, whereas CCGs could ration, if GPs spoke about doing less to “cut the garment according to the cloth” there was outrage. If we were not to give up and hand in our contracts, we had to stop doing things unless they were funded. What sort of healthcare service was, another speaker said, could not be for one single group (even doctors) to decide upon. He would have welcomed a media presence. The fetish of public good, private bad was not necessarily sacred to all. The chairman pointed out that it was a democratic decision. We had to live with the public’s choice of government. However, no election campaign would focus entirely on the NHS and this one in particular had quite another preoccupation. A GP from Lambeth pointed out that many of his patients were from the EU and, although were delighted we did not have them, reported that health services did work abroad. A doctor pointed out that no politician would start the honest public debate and the GPC needed to stand up and be counted. He thought that the growing number of sessional doctors had effectively voted with their feet and were “working privately” and all options, no matter how unpalatable, had to be considered whatever was ultimately decided. In contrast, a Liverpool representative suggested that the GPC should counteract the myth that the NHS was unaffordable and that charging should never happen at practices. All that was needed was an 11% increase in funding. The triad of cost, quantity and quantity of care however made another speaker how “just paying a little bit more” could possibly keep up with limitless demand. A Northumbrian GP told us that and ACO was to be fully active there in a few weeks with practices and trusts sharing responsibility for the whole budget. She felt that the powers that be were terrified of the exposure of real problems which would result. Any attempt to point out that cuts were inevitable had been stifled by management and she called for GPC support. An LMC secretary pointed out the political risk taken by any party which promoted change in NHS funding. The bravery needed to refuse a prescription because it was free was described. Medicines optimisation might be re–enforced by the NHS only paying for the “approved” brands. A GP from Cornwall who had worked in Australia pointed out that doctors there did have a choice or some discretion on making charges. The long-term nature of the benefits any public education was stressed and linked to the fact that so many children seen in urgent clinics did not, in fact, need to see anybody but could be looked after by their parents instead. The concept of providing “good enough care" was raised as opposed to “excellent care.” Managing patient expectations of free care was too much in a ten minute appointment and was not our job. The open use of the word “rationing” was welcomed but it really was not appropriate for the discussion to happen in the surgery. Patient representation on CCGs was not adequate or representative of the wider public. Postcode lottery rationing was deplored. Changes had to be a centrally mediated message. Patients however, would always report rationing for someone else. Patients would always “want everything all the time” and so the GPC needed to take control of any debate about what GPs could not provide. A Lancaster GPC representative pointed out that views varied on the committee and was in favour of more speaking out but that the BMA was always anxious about whether the profession would follow? The London EU population that reported co–payments worked were, perhaps, not the most representative of those most likely to suffer. Think tanks were funded by private providers. GPs needed to point out that politicians had brought low our profession with their failings.

To counter this a Northern Irish GPC member pointed out that it was “a rough, tough world” and that the public wanted it all ways. If Theresa May said she would raise income tax enough to properly fund the NHS there would be a different result to that expected in three weeks’ time. He pointed out that his patients in the Bogside visited the GP 6.8 times a year whereas many in the South made do with 1.8 with similar outcomes. Hence politicians and civil servants had told him GPs were “seeing people too often for the wrong reasons and if you want to kill yourselves that’s up to you.” Politicians were only interested in secondary care. He thought that GPs in the rest of the UK “were in happyland” and NI doctors would give their right arms for the FYFV. A quarter of practices had already closed in the Province. Soon practices in England would reach a similar TINA (there is no alternative) moment and have face up to a direct financial relationship with patients. This was met with a storm of applause.

A doctor from Edinburgh spoke of the difference between “collectivism” and “consumerism” and that realistic medicine could only be delivered collectively. “Use your NHS responsibly.” A Tower Hamlets GP approved of this and explained how demand management could be a success.

