

**LMC UK Conference 9th March 2018 - Liverpool

Morning Session**

Richard Vautrey spoke for the first time as GPC Chairman and started by thanking his counterparts from the other devolved nations. Doctors expect to work hard from the beginning of their careers and would go the extra mile. This willingness had been exploited for years and he recalled the days of 1:3-4 rotas. Tired doctors were potentially unsafe then as they were now. Exploitation of goodwill was dangerous and we should admit it. The system was still looking to scapegoat and to blame and was not learning from experience. Mr Hunt was right to be concerned about the GMC’s decision to challenge its own committee. But just as importantly the system must learn from mistakes and change to prevent NHS staff ending up in dangerous situations. It could be him or anyone of us scapegoated next time. It was unsafe and unjust and had to change. Contract changes is Scotland had had this at its heart. In Wales QOF had been suspended to enable prioritisation of care of the sick. In England the Workload programme had been produced. In Northern Ireland a pharmacist was to be linked to every practice. He thought that every practice in England should be so supported with a linked pharmacist from recurring CCG funds. He argued that talking therapies were taking longer to get than ever and mental health services were over pressed. The primary care team needed rebuilding with linked MH workers. Indemnity presented problems to team development. For GPs it was worse with an "indemnity tax" charged just for working and no wonder OOH shifts were hard to fill and juniors did not want to be GPs. He welcomed the state-backed system and said all we wanted was equality with consultants.

Premises were another massive problem and practices were handing back contracts as new doctors would not buy-in to premises. Hospital doctors were not asked to invest in bricks and mortar. The NHS could share the risk to stabilise practices on the brink. A fundamental premises review was needed, learning from the Scottish experience, and commissioners could not bury their heads in the sand. The partnership model had been tested to destruction by a decade of underfunding but we should be proud that partnerships had been the foundation of the NHS for 70 years. Their links to the community with business owners on the shop floor caring for patients with resilience and flexibility were second to none. It had even survived PCSE. Partnership and the registered list were under risk as out of area regulations were abused allowing access for the young and fit take priority over long term continuity of care for the sick. The partnership model needed reinvigoration by none could survive lack of funding. GPs had lived through Pharaoh’s Dream as a nightmare. No wonder the British Social Attitudes survey had shown a fall in satisfaction with services. GPs agreed. The 2008 banking crisis, a decade of austerity and now paralysis over Brexit had all harmed the NHS. GPs had seen pay cuts in actual and real terms for eight years. This attrition must end for the sake of recruitment, retention and morale. But the BMA was not just after more pay but new, recurring funding to build the workforce, for longer consultations, better IT, community services, locality working and to turn back patient satisfaction. In some parts of the UK governments had listened but all too often warm words had led to more money for hospitals. Despite the huge daily challenges GPs were doing their best and the GPC was doing it best to help them. We were stronger together and together we would make things better. Dr Vautrey spoke for some 18 minutes and received a standing ovation of less than one minute.

The first motion proposed by Hampshire & Isle of Wight enjoined us to celebrate the partnership model which just keeps on going. But modernisation was necessary to help partnerships to survive. A young Kent GP spoke against an incentive scheme to take permanent posts saying that it risked reducing the buffer provided by locum and sessional GPs and denigrated sessional GPs. Money was not the reason for fewer partners as so many portfolio GPs were ex-partners. Dr Ali from Plymouth spoke of the problems of well-founded practices failing because of the shortage of partners. Another spoke against the section recommendation that non-GP staff should become partners as she felt this sent a conflicting message to the government. She thought that no matter how many "Noctors" were put in the buck always stopped with GPs. A doctor from Cambridgeshire argued that none of the brave schemes in recent years, including the FYFV, had lacked leverage. The support needed to be made contractual and so real. Another young doctor had the temerity to argue against the reintroduction of seniority payments which he described as a "sticking plaster." Another brave young GP said he felt that GPC and older GPs were not really interested in younger GPs. It was a dangerous time to be a GP. It was time to acknowledge this with legislation and just rewards to reflect the workload and great risks run. The motion was carried but the section encouraging more non-medical partners was lost.

We were next invited to acknowledge the role of the wider skill-mixed team and pushing for direct, full reimbursement for employment and sickness costs. Against the motion a speaker felt that this was risking not properly funding general practice and would simply encourage more bureaucratic schemes. Another young GP from Kent (figuring prominently in these early stages) spoke in favour of the motion saying that other people could tick the boxes. A speaker from Sefton felt that direct reimbursement would restrict practices' abilities to choose skill mix and would be an effective step towards a salaried service. The spirit of the motion was to be supported but there would be unintended consequences for preferential funding of practices unable to attract partners. The proposer was happy for the motion to be taken as a reference and so not constraining GPC on policy which was duly agreed.