In summary it was agreed to endorse motion TD1–5 from N Yorkshire for the whole conference to debate but, as this spoke of the whole NHS, perhaps the BMA not the GPC, should lead the public debate? However the BMA was judged to be too cautious and so it was decided the GPC should lead. There was debate about the wording that rationing was “inevitable” with arguments for “already happening” and that it should be a national (or UK–wide) debate. Consensus was hard to achieve in this new format of conference. However witnessing the gestation of a motion was interesting. A GPDF spokesman who warned about the cost of any campaign was shouted down, not because of its £12m war chest, but because that was a problem for another day.

A discussion document on the advantages and disadvantages of all options including co–payments was proposed.

Afternoon Session

The next section was about forms and fees. The proposer from Mid Mersey pointed out how little understood the true costs of reports were. The questions were poor too. Why did the DWP ask GPs about how patients used the lavatory? He called for a new settlement for a unified fees scale. A Devon GP spoke about the endless demand for sports and charity–related reports in her practice. What could the consequences of an ill–informed response? An Avon speaker pointed out that the CAB on its website referred clients to their GP with only small print suggesting that some doctors would not concur and that others might charge for a report. The motion was passed without dissent.

Motion 19 was about the revision to recertifying letters of competence in IUCD and LARC fitting and the fact that contracts had passed to local authorities had re–enforced the ”need" for these extra requirements which would be a barrier to provision. Sessional and GPs taking a career break would be particularly disadvantaged. Analogies with the mission–creep of appraisal in the name of “equity and patient safety” were drawn. However a speaker from Liverpool felt that the new demands were not so onerous and that she would have concerns about a GP who did not satisfy the requirements. Faye Wilson declared an interest in that she managed the outsourced contract in Birmingham in opposing the motion. In fact the number of practices and practitioners providing LARCS had increased. The chairman of subcommittee felt the motion did not go far enough and wanted to suggest a rider to the effect that all gynaecologists should provide regular evidence of competence in consultation skills. The motion was carried overwhelmingly.

Devon proposed a motion on the violent patient scheme which only recognised violence logged by the police in practices “inside core hours" an appalling flaw. Expansion of the criteria was necessary. There was no argument required.

City & Hackney proposed that charges could be levied by practices for services not commissioned for their own patients under the NHS. There was strong opposition spearheaded by Gwent who thought it was a thin edge of a wedge. There was more heckling than in previous years. A doctor from Derbyshire took a different view and suggested GPs could provide such services cheaper and better than private providers. Tower Hamlets was afraid of a two tier service and privatisation by stealth. Another Derbyshire doctor thought the status quo was bizarre. Greg “shorts” Place from Nottingham said that “a profession on the verge of collapse” could not say to patients “pay us and we can do it.” Richard Vautrey pointed out this had been passed six times since 2004 but thought the debate was necessary. NHSE had stonewalled the question. The motion was carried by what looked like a smaller majority than expected.

The interface with A&E was next to be debated. The redirection of GPs into EDs could only exacerbate the collapse in general practice. The evidence base for the effect of GP triage on ED performance was poor. A GP from the Isle of Wight encouraged the integration of OOH and EDs. She thought the opportunity to work in EDs might encourage to retain GPs in portfolio working. The Wirral also supported the motion citing a local QIA which had looked at a series of ED attendances and only a tiny number had attended because they had not been able to get a GP appointment. Cambridge opposed the blanket criticism of placing GPs in EDs. The chairman of subcommittee said that bed occupancy, the numbers in the department at 8am and the number of ambulance arrivals had most to do with ED business. None of these were in the gift of primary care to influence. However high quality, primary care could reduce ED attendances. The motion was carried except for the final part opposing the placement of GPs in EDs which was narrowly lost on an electronic vote.

A motion on transfer of work was proposed by Devon in an elaborate nautical metaphor. Patients out of their depth were taken to hospital ships by speedboats. Patients were being thrown back in before they could safely swim ashore to their GP. Avon spoke against one part of the motion stating that GPs should shape proper community services and take a stronger leadership role to ensure they worked. Harrow spoke of being fed up with the stream of unfunded work and it was time to say no to hospital colleagues. GPC said that GP was “a sponge” and described the motion as helpful to work under progress. The motion was passed without much dissent.