Mark Corcoran was elected unopposed as Conference Chairman for next year.

Dr Shaba Nabi spoke about her experiences worrying about the "last man standing" crisis that had led her to leave her partnership. Now her practice in a deprived part of Bristol was to hand back its contract. A proper dispersal policy was needed to avoid a domino effect. There needed to be a public information campaign about the vulnerability of practices as they had no idea. Her practice had needed its PMS monies but no money was available however there was money for working at scale and for third party organisations to take over smaller practices. Matt Best from Devon spoke about the Plymouth experience where a quarter of the population had no permanent provider of primary care. Mark Sanford-Wood, Chairman of the Committee, encouraged conference to support the motion which it did unanimously.

The Chairman of GPC Scotland made an interesting report and said how damaging cynicism was to progress and it was necessary to assume good intentions on the other party and this building of trust was challenging but absolutely necessary to progress. In order to take things forward it was necessary to persuade other parties such as the national government. In Scotland the profession had persuaded them that traditional general practice was the answer to demographic change that meant the status quo could not continue. It had taken three years to establish the principles, not the details, of what was necessary in what was probably the most consulted upon contract ever. Ultimately a special conference of LMCs had strongly agreed that the proposals would strengthen and make more sustainable general practice. A poll of all doctors had supported the new contract by 71.5% of the vote. Even so there was to be no "Big Bang" or "magic wand" but £250m had been released to start making changes. Trusting relationships, well established, would help agree transition plans. The GP would become an expert medical generalist leading the team that would take over other roles but without loss of income as services gradually came out of the contract. There would be no loss of income for any practice. There was a new income and expenses guarantee. Each practice would complete an income and expenses report to make sure that the changes were not causing trouble. On premises there would be a 20% release of equity in the form of an interest free loan. Leases would be taken on by health boards. A shared data protection officer had been agreed. Professionalism and quality would be studied at practice and cluster level. LMCs would be involved on advising where money should be spent in future to improve quality. A new era of NHS management was envisaged which would have the "manners of the dining table rather than of the boxing ring."

Interestingly, it was a GP from Cumbria that proposed we should learn from the Scottish experience and wished that the border could be moved 30 miles, extolling the virtues of the new contract especially on premises. Cambridgeshire said that, despite the hard work done by GPC, "Saving General Practice" and the GPFV were just "wish lists." Precious time and effort were being wasted without real contract changes. A doctor from there spoke of four young colleagues moving to Australia. No scheme would keep them here. No more well-intentioned glossy documents would help. The refrain was, "make it real, put it in the contract." The Scottish Chairman reminded us that a willing partner in government was necessary to make contract changes. Richard Vautrey said it was the strength of GMC UK that English negotiators could learn from experiences elsewhere. The motion was carried.

Northamptonshire proposed that GP premises be fully resourced to meet the needs of the population. He recounted the promises broken by governments over the years at the same time as CQC was criticising inadequate buildings. All practices taking on new leases should have stamp duty land tax reimbursed to ensure equality. NHS Property Services came under scrutiny where 100s of practices now faced disastrous charges for woeful services. No increased costs could be "passed on to the customer" and practices were frozen in time as partners could not retire given the unknown future liabilities. Colleagues' health was suffering. GPC should "stand up to the bully." There was no opposition.

There was a debate about online consulting and how useful this could be but not used to cherry pick by private providers even if they were linked to NHS practices. It was carried.

Next we discussed the new GDPR which has, doubtlessly unintended, consequences of bureaucracy and potentially crippling fines against which there was no insurance as the offence would be criminal. We would also be liable for personal damages. It was argued that practices could not be a sole provider data controller. A speaker from N Ireland suggested that this would be the most important topic discussed today. There should be a review on the application of the GDPR for primary care recognising that the DH did not want this anyway. Grant Ingram from the GPC argued strongly against the DPO being out with the practice reminding us that we had rejected a similar motion in the past. Costs inherent in the GDPR should be reimbursed. The motion was carried in all its parts.

The themed debate which followed was on workload control. The GPC policy document was outlined. We heard how the GMC had written to all doctors asking for reports of unsafe working. LMCs could collate all such incidents in mass reporting. The GPFV had promised reduced workload but, to make it real, it needed to be in the contract. The most efficient part of the NHS was drowning and should learn from Scotland: another three years of collaboration would sink it. A new contract allowing GPs to say yes was needed. Another speaker said we should do less for less, not more for less. The conveyor belt was unsafe and resilience should not mean more risk-taking. There was evidence that people listened to weather forecasts and OPEL alerts but no one listened to us. A shrinking workforce could not sustain the political ambition of 7/7 working and would only lead to less safe practice and more expensive hospital admissions. We were haemorrhaging GPs either retiring or reducing clinical commitment. The UK population had increased by 40% during the lifetime of GP who is over 55. Another speaker questioned some practices seemed proud of doing 20 visits a day when doctors abroad did none and why did no one want to see a GP during a Royal Wedding? We would be best to look at our working practices or else the money would follow the patients to the hub. A Kent GP said we are working like drink drivers, taking a risk. This had been forced upon us by the government. We had to be empowered to say no. Clinical situations were growing in complexity - GPs could not do it all and young doctors would hardly want to take over from stressed, miserable senior colleagues. At a conference in Paris it was clear that GPs across Europe were far from happy with many of the same things we did. Consistently a figure of 25 consultations was raised. A speaker from Cambridgeshire said the GPC document did not go far enough and substantial change was needed. "Make it real and put it in the contract" she said. The "all you can eat buffet" of GP was mentioned and he felt colleagues could not justified in wearing overwork as a badge of honour. Nick Bray spoke of the value of proper data collection in primary care and the Somerset experience during the flu outbreak and how primary care had been supported by secondary care when some real figures were available. The loudest applause came for a GP who said we should take back control of what was needed and not patients. Who would man the hubs? We would be robbing Peter to pay Paul. Home visits for all that wanted them. Why were consultation rates two or three times higher in the UK than in similar EU countries? One doctor noted that the consultation rate in Eire was half that of N Ireland. This was almost certainly due to payments being involved. We could not just move the free for all NHS bottomless pit from practices to hubs. The workforce crisis was because of the workload Helena McKeown argued and it was making GPs sick. The hub model would do nothing for demand and be to the detriment of continuity of care. There was a risk that the hubs would be like New Labour's treatment centres and could also be floated off to the private sector. On the other hand a GP that worked for a hub said that doctors were flooding to work there, seeing 12-13 patients a session and no paperwork to speak of. All practices should be like that. Peter Swinyard amused the conference with talk of 5000 more GPs. He said that Eire's GPs still complained and they earned Euro 160k a year. Hubs did not do the whole job. A doctor spoke movingly of the personal experience of burnout and her telephone counselling. She did not require to become more resilient - she needed the GPC to become more resilient. She received a longer and warmer standing ovation than Dr Vautrey.

There was a vote on the principles in the paper. This was a graded vote with possible scores of 1-6 and conference averaged strong support. Next was on specifying work load limits which was overwhelmingly supported. Working to make resources to help localities was agreed and the locality approach was also supported but by far less a margin. The collection and publishing of hub-based working examples was also agreed.

**Afternoon Session Report**

After lunch and questions to the GPC the conference was addressed by the sessional GPC representative, the up and coming, Zoe Norris who reported positively about how LMCs were now including sessional GPs. Some with dedicated seats and others were able to establish representation that was reflective of the balance of the workforce. OOH GPs were still hard to contact. Some bad news included an extraordinary story of a sessional GP being told that if s/he stood for LMC they would not get any locum work. Elsewhere an LMC put a retired partner into the sessional seat without an election. She thought the focus needed to change now to help sessional GPs understand how they needed their LMC. Dr Norris is widely tipped (well by your correspondent anyway) as a future GPC chair. She ended with - guess what? - make it real and put it in the contract.

There was a flurry of self-congratulation over the address to conference for the first time by the trainee-subcommittee chairman, Thomas Micklewright. He told us that general practice was not “plodding along" and so the views of the doctors of the future needed to be taken into account now. Experiences of trainees in OOH work was often particularly poor with only telephone supervision and so depriving the service of the next generation of OOH doctors. More trainees were taking time off owing to ill health. In Wales there was still an expectation of trainees working OOH and then having to work during the day. He was delighted that 2/3 of LMCs had dedicated trainee seats. He asked LMCs and the BMA to reach out to trainees and for the government to urgently address burn out and dangerous practice reported by GP trainees. The future of the profession was to “freeze [on the picket line] and to fight together.

Next was the GP subcommittee chairman who made many of the same points during a motion expressing concerns about the proposed 3+1 training scheme which would lead to training GPs being “rota fodder” for hospitals. The next motion again considered trainee GP OOH work. Plenty of notice and proper supervision should be given. Fay Wilson who works in OOH in Birmingham questioned the part of the motion which appeared to suggest that training GPs needed direct supervision at all times.