The 5pm debate was a critical one attacking Primary Care Support England (Capita), proposed by Leeds who wondered why the contract had not been taken away after such comprehensive failure? Changes in the PCSE senior management had occurred but it was time someone who knew what they were doing was allowed to take over. Derbyshire (supported by Avon) had written to the five major shareholders of Capita to apply pressure. He opposed NHSE taking back control as it too was a failing organisation. A GP trainee from Dorset supported the motion saying how salaries had not been paid. Chairman of subcommittee commented on NHSE taking over pointing out that SBS had been no good either. To the surprise of no one at all the motion was carried except for the part about NHSE taking over.
A rider calling for Simon Stevens himself be held to account for the stunning failure of commissioning was proposed by the redoubtable Faye Wilson. Despite caution from the subcommittee chairman this rebuke to the chief executive of NHSE the rider was carried overwhelmingly.

At this stage I was strong armed out of the building by a Somerset delegation eager to for whisky.

LMC Conference, Friday 19th May 2017

The Final Countdown

As Somerset returned to the chamber for the afternoon session we heard the disappointing news that our chairman had been called to speak in a debate on a motion which had been thought to have been lost, out of time, in an unexpected period of contingency time just before luncheon.

Questions to the chair of the GPDF were testy especially concerning the considerable reserves held by the company. We were reminded that all LMCs were entitled to nominate a member of GPDF. Transparency over honoraria payments was demanded to applause. Stewart Kay pointed out that GPC doctors required remuneration including for travel and for lost superannuation. A question about regional LMCs was answered with the statement that as these organisations did not take decisions they were to continue to be funded by locally unless and until the GPC decided otherwise. "Anything was possible."

Motion 38 was about APMS contracts which were expensive, short term and often failed only to be replaced with even higher priced deals. Providers repeatedly bid low and then collapsed. NHSE claimed the

risk lay with the provider but in fact risks lay in damage to patient care, continuity of care and to surrounding practices. We were called to ask GPDF to engage counsel to challenge the notion that only APMS contracts could be awarded when procuring general medical services. The subcommittee chairman said that expert solicitor advice two years ago had found no holes in the law. He also suggested that the BMA should fund any QC time. The proposer asked, in response, "What the hell is the GPDF for?" She also pointed out that with Britain's exit from the EU, procurement law could change. The motion was carried nem con.

Clinical records and the need for funding to allow the full digitalisation and subsequent central storage or even destruction of paper records. The space saved would be a godsend to cramped practices. Derbyshire questioned the exact wording of the motion while supporting the sentiment. Did we really want "all clinical records" to be digitised and held in practices? Hospital, dental, optometry and all? A colleague from the same county however supported the motion. The irrepressible Greg "shorts" Place from Nottingham pointed out that Army and some insurance reports demanded paper records. Who would centrally store them? Capita? The subcommittee chairman pointed out the vast amount of work that would be involved but was with content with the motion which was approved.

The idea of exclusive e–referrals was questioned at this stage of NHS development and, in any event, GPs should not be responsible for dealing with any queries resulting. In Wales, however, the new system seemed to work well and said that waiting until the NHS was "adequately resourced" was a hostage to fortune. Mark Sanford–Wood was content with the word "exclusive" and supported the motion. The substantive first part of the motion was lost but conference generously agreed that GPs should be troubled with the subsequent queries however.

CQC was next to be savaged with stories of only positive comments being received on the day of inspection only to be surprised by the report. Rating on NHS Choices had been cited but research on local practices found no such consistency. A national regulatory body should behave better with transparency and accountability expected. Practices should know what to expect from inspections, be supported through appeal processes, that CQC be more consistent and based on evidence. There was never any doubt of the popularity of such a motion which uniquely united the profession.

Conference was asked to support EU nationals being granted immediate right of residence. Despite the Conservative manifesto, published the day before, containing an unequivocal commitment that keeping 140,000 EU NHS staff would be "a priority" the proposer suggested EU national doctors might even be under the threat of deportation. Speaker after speaker was called to support the motion however some denied the need to conduct another workforce survey. This was in fact the decision of conference.

It was also agreed to add GPs to the UK Visa Bureau to add GPs to the UK shortage occupation list to aid recruitment from outside the EEA.