There then followed an important debate about the Bawa-Gabar case and reflection in appraisals. The argument was that the statements from GMC and NHSE were not reassuring and that therefore GPC should direct doctors to defend themselves. There was no confidence in the DH inquiry into manslaughter charges would be behind closed doors and should instead be conducted by the cross party Health Select Committee. We heard how the GMC seemed to have given up any pretence to look after doctors' interests in “the public interest” and a gruesome analogy was made with the old practice of the condemned to pay the headsman in the hope he'd do a good, quick job with the axe. We were urged not to pass a motion of no confidence in the GMC by a speaker bearing in mind that our reflections on failings could still be subpoenaed by a Judge. Mark Sanford-Wood told us that the chairman of the Health Select Committee wanted no part in any enquiry. He felt that passing a vote of no confidence in the GMC would not help the GPC’s negotiations. It was clear that the motion would be passed overwhelmingly in all its parts.

Motion 26 was also about reflection for GP and trainees in appraisals and e-portfolios and the proposer suggested that increasing lawyers would be calling such reflections in evidence. Speakers agreed that reflection was a vital part of training and practice but that it could never be used to help apportion blame for systemic failings. The motion which said that we should be aware of the risks was passed unanimously.

The next debate was about the use of gross negligence manslaughter allegations and called for a change in the law. No doctor went to work to do harm. Every avoidable death was a tragedy for all concerned and the criminalisation of clinicians was wrong when systemic failings were often to blame and when valuable lessons could be otherwise learned. There were no speakers against the motion which was supported by subcommittee chair Dr Mark Sanford-Wood. It was passed without demur.

The next motion was about the use of unrealistically high standards in the assessment of practitioners' and practices' assessments. He called for the restitution of the “reasonable peer” or Bolam tests. Note taking was judged against the highest RCGP standards and clinical standards against NICE guidelines. There was no consideration of mitigating factors when applying theoretical standards of excellence. A doctor from Derbyshire spoke of a rapid consultation he had made on a care home patient which a relative had persistently complained, despite the patient coming to no harm. His brief note taking had been judged on behalf of the GMC by an ED consultant who had criticised his failure to record a hospital-based sepsis score. We must be judged by our peers. Another speaker recounted the vast amount of NICE guidance a GP should know, amounting to 25,000 pages. How many had access to expired nitric oxide measurement? We had to go back to the Bolam principles. There was no dissent.

The fun continued with discussion of Performance Advisory Groups and other investigatory groups, how complainants can remain anonymous, and that proceedings are conducted behind closed doors and the need for independent oversight. The effects on colleagues could be devastating. The chairman of subcommittee had no strong objection and the motion was passed overwhelmingly.

After a very interesting soap box session, during which the propensity of NHS111 to dispatch an ambulance and the good idea of offering every retiring GP an exit interview was among the ideas discussed, we moved on to the discrimination inherent in moves to restrict the prescription of OTC drugs. At the very least, in remote areas, dispensing doctors should be allowed to sell OTC medicines. Another speaker spoke of the lack of choice patients who live within a mile of a pharmacy have to choose to obtain drugs from a dispensing practice. The Chairman of the committee spoke of the need of ineffective drugs to be blacklisted and the protection of vulnerable patients so they can obtain medication. There were no speakers against any part of the motion which was supported overwhelmingly.

Then conference considered a motion about the shifting some work back to hospital from primary care. The mover, from N Ireland, wanted the standards in the English national contract to be applied across the UK. Hospital letters should be standardised and the clinician who ordered a test should deal with the result. It was simply best practice. A speaker from Cambridgeshire however was against a tariff applying for work that was dumped on us. Paul Hynan from Devon addressed discharge summaries having attended a RSM workshop on this topic where he had found a good understanding of GP workload. Nevertheless it was vital that these documents were of the highest standard at that trusts applied them. A speaker from Tower Hamlets spoke against applying sanctions for breaches in contract conditions. A speaker from Leicestershire said that GPs had bailed out secondary care for far too long; there really is not the time for it anymore so he supported sanctions. A speaker from Buckinghamshire opposed the motion suggesting that there was a business opportunity in applying a tariff for taking on some workload chasing up swab test results. Conference took the four nation application as a reference (as Scotland and Wales do not have a commissioner-provider split. The section on applying a tariff went to an electronic vote and was passed by a small margin. The section on sanctions being applied to trusts was lost.

The Somerset delegation left at this point but Dr Gus Robins undertook to report on the last few motions which concerned the length of the UK conference and the duties of GPs in matters of immigration law.