The next section was to consider motions resulting from the themed debates. 500 stated that NHS rationing was happening, that politicians refused to discuss this and demanded GPC to lead engagement in debate on what should be rationed. North Yorkshire had no fewer than 270 pathways offering barriers to care. Liverpool felt that actively challenging the concept that a publically funded comprehensive NHS would be a better policy. The GPC view was that this was a huge project and that doctors would be seen to have a vested interest, thus diminishing the effect of any such debate. The motion was narrowly passed with 130 to 112 votes.

501 instructed GPC to produce a discussion paper outlining alternative funding options for general practice, including co–payments. General practice was heading towards a "TINA" moment with half of GP trainees opting to work as sessional doctors. They had voted with their feet on the existing contract. Given the

current relatively poor health outcomes showed that the current NHS “all you can eat free buffet” contract was not working in patients’ best interests. LMCs should represent the profession delivering the best care, not necessarily in the NHS. An electronic vote carried the motion by 146 to 100.

502 asserted that independent contractor status should be the basic model for primary care and instructed GPC to ensure that all employment options were accessible to all GPs, to develop a framework that would limit financial and employment risk for contractors, whilst ensuring contractors could be incentivised to invest in partnerships and making sure that other workers were protected. Unsurprisingly the motion was supported.

503 considered mandating GPC to develop working at scale blueprints to cover everything from practices sharing back office staff all the way to superpractices, varying with local needs and geography. There was scope to reduce costs, increase profits and have greater influence in developments. We were asked to vote on a 1-6 basis to allow graded statements of support which Michelle Drage challenged as the word “mandate” in the motion without allowing for a binary vote was contradictory. Unfortunately standing orders did not allow wording to be altered. The chairman of subcommittee was content to accept the motion as a reference with the mood of the meeting taken into account. Sadly the result showed a random spread of opinion.

504 called upon support for the principle of the registered list remaining central and was almost fully supported by the conference.

505 was about working at scale allowing for improved practice resilience, flexible working arrangements and better integration of services. Conference was inclined to support this.

506 was that GPFV funding be allocated directly to individual practices so it will have a tangible effect at that level and not spent on management consultants. The policy lead however said that practical support was needed and not just money. Nevertheless the motion was carried.

507 was that the GPFV was failing to deliver resources to sustain general practice and demanded that GPC ballot GPs on a collective closing of patient lists in response. Mark Sanford–Wood responded once more, agreeing that the GPFV was failing, but pointed out that a previous survey had shown only a 34% positive response to closing lists. Legal advice had also indicated that a coordinated campaign would be judged a breach of contract and the BMA might be open to charges of incitement. The motion was carried nonetheless by nearly 2:1.

508 said how little practical help the GPFV had actually been to practices with "endless hoops to jump through to get a trickle of funding." Money was being wasted on management consultants and business cases with all the emphasis on 8-8 access. The emperor’s new clothes were mentioned by a speaker from Bedfordshire. Chaand Nagpaul had seen no improvement in London and it was already policy that the GPFV was inadequate. That said, the motion spoke of there having been “no change” but evidence from the country was that some improvements had started to be seen. Conference felt that no inroads had been made into recruitment and retention or workload by the GPFV.

As time slipped away before Somerset’s delegation had to leave motion 509 was about workload not being a defence against making mistakes and instructed GPC to negotiate a safe maximum number of patient contacts in a day. Limits to the duty of care expecting GPs to take on failings in other parts of the system with proper legal parameters to define where responsibility ends. Why should general practice never be able to declare it was at “black alert”? (Surely "OPEL 4"? Ed.) Mark Corcoran was concerned that we might fetter GPC with vague reference to “patient contacts” which could include matters other than face–to–face consultations. Brian Balmer who had written a safe working paper asked with whom GPC should negotiate?

He suggested professionals should limit themselves to 25 face–to–face contacts daily as a start. The Australian Royal College of GPs recommended that seeing more than 25 patients a day should raise questions about one's practice. The motion was not taken as a reference and carried.

And so we said farewell to the Edinburgh conference centre and set out into the evening to find a tram.

Barry Moyse